



Your voice, one vision

Consultation report 2017

*Review of the Queensland Mental Health, Drug and Alcohol
Strategic Plan 2014–2019*

Acknowledgements

We pay our respects to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal people and Torres Strait Islanders, their culture and customs across Queensland.

We also acknowledge people living with mental health and alcohol and other drug problems, as well as those impacted by suicide, and their families, carers and support people. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and able to focus on wellness and recovery, and have fulfilling lives.

Graphic recording, at its most simple, is a drawing of a conversation in real time.

The Commission captured conversations at the community forums to help visualise discussions, identify themes, and aid in the understanding of key concepts.



The images used throughout this report come from the Townsville and Brisbane forums and we'd like to thank those people for their valuable contributions as well as Jimmy Patch, graphic recorder, who added a dimension to those discussions.

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Commissioner's message

The mental health sector in Queensland and nationally has seen significant investment and undergone many changes over the past thirty years. Today, we see the shift away from people being institutionalised to the strengthening of human rights, evolving community models of care, and the increasing engagement of people with a lived experience. However, the prevalence of mental illness has not changed and more needs to be done to improve outcomes for Queenslanders.

Even with substantial systemic changes and investment by government, further effort is required to align investment, reform and outcomes.

Investment in the alcohol and other drug sector has not experienced the required level of growth, yet the nature of harms and the people experiencing problematic use have changed. Suicide rates in Queensland and nationally have been increasing and the toll on families, carers, friends, work colleagues and communities continues to leave lasting impacts. And people living with mental illness are still experiencing difficulties in accessing the supports and services needed in a timely manner. Some people are still falling through service gaps.

But there are good reasons to be optimistic and I believe that collectively we can make a difference. It is evident that no one agency or sector can do this alone and for the Commission to lead reform all key stakeholders must work together. Even though we have seen an increase in sectors working together, there is still a great deal more to be done.

Similarly, the siloed architecture of our service delivery system means that increased government investment is not having the required impact. This has been recognised at the national, state and local levels and there is growing evidence to suggest that joint planning and investment by the Primary Health Networks (PHNs), Hospital and Health Services, and the non-government sector is having a positive outcome. However, it is early days and close monitoring of this arrangement is required.

We were privileged that so many people shared their expertise with the Commission during consultations to renew the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*. This process has ensured our efforts are focused on the changing needs of Queenslanders.

As Commissioner, I would like to take this opportunity to personally thank the many people who shared their stories and journeys with us—who entrusted us with their experiences, often highly personal and traumatic, and who took the time to share with us what they believe has worked and what requires change. Your resilience, courage, generosity of spirit and commitment to hope for a better tomorrow is an inspiration to us all.

We hope to honour the trust you have placed in us to work with the public, non-government, private sectors, and the broader community to develop a renewed strategic direction, and to create long-term, sustainable outcomes for improving the mental health and wellbeing of all Queenslanders.



Ivan Frkovic
Queensland Mental
Health Commissioner



Executive summary

Three years since the release of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan), we have seen considerable reform at both the national and state levels. Many initiatives have been implemented that strengthen the service system and other changes will fundamentally change the way services are delivered.

There is now a need to realign our Strategic Plan to complement these reforms and build on its implementation to date. To set the direction going forward, the Queensland Mental Health Commission (the Commission) has set about reviewing the Strategic Plan and renewing our direction.

Our renewed direction must not only be based on research and evidence of what works, but also on the views and experiences of people with lived experience, their families and carers, service providers, and the broader community.

The Commission commenced reviewing the Strategic Plan in February 2017 and sought views from stakeholders about ways to:

1. improve and increase the engagement of people with lived experience, their families, carers and support people in the mental health, alcohol and other drugs and suicide prevention sectors
2. improve the mental health and wellbeing of Queenslanders
3. prevent and reduce the impact of mental illness
4. prevent and reduce the impact of problematic alcohol and other drug use
5. prevent and reduce suicide.

More than 250 stakeholders shared their views about these issues with many sharing the stories of their own personal journey with the Commission through written responses to discussion papers, at community forums held across Queensland and at roundtables. This report outlines the main issues raised by stakeholders, including people with lived experience, their families, carers and support people as well as policy, planning, service managers and frontline service providers from a wide-range of sectors.

While many of the issues raised were not new—the Commission heard that progress has been made in many areas—there is a need to systemically embed good practice to achieve sustainable change and improve outcomes for Queenslanders.

The findings outlined in this report, will inform future discussions with the State Government and other key stakeholders to develop and implement a renewed Strategic Plan.

Introduction

Mental health and wellbeing is important to all of us—our families, our community, governments and the economy. It plays a significant role in how we interact with each other, how well we learn and work and feel, and are included and participate in the community. It is fundamental to preventing and reducing the impact of mental illness, problematic alcohol and other drug use and suicide.

Improving mental health and wellbeing requires all of us, from across many sectors and levels of government and the broader community to work together towards a shared goal.

To drive reform towards improving mental health and wellbeing, the State Government released the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan) in October 2014. Developed by the Queensland Mental Health Commission (the Commission), the whole-of-government Strategic Plan sets a platform for change through the collective actions of State Government agencies over three to five years.

Three years on, and we have seen significant reform occurring across sectors and at the state and national levels within the health sector and beyond. State Government agencies have implemented more than 200 actions, many of which strengthen both the service system and reform the way Queenslanders receive supports and services.

In light of this progress and reform to date, it is important we renew the Strategic Plan and our direction, and set a path for continued progress towards improving outcomes for Queenslanders.

Our renewed plan must place the needs of Queenslanders at the centre. Not only should it be based on evidence and research but it also needs to be grounded in the everyday experiences of people with lived experience, their families, carers and support people, frontline service providers from all sectors, and the broader community.

This report outlines what the Commission heard from more than 250 stakeholders during public consultations and roundtables to renew our Strategic Plan and update action plans. It does not set out everything we heard but summarises the main issues raised by people across Queensland and which will be the foundation for reform into the future.

The Strategic Plan

The whole-of-government Strategic Plan seeks to realise a vision shared by all stakeholders that Queensland is:

a healthy and inclusive community, where people living with mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society.

To guide our collective efforts, the Strategic Plan sets six long-term outcomes:



1
A population with good mental health and wellbeing.



2
Reduced stigma and discrimination.



3
Reduced avoidable harm.



4
People living with mental illness and problematic alcohol and other drug use have lives with purpose.



5
People living with mental illness have better physical and oral health, live longer and have the same life expectancy as other Queenslanders.



6
People living with mental illness and problematic alcohol and other drug use have positive experiences of their treatment and support.

The Commission, in partnership with other agencies, including the Queensland Government Statistician's Office, has identified indicators to measure progress towards achieving the six long-term outcomes. Two Annual Indicators Reports have been published by the Commission in 2015 and 2017. It is not possible at this stage to know whether sustained improvements have been made, however the indicators provide an important guide to directing our efforts.

Renewing our plan

Although it is too early to know whether sustained improvements have been made towards achieving the six long-term outcomes, there is a need to continually align our efforts with reforms and emerging issues and building on progress that has been made to date.

The Commission commenced reviewing the Strategic Plan in February 2017, focused on five main issues:

1. improving and increasing the engagement of people with lived experience, their families, carers and support people in the mental health, alcohol and other drug and suicide prevention sectors
2. improving the mental health and wellbeing of Queenslanders
3. preventing and reducing the impact of mental illness
4. preventing and reducing the impact of problematic alcohol and other drug use
5. preventing and reducing suicide.

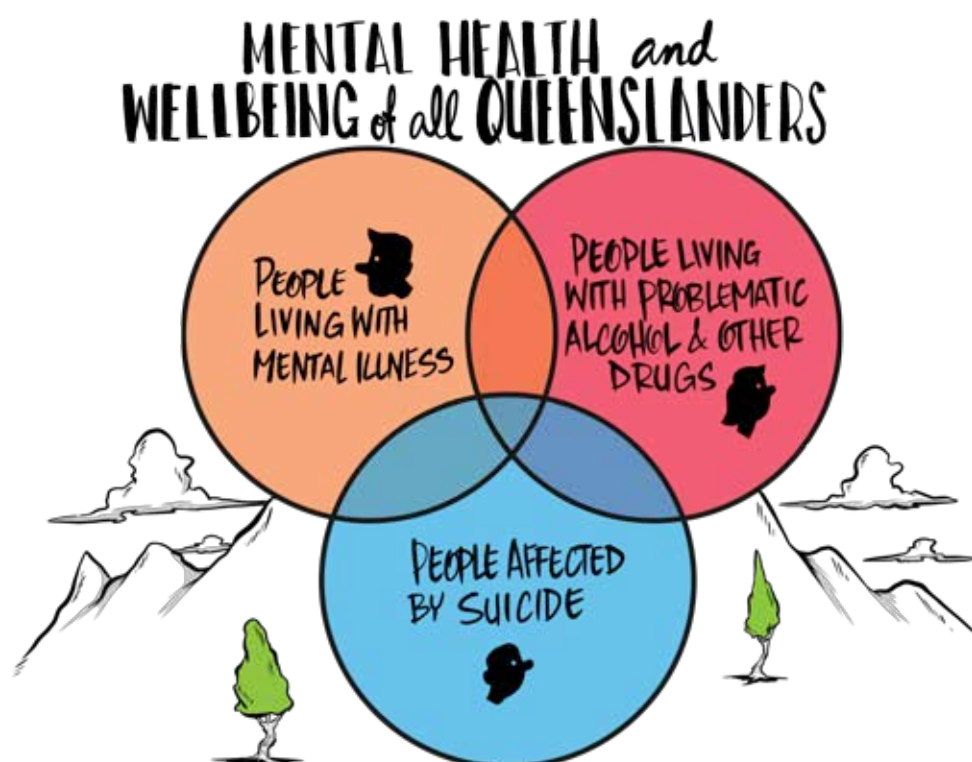
To shape our renewed direction, the review is taking into account what has been achieved so far under the Strategic Plan and national reforms. Most importantly, it will take into account not only the views of system leaders and decision-makers, but also the views of people across Queensland who have a lived experience, have a family member or care for someone with a lived experience, deliver services on the frontline, and the broader community.

What we have achieved so far

The Strategic Plan commits to identifying and implementing eight Shared Commitments to Action. Work to implement the eight Shared Commitments to Action has commenced and in many areas is well advanced. Some actions have resulted in systemic reform and others have strengthened the service system.

In the health system, reforms include the new *Mental Health Act 2016* and the *Connecting care to recovery 2016–2021: A plan for Queensland's State-funded mental health, alcohol and other drug services* (Connecting Care to Recovery).

In other sectors, reforms and service enhancements have and will make a significant contribution to improving mental health and wellbeing. They include: mental health coaches to better support schools; the *Queensland Government's Response to the report of the Special Taskforce on Domestic and Family Violence* (Not Now, Not Ever report); and the roll-out of the National Disability Insurance Scheme.



The Commission, in partnership with government and non-government agencies, also developed whole-of-government action plans to implement the Strategic Plan:

- *Early Action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015–17*, which aims to improve the mental health and wellbeing of Queenslanders and to reduce the incidence, severity, and duration of mental illness (Early Action Plan).
- *Queensland Alcohol and Other Drugs Action Plan 2015–17*, which aims to prevent and reduce the adverse impact of alcohol and other drugs on the health and wellbeing of Queenslanders (Alcohol and other Drugs Plan).
- *Queensland Suicide Prevention Action Plan 2015–17*, which aims to reduce suicide and its impact on Queenslanders as a step towards achieving a 50 per cent reduction in suicides within a decade (Suicide Prevention Plan).

In 2016, the Commission released additional actions plans focused on communities experiencing higher rates of mental illness, problematic alcohol and other drug use, and suicide:

- *Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18*, ‘Proud and Strong’, which aims to improve social and emotional wellbeing for Aboriginal and Torres Strait Islander Queenslanders (Aboriginal and Torres Strait Islander Plan).
- *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–18*, which aims to improve the mental health and wellbeing of people living in rural and remote Queensland (Rural and Remote Plan).

Across the five action plans, 26 State Government agencies committed to implementing 283 specific actions. The Commission will be reporting on implementation of all 283 actions in the 2016–17 Annual Implementation Report.



Connecting Care to Recovery 2016–2021: A plan for Queensland’s State-funded mental health alcohol and other drug services (Connecting Care to Recovery) was released on 10 October 2016 by the Minister for Health and Minister for Ambulance Services. It sets the direction and highlights priorities to enhance the state funded mental health, alcohol and drug services system to more effectively respond to people with the most severe mental illness or problematic alcohol or other drug use. It sets five priority areas:

1. access to appropriate services as close to home as practicable and at the optimal time
2. workforce development and optimising skills and scope
3. better use of information and communication technology (ICT) to enhance clinical practice information sharing, data collection and performance reporting
4. early identification and intervention in response to suicide risk
5. strengthening patient’s rights under the *Mental Health Act 2016*.

Future enhancements under Connecting Care to Recovery are focused on developing the range of service models across the care continuum, in particular, for community treatment, community support and community bed-based services. Significant new investment is targeted toward building and establishing additional adult and youth step-up step-down services, new residential services for young people, and crisis residential services for adults.

Over five years, Connecting Care to Recovery will deliver a range of service enhancements, covering:

- additional perinatal and infant mental health services
- child and youth initiatives
- adult mental health services and older adult initiatives
- resources for implementing the *Mental Health Act 2016*
- new investment in alcohol and other drug services
- enhancements to forensic and prison mental health services
- improvements to state-wide and specialist mental health services
- mental health, alcohol and other drug workforce initiatives.

A measurement strategy and an evaluation framework have been developed to assess outcomes related to the implementation of Connecting Care to Recovery, specifically service delivery improvements and the impact on the lives of people accessing public mental health, alcohol and other drug services. Evaluations will be undertaken at two-year intervals over the life of the plan, as well as a final summative evaluation.

Renewing our plan (*continued*)

National reforms

Our strategic direction must complement reform at the national level. The State and Federal Governments working together is most likely to make a difference.

There have been considerable national reforms across a wide-range of areas. Within the health system, reform has been largely driven by the Australian Government Response to the National Mental Health Commission's Review of Mental Health Programmes and Services¹, and the establishment and regional coordination role of Primary Health Networks (PHNs). Reform has also continued in the alcohol and other drug sector, with a strong focus on reducing the impact of crystal methamphetamine (ice) through the *National Ice Action Strategy 2015* and the finalisation of the *National Drug Strategy 2017–2026* (the National Drug Strategy).

Actions to support the implementation of the *National Ice Action Strategy 2015* are being developed through the Queensland Government's *Action on ice* draft plan.

Consultations with stakeholders

The views of people with lived experience, families, carers, supporters, service providers and community members are very important in grounding reform in the everyday experiences and needs of Queenslanders.

To hear these views, the Commission undertook extensive consultations across Queensland, commencing in February 2017 by:

- publicly releasing two discussion papers
- hosting nine community forums
- hosting roundtables and facilitated discussions.

Discussion papers

On 14 February 2017, the Commission released two discussion papers for public comment:

1. *A renewed plan for Queensland* which sought feedback on how to improve mental health and wellbeing and to prevent and reduce the impact of mental illness, problematic alcohol and other drug use and suicide.
2. *Engaging people with a lived experience: Renewed priorities*, which sought feedback on how to improve and increase engagement of people with a lived experience, their families, carers and support people in the mental health, alcohol and other drug and suicide prevention sectors.

The Commission directly sought feedback from specific stakeholders, including: all Hospital and Health Services Board Chairs and Chief Executive Officers, Queensland Primary Health Networks (PHNs), local councils, the Queensland Mental Health and Drug Advisory Council, and peak non-government organisations.

The Commission also sought feedback from organisations representing people from culturally and linguistically diverse backgrounds; disability advocacy groups; organisations that support lesbian, gay, bisexual, transgender and intersex (LGBTI) people; and Aboriginal and Torres Strait Islander Queenslanders

The discussion papers were promoted through the Commission's website and social media platforms, and by the Commission's partners in the non-government sector.

Community forums

The Commission hosted community forums in nine communities. Forums in eight communities were held over two days, with the first day focused on hearing the views of people with a lived experience, their families, carers and support people, and the second day open to local service providers and members of the public. The Commission also sought the views of young people at a forum hosted by the Noff Foundation in Southport on 7 July 2017.

Community	Date
Rockhampton	13 and 14 March 2017
Mount Isa	23 and 24 March 2017
Ipswich	28 and 29 March 2017
Brisbane	10 and 11 April 2017
Townsville	8 and 9 May 2017
Cairns	10 and 11 May 2017
Toowoomba	1 and 2 June 2017
Logan	29 and 30 June 2017
Southport	7 July 2017

The Commission was supported by members of the Queensland Mental Health and Drug Advisory Council, as well as peak non-government organisations to promote the community forums in their local communities and within their sectors.

Roundtables and facilitated discussions

A Lived Experience Roundtable was hosted by the Commission on 15 May 2017 in Brisbane. The roundtable aimed to develop a shared goal and future directions for increasing and improving the engagement of people with a lived experience, their families and carers, to influence the system and to strengthen the peer workforce and peer networks.

Roundtables and facilitated discussions were also hosted by the Commission to update the Early Action Plan, Alcohol and other Drugs Plan, and the Suicide Prevention Plan.

What we heard



The Commission heard from more than 250 people at the community forums. Around 38 per cent of people attending the forums said they had a lived experience and 61 per cent indicated they were a family member, carer, support person or friend of a person with lived experience. A similar proportion advised they worked for a government agency (40 per cent) or non-government agency (41 per cent)^a.

The Commission also heard from a wide-range of stakeholders from across sectors at the roundtables and facilitated discussions to update the action plans.

The Commission received 32 submissions in response to the discussion papers, including from individual members of the community, service providers, researchers and peak bodies.

The Commission heard from a diverse range of stakeholders with different backgrounds and experiences.

While many of the issues raised by stakeholders are not new, and more needs to change, in many areas stakeholders told the Commission that progress has been made. They confirmed a need to continue building on what has been achieved to date and adopt a systemic approach to embedding good practice as core business.

^a The percentages are based on 202 people who completed the voluntary evaluation forms at the community forums. A number of people indicated they had both a lived experience, were a family member, carer, support person or friend, and were also a service provider.

Overarching reform

Our stakeholders identified a number of overarching systemic issues which impact our efforts to improve mental health and wellbeing, and prevent and reduce the impact of mental illness, problematic alcohol and other drug use and suicide. These issues help us to identify areas of reform across all levels of government and direct our attention to systemic change which:

- puts people first
- balances the system
- improves coordination, collaboration and integration
- tailors responses for vulnerable groups and communities
- adopts a whole-of-population approach.

People first

One of the most consistent themes to emerge during the consultation was ‘people first, not the system’. Throughout all community forums, stakeholders expressed a view that services are often designed from the perspective of those working in the system. This presents a significant challenge for people trying to get the help they need for themselves and their loved ones.

The Commission heard that this results in people needing to navigate multiple services to get the right support, at the right time. Services are often not available when needed the most—on weekends and after hours. The Commission heard of people falling through the ‘gaps’ because they do not meet service eligibility criteria, and of services not adopting a holistic approach to providing support.

Many service providers the Commission consulted with acknowledged these issues and noted that funding arrangements and resource allocations, as well as procedures and policies, prevented them from adopting a more flexible approach to service delivery to meet the needs of people accessing their supports.

Together, community members and frontline service providers identified a need to design, resource and operate a system which is focused on the needs of Queenslanders. There was a particular call for services to be arranged around people, rather than relying on people’s ability to navigate multiple services and providers.

There were also strong calls for better engagement between services and local communities to build relationships and trust and to improve access. Consultations revealed that low cost engagement can be effective and can change the way services operate: from one which waits for people to come to them, to one which reaches out and connects with the community they serve.

There were a number of examples of good practice being implemented in some parts of the state where service providers were working together to address these issues but they were largely dependent on the interests of individual staff and organisations.

A balanced system

Stakeholders, from across a wide-range of sectors, have called for greater investment in programs that seek to promote good mental health and wellbeing and prevent mental illness, problematic alcohol and other drug use, and suicide.

This includes investing in services that reduce harms and promote recovery, and reduce the likelihood of mental health or problematic alcohol and other drug use developing and reoccurring: rather than a focus solely on treatment and late interventions.

Stakeholders pointed to compelling evidence that investing in policies, programs and services that promote wellbeing, and seek to prevent mental health and problematic alcohol and other drug use has benefits not only for individuals, but also for families and the whole community.

The Commission heard that the system is designed and funded to provide support only after the signs of poor mental health or problematic alcohol and other drug use or self-harm become apparent, or at the point of crisis. Many saw this as a lost opportunity. By providing supports early when a person shows the first signs of being at risk or experiencing difficulties, stakeholders strongly agreed that we can prevent and reduce the impact of mental illness, problematic alcohol and other drug use and suicide. We can prevent a substantial amount of distress, dependence, disability and harm as well as reduce the demand on acute services.

Many stakeholders noted that investment in tertiary services, such as hospitals and community-based acute care is important, but that in the medium to long-term, the demand on these services can only be reduced through an increased focus on prevention and early intervention and services which focus on a holistic approach to recovery.

It was noted, however, that increased funding for preventive programs, low intensity services and supports, and recovery services can help reduce and stem demand for more expensive acute services.

Better coordination, collaboration and integration

Greater coordination, collaboration and integration within and between services is integral to a recovery-oriented system, which places people first.

The Commission was told that no single service can solely meet the needs of individuals. Collaboration between a range of clinical and non-clinical supports is often required to ensure a person's recovery goals are met.

This requires an ability to adjust—as needed—the frequency and intensity of care and support being offered, through step-up and step-down supports, providing easy access to low intensity interventions, through to specialised treatment and recovery support services.

Similarly, collaboration and coordination between different levels of government, private and non-government organisations is required to deliver programs, such as whole-of-community mental health awareness programs, and those that reduce harms associated with problematic alcohol and other drug use, as well as reduce the impact of suicide.

Many stakeholders were optimistic that joint planning between Primary Health Networks (PHNs), Hospital and Health Services, and local providers is contributing to a more coordinated approach to mental health, problematic alcohol and other drug use, and suicide prevention at a regional level.

Others have raised concerns that an increasingly complex set of regional, state and federal planning processes and funding streams is making it difficult to implement programs and services with a state-wide reach, potentially contributing to duplication of activity, and a loss of focus and impact.

Some stakeholders gave examples of multiple organisations in a region being funded to deliver the same or similar programs and services. This results in duplication in some areas and gaps in others.

Examples were also given of efforts to improve coordination, for example, a Hospital and Health Service engaging with local council and community service providers to plan and coordinate responses to people experiencing severe mental illness.

However, participants were concerned that the examples of good practice were limited and that more needs to occur. Some of the barriers faced, included a lack of resources to undertake coordination and collaboration activities, and competition for funding, which impacts on the willingness of services working together.

Tailored responses for vulnerable groups and communities

Across Queensland, stakeholders identified a number of groups who were either experiencing higher levels or were at greater risk of mental health problems, mental illness, problematic alcohol and other drug use or suicide.

Key among these groups were young people, seniors, Aboriginal people and Torres Strait Islanders, people living in rural and remote communities, LGBTI people, and people from culturally and linguistically diverse backgrounds. Some stakeholders indicated that people living with chronic health conditions or disability were also experiencing higher rates.

The needs and circumstances of these groups were all different but one of the common issues identified by stakeholders related to social exclusion and marginalisation.

There was a call for more tailored approaches to address the specific needs of these groups as well as ensuring mainstream and specific services were better able to work together.

For some groups, limited access to support services, such as LGBTI support services for young people, meant they were required to travel long distances and in some instances not able to access supports at all.

Concerns about services in rural and remote Queensland fully operating in a sustainable way were raised. These concerns, particularly in remote areas, included recruiting and retaining appropriately qualified and experienced staff. Some services indicated they needed funding to provide incentives to initially attract people, as well as to retain them long enough to develop a rapport with the community and their clients. Options such as using technology and telehealth were also identified as providing viable options for delivering access to services.

More culturally capable services were identified as an important part of a service system able to support the social and emotional wellbeing of Aboriginal and Torres Strait Islander communities.

Cultural capability, as well as access to interpreter services, was also considered necessary to improving service delivery for culturally and linguistically diverse communities.

People living with disability and chronic health conditions require integrated health care which is able to address all facets of a person's physical and mental health needs.

Overarching reform *(continued)*

A whole-of-population approach

The Commission heard that a whole-of-population approach is central to creating a balanced system.

This approach attends to the needs of the entire population, as well as groups at higher risk, and people with ongoing mental health, alcohol and other drug use problems or those impacted by suicide.

It requires people having access to a wide-range of universal health and social services, as well as a range of low, medium and high intensity interventions, including acute care services.

During the consultations, participants highlighted the need for greater leverage, investment or coordination across several important areas of a population approach. These include:

- the universal foundation, through action to build and maintain safe, supportive and inclusive communities, workplaces and schools
- addressing the social and economic determinants, for example access to health, housing, education, training and employment
- planned and coordinated approaches for enhancing protective factors and reducing the influence of risk factors for vulnerable groups
- early intervention with those at risk, which involves both identifying early and effective responses and supports
- tailoring initiatives and services to meet the needs of groups at greater risk
- greater acknowledgement of the power and value of the natural supports of the person with a lived experience
- recovery as the central aim and shared concern of all services
- addressing the structural barriers to rightful and full social participation experienced by people with lived experience and other vulnerable groups.



Mental Health Housing Demonstration Project

The Department of Housing and Public Works is leading implementation of a two-year Mental Health Demonstration Project in the Fortitude Valley and Chermide Housing Service Centre and health catchments. The project is delivered in partnership with Queensland Health and in collaboration with Footprints Inc. It aims to support people who are experiencing difficulty maintaining or sustaining their social housing tenancy due to behaviours related to mental illness or related complex needs, through an integrated clinical health and non-clinical psycho-social responses.

The project commenced in 2015 and by 30 June 2017, 166 people had received assessment, clinical mental health treatment, in-home tenancy support, and were linked with other community and government services. An interim evaluation of the project found that participants had sustained their tenancies, improved their mental and physical health, and increased their social participation.

The final evaluation of the project is being undertaken by The University of Queensland.

To further support people with complex needs in navigating the housing system, the Department of Housing and Public Works, together with Queensland Health, through the Queensland Centre for Mental Health Learning, launched an online system to provide training for frontline service delivery staff. This system helps staff to better understand the needs of social housing tenants with mental illness, mental health and wellbeing issues, or related complex needs. Six online eLearning modules have been made available to all interested government and non-government organisations through www.tenancysupporttraining.qld.edu.au.



WHAT IS NEEDED

Overarching reform

The renewed Strategic Plan should set a direction to support a system that:

- Is arranged around the needs of Queenslanders, with policies, programs and services designed and delivered in a way that allows flexibility, removes barriers to accessing services, engages with the community, and is focused on meeting the holistic needs of the people it serves.
- Places a greater focus on prevention, with funding and resources directed towards initiatives which address the social and economic determinants, such as housing, educational attainment, employment, and increases social inclusion.
- Provides stepped care options linked to other support services such as housing, education and employment to support the recovery of people living with mental health problems, mental illness, problematic alcohol and other drug use and people affected by suicide.
- Tailors policies, programs and services to more effectively respond to the diverse needs of Queenslanders who experience high rates or who are at higher risk of experiencing poor mental health and wellbeing, mental illness, problematic alcohol and other drug use and suicide.
- Coordinates services, programs and funding to ensure equitable access and better outcomes for people.
- Promotes and supports collaboration within services and between service systems through better coordination, collaboration and integration across sectors.
- Supports integration by removing barriers and finding solutions to services working together and promoting integrated models of service delivery, including one-stop shops and case management models.





Engaging people with lived experience

Self-determination and having a voice in the decisions that affect you is a basic human right.

Evidence strongly suggests that by engaging people with lived experience, their families, carers, and support people as equal partners in the design, development, management and evaluation of policies, programs and services—we are more likely to improve outcomes for people.

People with lived experience, their families, carers, and support people also play a vital role as peer workers in partnering with treating teams and services. By sharing their journey and experiences they can help to reduce the impact of stigma, reduce harms, and provide hope that recovery is possible. Research conducted by Dr Louise Byrne² on behalf of the Commission on the key barriers and enablers to peer

workforce development showed that leadership commitment and action, and organisational culture is critical to the success of lived experience roles.

Many different terms are used by the mental health, alcohol and other drug and suicide prevention sectors to describe people with a lived experience. This report refers to people with a lived experience as those who have a direct personal experience of mental illness and/or problematic alcohol and other drug use. People with a lived experience of suicide, includes people who experience suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide or been bereaved by suicide.

The Commission's consultation process strongly focused on identifying ways to further increase and improve the engagement of people with lived experience, their families, carers, and support people in the mental health, alcohol and other drug and suicide prevention sectors.

To build on the work already underway to implement the Strategic Plan's Shared Commitment to Action 1, the consultations focused on increasing and improving engagement:

- to influence the system as equal partners in all levels of policy development and the co-design, planning, monitoring and evaluation of services
- through peer work and peer networks to support others through their recovery journey and raising community awareness.

Influencing the system

Valuing engagement

The benefits of meaningful engagement of people with lived experience, their families, carers and support people in influencing the system were widely accepted by stakeholders. Many saw this type of engagement as essential to:

- more effective and accessible policies, programs and services as a result of them being designed based on the experiences of people who are affected by them and rely on them
- reducing stigma within services by having people with lived experience contribute their views, experiences and ideas at every level
- providing greater accountability through involvement in quality improvement activities.

They also indicated that when engagement is done well at a systems level, it demonstrates a commitment to recovery principles and a genuine appreciation of the value of lived experience perspectives. This in turn can support individual recovery.



SPOTLIGHT ON PROGRESS

Stretch2Engage: Draft best practice principles for service engagement

In 2015–2016 a partnership between the Queensland Alliance for Mental Health, Queensland Network of Alcohol and Other Drug Agencies (QNADA) and Enlightened Consultants focused on developing draft best practice principles for meaningful engagement of people with lived experience, their families, carers and supporters in service design and evaluation.

Stretch2Engage: best practice principles for service engagement (Stretch2Engage), provides a framework to guide efforts to increase and improve engagement in the mental health, alcohol and other drug, public and non-government sectors.

Stretch2Engage was developed following extensive research, engagement and consultation, involving more than 250 stakeholders through:

- an online think tank of 177 people
- two face-to-face think tanks held in Cairns and Brisbane, with 74 people participating
- four targeted consultations to test the draft principles—held in Cairns, Toowoomba, and two in Brisbane.
- online testing of the draft principles involving those who had registered for the think tanks and people who could not attend the consultation sessions.

The engagement and consultation process targeted the views and experiences of diverse people and groups, including people from culturally and linguistically diverse backgrounds, people living in rural and remote communities, and Aboriginal people and Torres Strait Islanders.

Stretch2Engage defines engagement as encompassing the processes and techniques that organisations employ to involve people using services, their families, carers and friends in the design or redesign of their services. This type of engagement is different to engagement in direct service delivery and providing therapeutic support.

The Stretch2Engage framework is founded on values which acknowledge engagement of people with a lived experience, their families and carers as a human right, fundamental to citizenship. This sees engagement as being important in its own right, while acknowledging the benefits to services that engage effectively.

The core concept underpinning this framework is the need for a different approach to engagement—one which places the onus on the service to change their culture and adapt their approaches to engagement: to see engagement as core business.

The Stretch2Engage framework was presented to participants at the Lived Experience Roundtable, with the draft principles outlined as a new way of approaching meaningful engagement with people.

Engaging people with lived experience *(continued)*

Meaningful and supported

Stakeholders identified a number of examples of engagement processes considered to be good practice, including participation in Consumer Advisory Groups in Hospital and Health Services, being members of management committees, and participating in the recruitment of health staff.

Some people with lived experience described being involved in the co-design of programs and services but this experience was not shared widely. Peer-run services, Clubhouse models, and the Queensland Injectors Voice for Advocacy & Action were also noted as important examples of lived experience engagement embedded throughout an organisation.

However, a significant number of people with a lived experience, their families, carers, and service providers had not experienced this type of engagement or had experienced engagement processes they considered to be tokenistic, non-genuine and part of 'ticking a box'. For engagement to be perceived as genuine and respectful, people with lived experience, their families and carers identified a need to be reimbursed for their time and expertise.

Building and supporting the ability of more people with lived experience to engage was identified at the Lived Experience Roundtable. The importance of supporting the next generation and engaging with people from diverse backgrounds and perspectives was raised by many stakeholders. There was a strong call on the system to adopt tailored strategies to enable better engagement with people with lived experience, including those who may be experiencing homelessness, come from culturally and linguistically diverse backgrounds, or who are Aboriginal and/or Torres Strait Islander.

Being safe and feeling supported is critical to engagement. Experiences of stigma and discrimination were identified as being of particular concern for people with lived experience as a barrier to meaningful engagement. For people living with problematic alcohol and other drug use, stigma associated with illicit drug use and addiction hindered their engagement with services.

Concerns were also raised about potential consequences of providing feedback to services. People with lived experience expressed concern that their future access to a service may be impacted if they provide frank feedback and input. Having the option of anonymity or being involved in engagement activities with a different service (to the one that may be providing support) were suggested as possible ways to address these concerns. However, it is also important that the underlying issues and power imbalance that lead to this perception and experience are resolved.

Building capacity

Some stakeholders indicated there is also a need to build the capacity of organisations to effectively engage with the people they are there to support. Providing training, including pre-service training and support for service executives, managers and frontline staff on co-design principles and practices, and providing similar training and support for people with lived experience who are participating in co-design activities was identified as one possible solution.

Other options included having dedicated lived experience positions in government policy making areas to embed lived experience perspectives at a strategic level and having stronger relationships between policy makers, service providers and people with lived experience. A number of people with lived experience noted a need for greater accountability to ensure engagement is meaningful.

As noted by a number of service providers, having the right tools and resources are fundamental to effective engagement. Many noted a more systemic approach is needed and some indicated that trialling innovative approaches would help to not only showcase good practice, but also identify what is needed and the benefits of effective and meaningful engagement.

There was wide-spread support for piloting the new Stretch2Engage framework across government and the non-government mental health and alcohol and other drug sectors. Stakeholders indicated a pilot would help identify what resources are needed for effective engagement, develop tools and potentially support a more systemic approach to engagement across sectors. Other stakeholders indicated effective and meaningful engagement should be embedded as a deliverable in funding agreements.

Peer work and networks

Stakeholders gave many examples of how peer workers provide a unique perspective to support people on their recovery journey. They provide an example of hope and show that recovery is possible; practical assistance with recovery through the purposeful use of own experience; and a person-centred, humanistic approach that complements the clinical approach of other members of the team.

We also heard examples of how peer workers influence the system from within, for example, through joint training of staff; providing a lived experience perspective to discussions about workplace policies, procedures and practices; and challenging stereotypes and stigma.

There was a universal call to build the peer workforce in the mental health and alcohol and other drug service systems. This not only related to increasing the number of peer workers but also strengthening systems and creating cultures in which peer workers are valued as equal partners in the workforce. Specific issues identified during the consultations included: organisational culture and systems; role clarity, and workforce development.

Organisational culture and systems

People with lived experience told the Commission that senior management support and ‘buy-in’ is crucial to setting an organisational culture that is recovery-oriented, values lived experience perspectives and peer work, and sees peer workers as equal members of teams. They spoke about a number of Hospital and Health Services and non-government organisations who had focused their attentions on building their peer workforce and were making progress towards building their organisational culture and systems.

However, stakeholders indicated that more work needs to be done. They pointed to a need to train other workers, including managers about the importance of lived experience and peers. Others indicated that a whole-of-service approach is needed to support the inclusion of peer roles and some suggested that specific requirements be included in funding agreements as a way of ensuring appropriate systems are in place to support the peer workforce and reinforce a recovery-oriented culture.

A number of people with lived experience told the Commission there is a need to train managers in how to appropriately support peer workers in their own recovery journey, including by making reasonable adjustments particularly when a peer worker becomes unwell.

The role that peer workers play in changing organisational culture was also highlighted by stakeholders. Participants at the Lived Experience Roundtable told the Commission that having a peer workforce can reduce stigma and discrimination, raise awareness about the perspectives of people receiving services, and encourage others to be more open about their own lived experience.

Role clarity

Many stakeholders across Queensland talked about the diversity of roles that are described as peer workers, due to different services and settings.

However, within those services, stakeholders told us there is a need for greater role clarity: including their role within teams as equal and valued members of staff. They indicated a need for inbuilt support and supervision mechanisms, as is the case with other professions in the team. Participants noted the additional challenges for peer workers in organisations where these are new roles and the importance of support for these workers. People with lived experience asked that services with an established peer workforce share learnings and offer support to other organisations that have not previously had a peer workforce.

Career pathways

Workforce development was raised by many consultation participants as an area requiring a stronger focus. Some people with lived experience indicated that developing and supporting career pathways from a person using services, to peer worker, and into more senior roles was critical to the sustainability and growth of the workforce.

Ongoing education and training was also raised as important, both for existing peer workers and for those considering a career in peer work, for example, providing support to access the Certificate IV in Mental Health Peer Work. Establishing mentoring programs was suggested as a way of supporting leadership development in peer workers and other people with a lived experience who may be interested in moving into these roles.

Peer networks

Peer networks involve people with a lived experience, their families and carers, sharing their personal experiences with others in an effort to reduce stigma and discrimination, demystify mental illness and problematic alcohol and other drug use, as well as to break down barriers to people seeking help. Many peer networks operate throughout Queensland and operate under different names such as ambassadors and lived experience networks.

Community members and service providers indicated that through these networks, they gained a better understanding of the issues impacting people at risk and those with lived experience, their families, carers and friends. They indicated there are a number of different groups who provide education to services and the broader community through peer networks, but there does not appear to be a systemic approach. Rather, services and community members access peer networks by contacting known organisations such as *Roses in the Ocean* and *beyondblue*.

Stakeholders noted that people in these roles need training and support, acknowledging too the impact these kinds of roles may have on their own wellbeing and having strategies in place to manage this. They also noted that additional funding is required to make these networks more sustainable.



WHAT IS NEEDED

Engaging people with a lived experience

To increase and improve engagement of people with lived experience, their families, carers and support people in the system, we need to:

- Embed co-design and engagement in policy, program and service design across human services as well as include a requirement to engage in funding agreements.
- Trial and evaluate the Stretch2Engage framework and other innovative approaches, across government, private, non-government mental health and alcohol and other drug sectors with a view to identifying what works, and the resources and practices needed to meaningfully engage as a core part how we do business.
- Increase and strengthen the peer workforce in the government, private and non-government mental health and alcohol and other drug service system—including improving organisational culture and systems, role clarity and workforce development through career pathways and access to professional development.
- Continue action to support peer networks and the people who share their personal experiences within them, including systems and resources to ensure ongoing support and sustainability.





Improving mental health and wellbeing

The World Health Organisation defines mental health as a state in which people are able to realise their own abilities, cope with the normal stresses of life, work productively, and make a contribution to their community³. Good mental health and wellbeing not only benefits individuals, but has significant social and economic benefits.

Most Queenslanders, experience good mental health and wellbeing most of the time. How we feel about our life is an important indicator of mental health and wellbeing with around 62 per cent reporting they are generally very satisfied with their lives^b.

Any of us can experience poor mental health and wellbeing, whether we are living with a mental illness or not⁴. Poor mental health is a contributor to, and a consequence of, wider social and health inequalities. Compared to those who report high levels of positive mental health, moderate and poor mental health are associated with poorer physical

health, lower productivity and limitations in daily living presenting a significant source of individual, social and economic burden.

Psychological distress is a commonly used indirect measure of the overall mental health and wellbeing of the population. In 2014–15, 12.0 per cent of Queenslanders adults reported experiencing high or very high levels of psychological distress⁵, suggesting that their ability to fully engage and cope with everyday tasks may be affected.

Mental health is influenced by a wide-range of individual, social and environmental factors, and many of these factors have their strongest influence in the settings of everyday life, like our homes, schools, workplaces and in our communities.

Effective action to promote mental health and reduce the incidence and impact of mental illness requires collective effort across all sectors.

Stakeholders across Queensland confirmed the need for cross sectoral action focused on improving and maintaining mental health and wellbeing. Its importance in the everyday lives of Queenslanders was acknowledged as well as its role in preventing and reducing the impact of mental illness, problematic alcohol and other drug use and suicide.

Participants stressed the need to focus attention on the social and environmental factors—such as educational attainment, employment, housing, and social inclusion that have significant influence on mental health and wellbeing—and not only on individual factors.

Community awareness and capacity

Shifting conversations within the community and the services from focusing solely on illness to wellbeing was a consistent message heard by the Commission. This includes the need for information, resources and skills to improve mental health and wellbeing.

The Commission heard that despite the increasing dialogue about the benefits of mental health and wellbeing, this is not always matched by clear understanding about what is mental health and wellbeing. Community members and service providers at forums indicated there continues to be confusion about the difference between mental health and mental illness and the tendency to focus on mental illness or mental ill-health.

The Commission heard about the need to improve knowledge and skills among individuals, communities and service providers to support and maintain positive mental health and wellbeing, rather than only equipping people to respond to signs of mental illness.

The Commission was told it is not easy for people to identify appropriate information and resources focused on positive mental health and there is a need for clearer guidance to understand and apply this information. The importance of embedding a focus on wellbeing across all government agencies was advocated.

The Commission was reminded that awareness must be matched by support and access to appropriate services. Stakeholders often expressed concern and frustration at the limited access to appropriate available responses and services when people were experiencing or showing the first signs of poor mental health and wellbeing.

Stakeholders, across the state and in roundtables, identified the important role played by services such as housing, education, justice and family support services, as well as the role of sporting clubs, and other community-based groups in promoting good mental health and wellbeing.

Many human and social services also provide a much needed ‘soft entry point’ that supports people’s access to more specialised mental health services when they are needed.

b Unpublished, Australian Bureau of Statistics (2015), Microdata from General Social Survey 2014.



SPOTLIGHT on PROGRESS

Wheel of Wellbeing providing a common approach

Wheel of Well-being



Worldwide research shows people with higher levels of wellbeing are more creative, more productive, and better at problem solving. From a health perspective, when your wellbeing is strong, you are less likely to catch a cold or feel pain, and you are more likely to recover from illness and injury more quickly, and even live longer. Just as we look after our physical health through healthy eating and, physical activity, there are things that we can do to look after our overall wellbeing and mental health.

Developed by Maudsley International, the Wheel of Wellbeing (WOW) provides a flexible framework that represents the six universal themes that contribute to mental health and wellbeing: Body, Mind, Spirit, People, Place and Planet. Within the framework, each of the six themes offers positive and practical actions to improve and maintain wellbeing.

From small beginnings, the positive and influential contribution of WOW to our aim of improving the mental health and wellbeing of all Queenslanders is evident. It is proving to be highly effective in engaging diverse audiences in considering how mental health and wellbeing relates to them and actions they can take to improve the mental health and wellbeing of themselves, their families, their workplaces and their communities. This includes community members, service providers, people living with mental illness, as well as policy makers.

From initial awareness-building, we are seeing evidence of WOW activity and practice being used and embedded in a wide-range of contexts, including schools, community groups and interagency networks and services. WOW has provided a much-needed common approach that, due to its flexibility and accessibility, is responsive to a wide-variety of needs and contexts.

*"the INFORMATION and TOOLS PRESENTED
in the WOW WORKSHOP HAVE the
POTENTIAL to IMPACT the PROGRAMS
WE RUN and INFORM US OF the NEED
FOR A WHOUSTIC APPROACH to WELL-BEING."*

- PROGRAM PARTICIPANT



SPOTLIGHT ON PROGRESS

Regional Mental Health and Wellbeing Hubs

Communities, agencies and services throughout Queensland are driving approaches for better mental health and wellbeing. The Regional Mental Health and Wellbeing Hubs (Regional hubs) is one example where local agencies are supported to develop, deliver and review the effectiveness of local community approaches.

Regional hubs:

- ensure individuals, services and agencies are informed and knowledgeable about mental health and wellbeing
- are equipped to contribute to individual and collective wellbeing
- understand and respond to the mental health and wellbeing needs of particular groups.

Different approaches are emerging through this initiative, based on local needs and strengths.

Logan and Southern Moreton Bay Islands Hub

The Logan and Southern Moreton Bay Islands Hub (Logan and Islands Hub) engages the Logan community to support and embed positive mental health by working with services and practitioners, and through partnerships with school and community agencies to provide wellbeing training for parents and the community.

In 2016, more than 80 government and non-government service providers from Logan and the Southern Moreton Bay Islands attended WOW one day workshops. Participants reported using what they learned in a variety of ways, including:

- embedding into programs for carers
- incorporating WOW as an integral element of a Wellness Recovery Action Plan program
- using WOW in client assessment and treatment planning
- using for self and also in a wellness session for students and staff
- running an eight-week DIY Happiness program in Kingston.

In 2017, the Logan and Islands Hub is continuing to build and embed wellbeing by:

- maintaining existing practitioner skills and understanding through wellbeing practice meetings and regular information updates
- developing further partnerships with other services and groups to build capacity of staff and parents through eight week and one day WOW programs—for example with migrant and refugees or families
- working alongside Logan City Council to potentially introduce WOW to community centres across the city in 2018.

The enthusiasm for the potential of WOW to positively impact the lives of people in communities continues.

*"I FEEL I'M BETTER EQUIPPED to
PASS ON and TEACH MY DAUGHTER
HOW to BE HAPPY. THANK YOU SO
MUCH FOR this OPPORTUNITY."*
— PROGRAM PARTICIPANT

Central Highlands Mental Health and Wellbeing Hub

The Central Highlands Regional Mental Health and Wellbeing Hub (Central Highlands Hub) is working with volunteer community members to drive wellbeing approaches in their communities by establishing satellite hubs. The Central Highlands Hub is supporting and mentoring community members to achieve the goals for their communities through awareness raising and education and skill building, with the aim of establishing a sustainable local community hub, not reliant on funding to thrive.

The satellite hubs run activities in support of big ticket events, such as International Women's Day or at local community events such as the Capella Christmas Fete. Each hub has organised, promoted, planned and delivered their own one day local WOW workshop with support from other community hub members from across the region.

More than 200 participants from community, education, health, government and non-government organisations have participated in the WOW workshops and activities across the Central Highlands. Particular effort has been made to reach out to groups or individuals who would benefit from participation. Participants reported many positive changes in their lives and their communities.

Improving mental health and wellbeing *(continued)*

Whole-of-life approach

The Commission heard that our mental health and wellbeing needs are dynamic and vary across our life span, requiring a whole-of-life approach. Stakeholders emphasised the importance of services and programs appropriate and responsive to the developmental stage and needs of individuals.

Stakeholders across Queensland and at roundtables acknowledged the perinatal period and early years, from conception to childhood, as a life stage that requires priority focus by all sectors. It is during this time that the foundation for lifelong mental health and wellbeing is established.

The importance of stable, caring, nurturing early relationships and environments was presented. This begins with appropriate support for parents and caregivers to provide secure attachment and nurturing during the perinatal period, starting at conception and continuing through the first years of life. Following birth and during childhood, the best possible start must be supported through child and family focused policy, programs and services across all sectors and in the community.

Stakeholders highlighted a number of effective prevention programs, including readiness for parenthood, home visiting programs, and intensive family support and practical assistance. Addressing early developmental issues, including language acquisition and behavioural regulation was stressed as critical for supporting future achievement and wellbeing. Others stressed the importance of assisting children to build resilience early in life as a protective factor against mental ill-health.

Many noted the significant pressures faced by many parents and families, including lower income and sole parent families.

Schools were universally identified as critical to good mental health and wellbeing. Being supported to achieve educationally and socially, as well as feeling included as part of the school community were considered essential to the wellbeing of school-aged children and young people. Whole-of-school approaches that focus on school ethos, as well as curriculum and programs are most effective at meeting universal needs, as well as supporting children and young people who are at higher risk. Cross-sector collaboration, service integration and the provision of holistic, person-centred approaches were emphasised as essential to supporting the needs of children and young people.

Many advocated for a better understanding of the comprehensive approaches to support social and emotional wellbeing already embedded in school curriculum and programs. Some community stakeholders had limited understanding of what was currently provided. The problems with one-off approaches that are not integrated into a broader approach were also identified.

Stakeholders acknowledged the specific groups of children and young people who require attention, including children and young people under the care of child safety or youth detention systems.

The benefit and continued need for the education, child safety, and health and justice systems to collaborate in their planning and delivery of services at all levels was raised. This was most important for vulnerable children and young people.

It was recognised that most adults spend more time at work than in any other place. It was broadly acknowledged that businesses are more attuned to the importance of mental health in the workplace than at any time in the past. During roundtables we heard that businesses are seeking practical guidance and resources to help them prevent harm, promote good mental health, and respond to mental health issues, when needed.

The Commission heard that approaches need to be customised to the needs of small, medium and larger organisations, as well as specific occupational groups and industries. The success of 'fit for purpose' approaches such as Mates in Construction was stressed. Participants also accentuated the need to not rely on awareness raising or training alone. Systemic approaches that take into account leadership and workplace culture were seen as vital.

The increasing imperative to address mental health in the older years was underscored. Many forums highlighted we live in an ageing society. Some people argued we need to create a more positive view of ageing. Others pointed out the older population is often an under-used resource, wanting to benefit the community. The substantial issues of social isolation, economic disadvantage, elder abuse and exploitation were highlighted as areas of priority.

Stakeholders across the state and during roundtables raised the benefit that children and young people gain from interacting with older people. They noted that older people often act as role models and that the interaction can reduce the impact of isolation for many older people and benefit both age groups by promoting social inclusion.

Life transitions from infancy to childhood, to adulthood, and into our retirement years were also recognised as times of great change and opportunity, and times when people are at a greater risk of experiencing mental health problems. Stakeholders indicated some people may need additional support to improve and maintain their mental health and wellbeing through these stages.



SPOTLIGHT ON PROGRESS

Whole school approaches to mental health and wellbeing

Social skills and social and emotional learning are fundamental to children's mental health, academic learning and motivation to achieve. The relevance of the school environment on a young person's future health, academic success and behaviour is a known protective factor, which can help them to deal more effectively with life stressors.

The Department of Education and Training has employed eight mental health coaches to actively promote and provide advice on the implementation of whole-of-school approaches to social and emotional wellbeing across all school activities and the curriculum.

Bundamba State School recognised the need for a shift in school culture to improve student engagement and academic achievement. In 2012, a review of school data, including Australian Early Development Census data showed 27 per cent of students were significantly delayed in the social competence domain; NAPLAN reports indicated students were performing below national minimum standards; and school-based learning and behaviour data identified significant levels of support needs.

The school community focused on social and emotional learning as a key initiative, in an effort to provide a school-wide approach to improving the wellbeing and academic learning of its students.

In partnership with Griffith University, Bundamba State School introduced a system for teaching social and emotional learning to students from Prep to year three, with success of the program measured over four years. From 2012–2015, data showed significant improvements in students' social skills and NAPLAN results. The general school climate improved, and students and school staff reported positive feelings about the school that were significantly above the state average. Behaviour incidences reported in OneSchool dropped by up to 41 per cent.

The Department of Education and Training continues to encourage schools to incorporate social and emotional learning into whole school approaches to education.

Social inclusion and connections

Social inclusion and positive connections were seen by stakeholders as fundamental to mental health and wellbeing. Stakeholders focused on two aspects of social inclusion: the broader community and marginalised groups (including people with lived experience).

All forums identified a need to support and protect the social inclusion of all groups within their communities to improve mental health and wellbeing. This includes ensuring all Queenslanders enjoy the benefits of safe, inclusive neighbourhoods, with access to affordable housing, transport, education, employment.

There was a particular focus on people who come from culturally and linguistically diverse backgrounds, Aboriginal people and Torres Strait Islanders, LGBTI people and people who are homeless, as well as older people.

Stakeholders emphasised the need to look beyond the individual to address the social and structural barriers that inhibit inclusion and participation. A number of examples of good practice were identified by stakeholders, including the work of local councils and local community groups and sporting clubs.

Social media was identified as one of the ways people, particularly young people, connect with each other. This was seen as both having a positive effect and a negative impact on the mental health and wellbeing of Queenslanders.

The positive effect relates to the amount of information and Apps increasingly available to assist people experiencing problems. The negative impact relates to the potential for bullying and uncensored, sometimes incorrect and harmful, information about mental illness, problematic alcohol and other drug use, and suicide.

Improving mental health and wellbeing *(continued)*

Impact of trauma and adverse life events

Many stakeholders noted the impact of trauma and adverse life events on mental health and wellbeing, including family and domestic violence, child abuse and neglect, and the intergenerational effects of grief and loss experienced by some in our community. Most particularly, stakeholders indicated that intergenerational and present-day traumas have a profound impact on Aboriginal peoples and Torres Strait Islanders. The lifelong emotional, physiological, developmental and neurological consequences of trauma and adversity, and the need for prevention and early intervention approaches were raised.

Acknowledgement of the growing attention to the negative consequences of violence and abuse at all stages of life, particularly childhood, was noted. Stakeholders also identified the need to continue efforts in this area, including the need to attend to the effects of child abuse and neglect, address bullying in schools and work settings, and decrease elder abuse.

The value of trauma-informed approaches to service delivery and care was highlighted and the need for this to be embedded as a foundational approach across service systems was strongly advocated. While also noting strength and resilience, the intergenerational trauma related to the past systematic removal of children, and the continuing impacts of disadvantage, loss and grief experienced by Aboriginal peoples and Torres Strait Islanders were emphasised as critical areas for continued attention. The circumstances of immigration and resettlement and associated trauma were also raised.

Social and economic conditions

While many Queenslanders are able to manage the stressors of everyday life, it was acknowledged that increasingly housing, utility and food costs, and economic and employment conditions are taking their toll. These require policy and program responses beyond the control of individuals and community.

In some parts of the state, unemployment and financial pressure was identified as a key factor in the overall mental health and wellbeing of individuals, families, and the community. Stories were shared of the ripple effect of economic downturn eroding central aspects of the social fabric, including communities that can no longer support football competition due to people moving away to find work.



WHAT IS NEEDED

Improving mental health and wellbeing

To improve the mental health and wellbeing of all Queenslanders we need to:

- Adopt a whole-of-life approach, which recognises and responds to the changing needs and settings of our life, with a particular focus on transition periods and on the places where we grow, learn, work, live and connect.
- Increase the capacity of all agencies to improve positive mental health and wellbeing through policy, program and service development and implementation.
- Increase knowledge, skills and access to resources about what can be done to improve and maintain positive mental health and wellbeing among individuals, communities and services.
- Ensure strategies to improve mental health and wellbeing are tailored to the developmental, cultural and contextual needs of individuals and groups.
- Strengthen factors that support good mental health and wellbeing with a particular focus on maternal and family wellbeing, childhood learning and development, healthy ageing, and social inclusion and community participation.
- Strengthen equitable access to housing, transport, education, employment and a full range of social services through universal, non-stigmatising and well-linked health, social, family, childcare, financial, vocational, and aged care services and programs.
- Maximise recovery, inclusion and wellbeing of people living with mental illness and problematic alcohol and other drug use by supporting their access to resources, services, physical health and participation in all areas of life.
- Strengthen the capacity of schools, services, workplaces and communities to support and protect the inclusion of people experiencing mental health problems.
- Build understanding across services and the community on the impact of trauma, violence, abuse and life transitions on mental health and wellbeing, with a focus on domestic and family violence, child neglect and abuse, elder abuse and neglect, workplace bullying, family breakdown, grief and loss, natural disasters and drought, and transitions between care and supports.
- Support community and economic participation and social inclusion of all groups with a focus on those who are most likely to be excluded.





Reducing the impact of mental illness

Around one-in-five Queenslanders will experience mental illness^c in any one year and almost one in two Queenslanders aged between 16 and 85 years will experience mental health problems at some point in their lives⁶.

People experience mental illness in different ways. Some people will experience a single episode, others will experience episodes from time-to-time, and others will experience symptoms which are persistent and severe for long periods or throughout their lives. In stating this however, people living with mental illness, can experience good mental health and wellbeing, be happy and live lives with purpose.

Experiences of mental illness vary in both severity and duration. According to the National Mental Health Planning Framework, approximately 23 per cent of Queenslanders are at increased risk of mental illness, 9 per cent experience mild mental illness, more than 4 per cent experience moderate mental illness, and 3 per cent severe mental illness⁷.

The duration and severity of mental illness is dependent on many factors including, personal characteristics and experiences, family history, environmental and socioeconomic influences. The lived experience of mental illness also varies and is commonly associated with, for example, poorer physical health and wellbeing; interrupted ability to participate in education and employment; the ability to engage in meaningful activities; and limit the ability to engage with families, friends, work colleagues and the broader community⁸.

Stakeholders identified a number common themes and ideas in relation to preventing and reducing mental illness throughout the consultations. They confirmed the need to focus on mental health and wellbeing as a protective factor to prevent mental illness but also as an important part of recovery and reducing the impact of mental illness.

Prevention and early intervention

Stakeholders across Queensland in community forums and at roundtables universally called for an increased focus on prevention and early intervention. Participants raised frustration at the perceived reliance on the 'ambulance at the bottom of the cliff' or on intervening only when a person becomes ill. Many identified that prevention activities should address risk and protective factors that have the greatest influence on the development of mental illness, and which operate in the everyday environment of family, schools, workplaces and community. Stakeholders confirmed the need for a whole-of-government and cross-sectoral approach.

Early intervention was identified as an important part of an effective system and involves identifying and responding when a person is at risk or showing the first signs of problems.

Some stakeholders, including people with lived experience, their families, carers and support people indicated that people experiencing mental illness were not able to access appropriate treatment and supports until their illness reaches crisis point or a level of severity.

Many stakeholders indicated that some people will not approach a health service due to stigma, but instead will raise concerns and talk to natural supports such as school personnel and other social support, community and neighbourhood groups. People working in the private sector, such as community workers and financial counsellors were also identified as being key to supporting an effective early intervention approach.

These groups may have the capacity to identify when someone is at risk, but as noted by stakeholders they need services they can refer people to. It was also noted that there is a need to build the capacity of these natural supports to identify and respond appropriately, but also to debrief with others, particularly if they are supporting someone at risk of suicide.

^c For the purpose of this report and consistent with the Early Action Plan, the terms 'mental illness' and 'mental disorder' are used to describe a wide-spectrum of mental health and behavioural disorders that affect how a person feels, thinks, behaves and interacts with other people.

Stakeholders saw the health system from GPs, psychologists and hospitals, and acute care services as playing an important role in responding when a person is identified as being at risk or experiencing early signs of difficulties; although, many people reported having problems accessing this type of assistance early on when they needed it. Some stakeholders indicated that people needed to be very unwell before they could access medical and hospital treatment, including detoxification and acute mental health treatment.

The importance of tailored prevention and early detection during the perinatal period, childhood and adolescence, adult years and older years was highlighted. The need to recognise and respond to particular groups was also raised. Stakeholders highlighted the importance of partnerships between health, education, social services and the broader community to effectively prevent and intervene early across the life course. Many stakeholders referred to the need to 'get in early in life' when the first signs of mental illness or an episode of mental illness occurs. They particularly called for greater attention for early intervention during late childhood and adolescence when many mental health conditions are first experienced and when the first signs of an episode occur.



Over recent years, a growing body of evidence has pointed to the need for Australian businesses to take the mental health of their employees as seriously as they take their physical health and safety.

Sunshine Coast Council is one of the largest and most diverse employers on the Sunshine Coast, with its 1700 employee's representing approximately 2 per cent of the coast's overall workforce.

Feedback from employees in 2014–15 reinforced the need for a heightened focus on mental health in the workplace. In early 2015 the council launched FRESHminds, which is based on six individual, team and organisational evidence-informed strategies recommended by the Mentally Healthy Workplace Alliance.

The FRESHminds program aims to promote a mentally healthy workplace through: increasing employee awareness and understanding of mental health; promoting and encouraging early help seeking behaviour; reducing the stigma associated with mental illness; skilling leaders on how to support employees during stressful events or recovery from mental illness; supporting employees and their families; and addressing identified sources of workplace stress.

Council strategies include:

- policy and strategic integration of its focus on promoting a mentally healthy workplace
- supporting Mental Health Awareness and Recovery policy and procedure
- designing and managing work to minimise harm
- a suite of training opportunities for all employees
- training and human resources support for leaders
- an awareness campaign that included an employee commitment to improve their mental health and wellbeing.

A video featuring council employees sharing their mental health stories was designed to encourage people to talk more about mental illness in the workplace. Underpinned by research, the video aims to connect individuals with people who have personally experienced mental illness, or had someone close to them affected by mental illness, while having a positive impact on reducing stigma and encouraging health seeking behaviours^{8,9}. Education and awareness based on these experiences can often encourage help seeking behaviours and promote early intervention.

The program has realised a number of benefits for both the organisation and its people.

Reducing the impact of mental illness *(continued)*

Physical health

Stakeholders recognised the increased risk of mental illness experienced by people living with chronic health conditions and disability. Those consulted as part of the roundtables as well as several stakeholders who provided written submissions, identified a need for greater focus on preventative health initiatives and supported healthy ageing.

Many stakeholders talked about the need to pay greater attention to the physical health of Queenslanders living with severe mental illness. It has been noted that people living with mental illness are more likely to experience a range of health conditions and have lower life expectancy than the rest of the population.

Many have expressed the view that the health system is not geared towards meeting people's whole health needs.

It was pointed out that while people may be receiving regular care for mental health issues, their physical health issues can go unnoticed and unattended to. Models of integrated physical and mental health care were identified as required to address these issues.

Community awareness of mental illness

Stakeholders consistently indicated that community awareness and understanding about mental illness is still limited and often informed by misconceptions. This reinforces negative stereotypes, increases stigma and discrimination and impacts on recovery. It also diminishes the opportunity for early detection and access to appropriate services and support.

The important role of families, friends, colleagues and service providers across all sections of the community in identifying possible signs of mental illness and securing appropriate support was continually emphasised. The need for appropriate training as well as connection to relevant and responsive services was also raised. Many noted that programs such as Mental Health First Aid training were available and were seen as an important part of raising awareness. However, the ability of some to access this training is limited due to cost and access issues.

Others noted that this type of training may not be what is needed and that training and awareness raising efforts should be tailored to meet the needs and roles of the groups receiving the information.

The Commission also heard that to be effective, awareness and capacity building needs to occur at multiple levels and be customised to the needs of different groups, settings, sectors, target audiences and priority groups. Effectiveness is also enhanced by embedding activity within existing community infrastructure.

Positive messages through media campaigns and social media were also identified as potentially supporting increased awareness as well as addressing community misconceptions.

Treatment and support services

Treatment and support services are integral in supporting recovery and in reducing the severity and duration of mental illness. Stakeholders, particularly those who had received mental health treatment, their families, carers and support people gave many examples of positive experiences of health treatment and support. In particular, examples were identified of partnerships between tertiary services and community-based services as particularly effective in meeting people's holistic needs. Stakeholders indicated a focus on human rights, being accepted and respected, as well as considering issues other than mental health treatment, such as education, training and employment, as being important in the recovery journey.

However, a significant number reported that this approach is not always taken, with some indicating that discharge processes and planning need to include coordination and collaboration with other services, such as housing. Examples were given highlighting limited communication between mental health treating teams in hospital and the non-government sector during the discharge process.

The NDIS represents one of the most transforming reform agendas in the disability sector in decades. However, it was also identified as one of the most significant issues facing those living with mental illness. In some parts of the state there was considerable uncertainty expressed by many people with lived experience of mental illness, families and carers about eligibility and the type of support they would be able to access through the NDIS.

Some non-government organisations, particularly in more regional and remote areas of the state raised concerns about being able to recruit and retain staff under the new payment schedules. Others raised issues about whether people who had packages approved in another state would have access to the same supports in Queensland, and vice versa.

A life with purpose

Having a sense of purpose and meaning is fundamental to us all, including for people living with mental illness. Many stakeholders emphasised the need to pay greater attention to enabling people to participate fully in community life.

Vocational pathways and employment were seen by many people living with mental illness as fundamental to recovery. Of importance was not only an income, but the satisfaction that comes from having a job and a role in the community.

Many people indicated that finding employment if you are living with a mental illness is challenging. As indicated by many stakeholders with lived experience, community attitudes and stigma surrounding mental illness acts as a barrier. In some cases, people may need additional assistance in the workplace.

The important role of social enterprises as a way of connecting people to economic participation was noted in Toowoomba as one option available to people living with mental illness. Stakeholders participating in the Early Action Roundtables highlighted the need to develop organisational procurement policies that help create pathways into training, employment and meaningful participation. It is important that a shift towards the value of social outcomes, above economic efficiencies is adopted. Disability Employment Services were also considered helpful, as were clubhouses and non-government organisations that provided practical skill development opportunities.

Stigma and discrimination

The effects of stigma and discrimination were frequently identified as a significant barrier to preventing and reducing the impact of mental illness.

Many people indicated they had experiences of being subjected to negative attitudes and practices based on stereotypes and inaccurate understanding. This can contribute to feelings of shame and reluctance to seek further help. Stakeholders identified a need to change both community attitudes and the culture of services and improve awareness about mental illness.

Community members and service providers also indicated that self-stigma meant that some people do not talk about their difficulties or seek help, particularly from clinical services.

Stakeholders identified a number of ways to overcome this issue, which include using 'soft entry points' to providing support, for example through organisations usually associated with health services such as Queensland Government Agent Program (QGAP) offices in rural and remote Queensland.



WHAT IS NEEDED

Reducing the impact of mental illness

To prevent and reduce the impact of mental illness we heard that a cross-sectoral and whole-of-life approach is required to respond to the changing influences and circumstances that increase the likelihood of mental illness occurring. We also need to:

- Increase the capacity of all agencies to prevent mental illness through policy, program and service development and implementation.
- Support programs that increase the influence of protective factors such as educational attainment, employment, housing, social inclusion and supportive families, workplaces and communities.
- Promote and support prevention and early intervention approaches tailored to the perinatal period, early years, school age, children and young people in care, workplaces and workforces, and older people.
- Ensure all individuals, service providers and the community are supported with the awareness of and capacity to appropriately respond to the signs and symptoms of mental illness, and to provide support and/or seek and access help for themselves or others.
- Ensure access to mental health care that:
 - meets the needs of the whole person and integrates supports to meet clinical, psychosocial, housing and employment needs
 - provides options for stepped care and facilitated transitions from generalist to specialist and clinical and non-clinical care.
- Provide treatment services which respect human rights and which are focused on recovery.
- Adopt a holistic approach to recovery which includes improving the physical health of people living with mental illness and supporting lives with purpose through community and economic participation, including access to housing, education, training and employment opportunities.
- Design and implement a service system which not only supports people who are eligible for services under the NDIS, but also continues to provide an appropriate level of support and services for people living with mental illness who may not be eligible for NDIS.
- Recognise and address the impacts of stigma and discrimination experienced by key groups to promote social and economic inclusion, including people living with mental illness; children with parents or family members living with mental illness; children in care of child safety; young offenders; LGBTI people; Aboriginal peoples and Torres Strait Islanders; and culturally and linguistically diverse communities, including refugees and asylum seekers.
- Reduce stigma and discrimination within the service system to enable more people to seek and receive help early.





Reducing alcohol and other drug related harm

Queenslanders from all walks of life use alcohol and other drugs. Not everyone will experience harm. Factors such as the type of drug used, the frequency and quantity of use, the age of first use or exposure, and socio-economic factors all play a role in whether a person will experience harms.

More Queenslanders are at risk of harm relating to alcohol consumption and tobacco than any other drug. Around one in five Queenslanders¹⁰, aged 14 years and over report drinking alcohol at levels which place them at risk of harm, such as liver or heart disease, during their life time, and around two in seven people at levels which place them at risk of harm when they are drinking¹⁰.

About one in seven people in Queensland report smoking tobacco daily. About one in six people report using illicit drugs, with cannabis the most commonly used¹⁰. Although a relatively small proportion of Queenslanders use other drugs, such as methamphetamines, including crystal methamphetamine (also known as ice)¹⁰ the risk of harm and the impact is significant.

Problematic alcohol and drug use can have wide-ranging impacts on individuals, their families and significant others, the community and on the economy through increased demand on government services and lost productivity.

The Commission heard from people with lived experience, their families and friends as well as service providers and experts in the field about ways to further reduce problematic alcohol and other drug use. Facilitated discussions to update the Alcohol and Other Drug Action Plan also provided a wealth of input into what would make a difference in Queensland, building on the progress that has already been made.

Their combined feedback was consistent and called for a continued harm minimisation approach within a holistic mental health and wellbeing framework, and which addresses all drug types, but particularly focusing on alcohol as the drug impacting the most Queenslanders. Recent community focus on crystal methamphetamine (ice) was acknowledged by many and there was a need to continue a focus on reducing the harms associated with this drug.

A harm minimisation approach

Participants at the alcohol and other drugs facilitated discussions strongly supported Queensland continuing to implement a whole-of-government approach to preventing and reducing the impact of alcohol and other drugs, which adopts a harm minimisation approach. This approach is aligned to the National Drug Strategy and requires actions focused on demand reduction, supply reduction and harm reduction.

Stakeholders considered it imperative that demand-supply-and-harm-reduction are considered holistically, having regard for the mental health and wellbeing of people experiencing problematic alcohol and other drug use, their families and friends.

Addressing all drug types

Many stakeholders recognised that poly-drug use (use of two or more drugs) was common and the need to maintain a broad focus across all drug types (legal and illegal) needs to continue.

A number of stakeholders raised concern in relation to the impact of ice on individuals, families, services and the community. It was widely acknowledged that a small proportion of Queenslanders use ice but that the impact was substantial. All agreed that effort needs to continue to reduce the impact of this drug but efforts should not divert attention from harms related to other drugs such as alcohol and tobacco.

They highlighted the need to maintain a focus on alcohol, especially alcohol fuelled violence, foetal alcohol syndrome disorders (FASD) and its use in the context of domestic and family violence, and child abuse and neglect.

Across the state, community members indicated that views around the social acceptability of alcohol use were, in part, leading people to not recognising when they were engaging in problematic use, as well as for those people close to them.

Reducing alcohol and other drug related harm *(continued)*

Stigma and discrimination

Stigma and discrimination are often the main issues preventing people from seeking and getting help, as well as hindering recovery. It was noted by a person with lived experience during consultations that ‘addiction should be treated as a health problem not a moral failing.’

Stigma, particularly in relation to illicit drug use, impacts on access to services. Many stakeholders talked about their experiences of trying to access services and supports but feeling that their problematic drug use led to their needs being deprioritised.

Having employment was considered a very significant factor in recovery. However, people with lived experience of alcohol or other drug use talked about difficulties finding employment, particularly if they disclosed their history of problematic use.

Increasing community awareness and the involvement of people with lived experience in education and training activities was identified as one way of reducing stigma and discrimination.

Community and service awareness

One of the issues raised by many, particularly those with lived experience, was the way alcohol and other drug use, particularly the use of ice, is portrayed in the media. Some indicated this was leading to fear and misunderstanding within the community, resulting in increased stigma and discrimination.

At the same time, problematic alcohol consumption does not receive the same attention. Many indicated there is a need to continue to change the culture of alcohol consumption.

Stakeholders indicated there is a need to educate the community about the different types of drugs and their impact within a harm minimisation framework. Participants at the alcohol and other drugs facilitated discussion indicated that community awareness activities need to be based on evidence and raise awareness about the facts of problematic use.

Stakeholders also identified a need to raise awareness about problematic alcohol and other drug use within the broader human service system, for example within child safety, justice, housing, and employment sectors. They noted that while there are developed programs such as Mental Health First Aid courses focused on mental health and suicide, there are very limited programs available in relation to problematic alcohol and other drug use.

Access to services

A considerable number of stakeholders reported positive experiences of alcohol and other drug treatment services and indicated that treatment does work.

However, it was recognised that many people experience barriers to accessing some treatment services. Although not needed in relation to all types of drugs, access to medically supervised detoxification services were identified throughout the state, particularly in rural and remote Queensland, as an issue.

Other barriers include eligibility criteria for services (particularly between mental health and alcohol and other drug services). The accessibility of residential rehabilitation services was also viewed as being very limited.

For Aboriginal people and Torres Strait Islanders and communities there was an identified need for increased culturally-safe treatment services and an increase in the representation of Aboriginal and Torres Strait Islander people employed in the alcohol and other drug sector workforce.

Stakeholders acknowledged the recent release of Connecting Care to Recovery is likely to increase the number of services available across the state, and that joint planning with the Primary Health Networks (PHNs) is promising. They also indicated the expansion of services such as the Queensland Injectors Voice for Advocacy and Action into regional Queensland has had a positive impact.

A number of stakeholders indicated that workforce development was needed both within the alcohol and other drug sector and in the broader service system.

Concerns were raised regarding recruitment and retention of appropriately qualified and skilled staff to provide services within a growing alcohol and other drug non-government sector. As noted by some stakeholders, when providing funding, consideration should be given to developing a workforce.



Queensland Injectors Voice for Advocacy and Action Social Media Outreach project

The Queensland Injectors Voice for Advocacy and Action (QulVAA) is a community-based organisation which represents the interests of injectors and illicit drug users. QulVAA applies a peer-based philosophy. The Social Media Outreach project is providing evidence-based health, lifestyle and wellbeing messages to Queenslanders who use illicit substances, particularly people who inject drugs. The project particularly focuses on people who live in regional and rural communities and/or are experiencing social isolation and discrimination.

It works through the sharing of online information and the recruitment of volunteer leaders in six locations across Queensland (Ipswich, Toowoomba, Sunshine Coast, Townsville, Rockhampton and Cairns).

The project aims to:

- improve the health and wellbeing of people who inject drugs
- strengthen the resilience and personal networks of people who inject drugs by supporting development of healthier personal relationships and support networks
- increase awareness of harm reduction strategies
- improve life expectations and outcomes through meaningful engagement and social connection
- increase connectedness between peer networks of people who inject drugs
- increase awareness of community supports and linkages for people who inject drugs (including people living with dual diagnosis).

Support for families

Families play a significant role in modelling appropriate alcohol and other drug use, as well as supporting family members to seek help when they are experiencing problematic use.

Families of people living with problematic alcohol and other drug use reported having difficulty accessing information and seeking help. Like their family members who were experiencing stigma related to their problematic use, families also reported being subjected to stigmatising views.

Some stakeholders also indicated that stigma had a profound impact on the ability of some families to seek help. They also indicated that fear of Child Safety Services involvement meant that some parents and caregivers were reluctant to seek help for problematic use. Others indicated that parents were concerned about seeking help for their children who were experiencing problematic alcohol and other drug use because they were concerned about being labelled as 'bad parents', or worse.

It was suggested by some stakeholders, including the Australian Drug Foundation, that the Triple P Positive Parenting Program could focus on problematic alcohol and other drug use from a number of perspectives, including role-modelling appropriate alcohol use, encouraging parents and caregivers to seek help when a family member is at risk or experiencing problematic use, as well as seeking help in relation to their own use.

Another issue identified by stakeholders related to limited treatment and support options when a parent or caregiver is experiencing problematic alcohol and other drugs use and the need for appropriate treatment options and pathways for families.

The Queensland Network of Alcohol and other Drug Agencies told the Commission that only one residential rehabilitation service in South East Queensland accepts mothers with under school-aged children, and only one Aboriginal and Torres Strait Islander family residential option existed in Far North Queensland. They also indicated there are no specific residential services for fathers with under school-age children in Queensland.

The Victorian Family Drug Court, which is currently being evaluated, offers a 12 month program for a parent with at least one child aged under three years who is in out of home care. The program involves mandatory drug setting, case management and support from multidisciplinary teams. As indicated by Queensland Network of Alcohol and other Drug Agencies in their submission, the model provides an opportunity for families to stay together, if it is in the child's best interests.

Reducing alcohol and other drug related harm *(continued)*

The criminal justice system

Community and non-government stakeholders across the state welcomed the reintroduction and expansion of court diversionary programs, including the revised Drug Court. However, some saw a need to consider the criminal justice system as a whole—from the point of contact with police, through to post-prison release support.

The wellbeing of people in prison was raised at a number of forums throughout Queensland. In particular, people at forums raised concerns about an appropriate level of support while transitioning back into the community.

Stakeholders indicated that while there is still a need to continue to improve alcohol and other drug rehabilitation while a person is in prison—the time of greatest risk for overdose and other harms was at the point of being released and in the days and weeks that follow. Stakeholders advised there is a need to include rehabilitation opportunities as part of the post-release support programs.

New approaches to harm minimisation

Many participants supported exploration of new harm reduction initiatives. Pill testing at large events or festivals was considered by many to be an important step forward in reducing harm. Safe drug using spaces or rooms were also raised by some stakeholders as a way of reducing harms particularly for people who are homeless or rough sleeping.

Local action plans

Stakeholders in community consultations called for a greater focus on place-based approaches as a way of tailoring responses to local needs. Through local plans, more effective demand, supply and reduction strategies can be developed, as well as better coordination of efforts and activities. Local Drug Action teams funded through the National Ice Strategy and Liquor Accords, which involve local police, businesses, councils and community organisations were identified by some stakeholders as being very effective.



Good Sports—encouraging Queenslanders to reduce risky alcohol consumption

Good Sports is a national, evidence-based, accreditation program that supports amateur community sporting clubs to create a culture of responsible drinking. It aims to introduce, improve, and maintain alcohol management policies and practices, with implementation funded by the Queensland Government and delivered by The Alcohol and Drug Foundation.

As at 4 September 2017, in Queensland there are 897 sporting clubs participating in the program. One hundred and twenty nine of these clubs have received the highest level of accreditation. The majority of the clubs are in regional, or rural and remote areas which supports the reduction of problematic alcohol and other drug use in areas that have a higher prevalence of lifetime risky alcohol consumption than the state average.

The Good Sports program supports clubs to reduce binge or harmful drinking at the club, maintain a smoke-free environment, work to provide an inclusive and welcoming space that promotes safe behaviour, generate community support and respect, and fulfil their duty of care to members and patrons. Additional benefits to the clubs include increased club membership and revenue.

Clubs that are accredited under this program can also become accredited under the Good Sports Healthy Eating Program. In Queensland 682 clubs participated in the Healthy Eating Program. Overall, a healthy club environment helps children and adults to develop healthy attitudes and behaviours toward alcohol consumption and eating habits.



WHAT IS NEEDED

Reducing alcohol and other drug related harm

To prevent and reduce the impact of problematic alcohol and other drug use we need to:

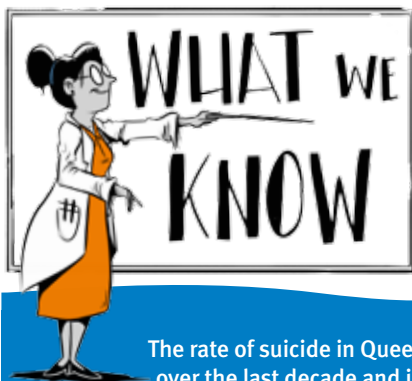
- Continue to implement a harm minimisation framework, which addresses all drug types and adopts a holistic approach to the mental health and wellbeing of people experiencing problematic alcohol and other drug use.
- Raise awareness about the facts relating to problematic alcohol and other drug use and how to support people experiencing problematic use in the community and within the health and human services sector.
- Increase the availability of alcohol and other drug services, including hospital, residential and home based detoxification services and supports.
- Increase support for families of people experiencing problematic alcohol and other drug use and access to family-centred treatment and supports.
- Increase support and treatment through other service systems, such as housing, employment and the child protection system.
- Build on the substantial reforms in the criminal justice system by further improving responses from the point of police contact through to transition from prison to reduce problematic alcohol and other drug use related harm.
- Consider new options for harm minimisation initiatives such as pill-testing.
- Focus on workforce development and capacity building by recruiting, retaining and training diverse staff to more effectively respond to alcohol and other drug issues.

What's WORKING?



What can we IMPROVE?





Reducing suicide and its impact

The rate of suicide in Queensland has increased over the last decade and in 2016, 674 people took their lives in Queensland¹¹. For every person who dies by suicide, an estimated 30 people attempt suicide¹².

Suicide and suicide attempts have substantial and lasting impacts on families, friends and the broader community, who may experience challenges to support a person experiencing suicidal behaviour and cope with the aftermath of a suicide.

There are also significant impacts on service providers who provide support and treatment, and first responders: including police and ambulance officers. In addition to the impacts on individuals, suicide deaths and attempts have a substantial impact on society and the economy¹³.

The factors that contribute to suicide are many and varied. Mental health issues are a factor in many suicides, but so are factors such as poverty, hardship, loneliness, isolation, conflict, relationship breakdown, legal issues, physical illness, and disability¹³.

While many sectors have a role in suicide prevention, health services play a particularly critical role. The available evidence shows that about a quarter of people who die by suicide in Queensland have had contact with a Queensland Health service in the seven days prior to their death¹⁴.

During the consultation process, the Commission heard about the need for better alignment between state and national suicide prevention plans and improved coordination of suicide prevention activity. Our approach to suicide prevention needs to be evidence-based and informed by those who have been impacted by suicide.

We heard about the need to supporting appropriate community conversations, help people stay connected to others, provide appropriate care to those at imminent risk, and support families and others who are impacted by suicide.

Working together

Many stakeholders welcomed a renewed focus on suicide prevention across government and community in recent times.

At the same time, the Commission also heard that our approach to suicide prevention remains overly fragmented. Calls have been made to better align state and national suicide prevention strategies and better coordinate the activities and funding under these strategies.

The consultation forums have reinforced the need to continue raising the profile of work at the national, state and local levels. This is seen as important to foster better collaboration, maximise resources, reduce the chances of duplication, and to improve public confidence that action is being taken. Some highlighted that collaborations between Primary Health Networks (PHNs), Hospital and Service Services and local providers have helped improve regional coordination of suicide prevention activity.

Others raised the need for some preventative activities to have a more state or national approach in their design and implementation. This is particularly so for activities like media training and awareness campaigns.



SPOTLIGHT ON PROGRESS

A regional approach to suicide prevention

Our state's Hospital and Health Services, Primary Health Networks (PHNs), primary health care providers, non-government sectors, emergency services and people with a lived experience of suicide, are working collaboratively to support and develop a more coordinated and integrated regional approach to suicide prevention.

As a centrepiece of their local health plan, Western Queensland Primary Health Network (PHN) have joined forces with the Queensland Aboriginal and Islander Health Council and the region's four Aboriginal Community Controlled Health Organisations to enhance delivery of social and emotional wellbeing services.

A new commissioning framework, developed along with local Aboriginal Community Controlled Health Organisations is expected to support transition of these services to community control, improve collaboration, increase the Indigenous health workforce, and improve the cultural competence of mainstream services.

Mental Illness Fellowship Queensland is working with Brisbane North Primary Health Network (PHN), *beyondblue* and Redcliffe Hospital to develop and deliver a trial follow-up community-based suicide prevention service in the Redcliffe region.

The Way Back Support Service is a *beyondblue* initiative providing non-clinical follow-up care and support. Clinical support will also be available at this site to meet an identified gap in the Redcliffe community.

This new trial service complements and works collaboratively with the Redcliffe Hospital to improve the immediacy of follow-up response for individuals who have recently attempted suicide.

The Townsville Suicide Prevention Network is working with local agencies and community groups across its region to support the localised implementation of whole-of-community, systems-based approach to suicide prevention.

Informed by lived experience, the recently released Townsville Community Suicide Prevention Action Plan outlines steps being taken to implement actions across ten evidence-based strategies.

As part of a strategy to improve the ability of community members to intervene and support those at risk, the network will help coordinate access to a range of training opportunities for business, government agencies, non-government organisations and schools.

Using evidence and learning from lived experience

It is widely agreed that our suicide prevention activities need to be based on sound evidence.

Crisis intervention, follow-up care and support, training and education and means restriction were seen as important components in any evidence-based suicide prevention strategy.

Many stakeholders recognised that Queensland has been a leader in building the evidence-base for suicide prevention, having made substantial investments in data systems and research over a long period of time.

It is important that this evidence is as accessible and relevant as possible to the work of those who are planning, implementing and evaluating suicide prevention activities, including those working at the state and local levels.

Timely data on suicides and suicide attempts is widely seen as vital, to help create a shared understanding of who is at greatest risk, determine where and how to focus prevention efforts, and support evaluation.

The need to continue building and sharing evidence on what works to reduce suicide was repeatedly raised across the forums. This includes improving understanding of what works for known higher risk and vulnerable groups.

Many people talked about the need to learn from the experiences of those who have attempted and been bereaved by suicide to inform the design and implementation of suicide prevention initiatives and resources.

An energised lived experience network has emerged in Queensland in recent years and is playing an important role in shaping major initiatives in the health system and elsewhere.

Reducing suicide and its impact *(continued)*

Community awareness of suicide prevention

People with lived experience have advocated for greater public awareness of suicide and its prevention.

This is seen as important for engaging the community, reducing the stigma that prevents people seeking help, and encouraging members of the public to reach out to those who may be at risk.

Some stakeholders called for wider support of campaigns to increase awareness of suicide, while others have noted the role media can play in dispelling misconceptions, encouraging help seeking, and influencing public policy.

Many stressed that increasing public awareness of suicide needs to be done with care, as it can have negative consequences—including the potential to increase suicide and cause unnecessary community alarm. The need to avoid sensationalist or insensitive media coverage was highlighted.

Initiatives like Mindframe are seen as instrumental in guiding responsible reporting of suicide in the traditional media. A number of stakeholders have stressed the need to improve the way suicide is portrayed through new media, including social media.

Wellbeing as a foundation for suicide prevention

The Commission heard that suicide prevention begins with promoting good mental health and wellbeing in our communities, homes, families, schools, workplaces and other places where people connect. Many have highlighted the value in strategies that help build people's resilience in the face of stress.

Having a sense of belonging and connection to others was widely acknowledged as one of the most important protective factors against suicide. The importance of helping those vulnerable to social isolation and exclusion to connect with others was stressed in many of the forums held across the state.

Assisting community members to cope with periods of hardship and crisis is also seen as vitally important in suicide prevention, whether this hardship is caused by acute or chronic health issues, relationship problems, abuse and neglect, natural disaster and drought, financial difficulties or for other reasons.

An evidence-based approach to suicide prevention

The World Health Organisation identifies eleven evidence-based elements that may be included in a comprehensive suicide prevention strategy¹⁵. These elements have been adopted as a framework for the *Fifth National Mental Health and Suicide Prevention Plan*.

Surveillance: increase the quality and timeliness of national data on suicide and suicide attempts.

Means restriction: reduce the availability, accessibility and attractiveness of the means to suicide.

Media: promote the implementation of media guidelines to support responsible reporting of suicide.

Access to services: promote increased access to comprehensive services for those vulnerable to suicidal behaviours.

Training and education: maintain comprehensive training programs for identified gatekeepers.

Treatment: improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.

Crisis intervention: ensure that communities have the capacity to respond to crises with appropriate interventions.

Postvention: improve response to and caring for those affected by suicide and suicide attempts.

Awareness: establish public information campaigns to support the understanding that suicides are preventable.

Stigma reduction: promote the use of mental health services, and services for the prevention of problematic alcohol and other drug use, and suicide prevention.

Oversight and coordination: establish institutions or agencies to promote and coordinate research, training and service delivery in respect of suicidal behaviours.

The Commission heard examples of many programs operating in our schools, workplaces, and communities that seek to help people connect, build resilience and cope with adversity. There was a widely held view that these approaches needed to be more wide-spread and pay attention to needs of known vulnerable groups.

Identifying and responding to those at risk

Throughout Queensland, stakeholders told us about the many different types of individuals, groups and services people may turn to or confide in when they are facing hardship or experiencing suicidal thoughts.

Health and social services, businesses, and community organisations such as sporting clubs and agribusiness were all identified as places people at risk may share their problems. People may also have contact with the wide-range of Queensland Government agencies operating across metropolitan, regional and rural areas.

Community stakeholders indicated that many individuals, organisations and groups across the community could be better supported to reach out and respond to those at risk. A number of resources have been highlighted that can help people feel more confident to have conversations with those they are concerned about, like Conversations Matter and Conversations for Life. It was suggested that these types of resources could be promoted more widely.

Some community groups, including frontline workers are more likely than others to have contact with people at risk of suicide. These groups may need more tailored suicide prevention awareness support and training to help them respond appropriately.

The consultation forums emphasised that improving the ability of community members and groups to identify people at risk of suicide will only be effective if there are also formal and professional support systems to refer people to.



Building schools knowledge and skills

The Department of Education and Training is implementing an evidence-based and systematic approach to building the capacity of its workforce to detect and respond to students experiencing mental health concerns and suicide risk.

The online Mental Health Resource Hub brings together resources to assist principals, teachers and other school staff to support and respond to the mental health and wellbeing needs of students.

Specialist student support personnel have been equipped with suicide risk detection and management skills and knowledge. STORM suicide prevention and postvention training has been delivered to all secondary Senior Guidance Officers and Guidance Officers. Suicide Risk Continuum Training has also been delivered to all primary Senior Guidance Officers and Guidance Officers.

Reducing suicide and its impact *(continued)*

Care and support for people at imminent risk

The need for a more person-centred approach to supporting people at high risk of suicide was consistently raised across the consultations.

Stakeholders highlighted the wide-spectrum of supports needed to respond to those at risk, including a range of clinical, non-clinical, peer and informal supports that are available face-to-face, by telephone and online.

While some people have positive experiences of care following a suicide attempt, this is not always the case. Many report significant shame about seeking help and judgement from health staff. It was stressed that support needed to be sensitive and easily accessible, affordable, and available in times of need. Many also highlighted the need for tailored supports that meet the specific needs of higher risk groups.

Difficulties navigating complex health and social services and accessing timely support can leave families feeling they are carrying the full responsibility of keeping their loved one safe.

Families have emphasised the need to know they have support and back up to help their loved one recover from a suicide crisis or attempt.

Frontline staff working in emergency rooms and acute mental health services told the Commission they can find it difficult to meet the needs of people with more complex suicidal behaviours, particularly those who regularly engage in self-harm.

The need to improve links between emergency care and a range of clinical, non-clinical peer and afterhours supports was widely acknowledged during the consultations, as was the need for alternatives to emergency department and hospital-based care for those with complex needs.

The Commission was told that follow-up care should be an integral part of discharge planning for every person presenting to emergency or acute care for a suicide attempt, with mental health professionals noting that the hours, days and weeks following an attempt are a high risk for further attempts.

Working collaboratively across agencies and breaking down information sharing barriers was seen as vital for supporting those at risk, particularly when the person is a client of multiple services.



SPOTLIGHT ON PROGRESS

Conversations that matter

Many stakeholders highlighted the importance of helping community members feel confident to have a conversation and support those they are concerned about.

Conversations Matter is a suite of online resources developed by the Hunter Institute of Mental Health to support community discussion about suicide: www.conversationsmatter.com.au.

The resources provide practical information to guide conversations about suicide and can be used to support one-on-one conversations or group discussions.

Developed with the support of academics, service providers, people with lived experience and community members, the resources are designed for:

- community members who need general advice about ways that suicide can be talked about safely
- professionals who need advice about how best to engage with and support communities to talk about suicide
- professionals working with culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities.

Conversations for life is a suicide prevention mobile app and instructor-led program developed by ConNetica to help build people's confidence, willingness and ability to have conversations with people they are concerned about. A youth version of the app, Chats for life has also been developed: www.connetica.com.au/conversations-for-life.

These programs are designed to assist community members support each other's mental health and to share knowledge and skills to prevent suicide. They help people know what to do in a crisis, and help them plan for and provide support for those who may be at risk.

MATES in Construction is an integrated approach to suicide prevention and mental health promotion for the construction, mining and energy industries. It starts conversations around mental health seeking to reduce stigma, trains and assists workers, as well as operating a 24/7 help line and case management support for individuals.

The MATES in Construction concept is based on the premise that if the industries within Australia are to improve the mental health and wellbeing of workers and reduce suicide then it cannot be left only to the mental health professionals, but rather everyone must play their part:

www.matesinconstruction.org.au.

Supporting families and others bereaved by suicide

The loss of a loved one to suicide is devastating and the effects are long-lasting. Bereavement is complicated, and includes feelings of loss, shame, anger and guilt. This can be compounded by social stigma that makes it difficult to talk about a loved one's death and can result in people pulling away and feelings of isolation.

The need for bereavement supports for those who have lost a family member, friend or work colleague to suicide was raised many times in the consultations. This includes age-appropriate support for children and young people.

Face-to-face support from others who have been bereaved has been identified as particularly helpful in the grief process. It was noted that while peer support groups are invaluable for those bereaved, these groups tend to come and go and can be difficult to access.

Suicide can have a major impact on frontline service providers as well as a substantial ripple effect across the broader community. The impacts on emergency personnel, Aboriginal and Torres Strait Islander families and communities, rural and remote communities and schools were a source of concern for many stakeholders.

The wider provision of post-incident and community supports following a suicide was encouraged to reduce the impact of suicide, promote community healing, and reduce the risk of further suicides.



Enhancing the health system response to suicide

In 2016, the Queensland Suicide Prevention in Health Services Initiative was established to help drive improvements across the health system, with a \$9.6 million investment over three years.

The initiative has three components:

1. Establish a Suicide Prevention Health Taskforce to develop and implement evidence-based suicide prevention policy, strategies, services, and programs in a health service delivery context.
2. Review deaths by suspected suicide of people who had recent contact with a health service to inform future actions and service improvements.
3. Continued implementation of training for hospital emergency department staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk.

The Gold Coast Mental Health and Specialist Services are tackling the challenge of suicide prevention in the health system through implementation of the Zero Suicide framework within the service.

The Suicide Prevention Strategy recently launched by Gold Coast Mental Health and Specialist Services is based on a model working successfully in the United States of America and is a first for a major Australian health service.

This systems approach to suicide prevention focuses on a number of broad strategies that starts with instilling the belief that suicides can be prevented in people under the care of a health service.

The service has also established a Suicide Prevention Pathway that builds on principles of:

- engagement
- assessment and risk formulation
- safety planning
- care planning that addresses the drivers for suicide
- effective transitions from care.

For the Gold Coast Mental Health and Specialist Services, the 'Journey to Zero' is about reducing the incidence of suicide and its devastating impact on everyone it touches. Achieving zero suicides is an aspirational goal, but this is about taking the journey and changing the mindset to prevent suicide.

Reducing suicide and its impact *(continued)*

Tailoring approaches for vulnerable groups

The Commission has been told that strategies need to target groups with a high risk of suicide if there is going to be a meaningful reduction in suicide rates. This includes approaches designed to address known risks for:

- young and middle-aged men
- Aboriginal peoples and Torres Strait Islanders, particularly young people
- people living with chronic health issues or disabilities
- children and young people known to the child protection system
- people living in rural and remote communities
- members of LGBTI communities, particularly people who are transgender.

It has been stressed that not all members of these groups are vulnerable to suicide. These groups are, however, more likely to experience a range of stressors and other factors linked to a higher risk of suicide, including economic hardship, isolation and social exclusion. Various strategies were suggested for reducing suicide among vulnerable populations, from promotion of social inclusion, to tailored supports and safe houses.

The Commission heard that it is important to build on existing strategies and recommendations for suicide prevention among vulnerable groups where they already exist, rather than duplicating this work.

The National Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project was highlighted as an example of an evidence-based and culturally appropriate foundation for Aboriginal and Torres Strait Islander suicide prevention.

The recently released National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy was also identified as providing guidance for suicide prevention among the diverse LGBTI community.

Stakeholders called for direct consultation with affected groups, to ensure responses address the unique issues experienced by different groups and are tailored and effective.

Place-based approaches

All communities consulted indicated that place-based approaches, managed and directed by local communities are more likely to be effective in improving mental health and wellbeing and preventing and reducing suicide.

They indicated the benefit of localised approaches support communities to identify their own needs, design appropriate responses, and to work together better. Some stakeholders indicated that this needed to extend beyond developing and managing projects but also to communities having a direct say in what services are funded in their communities.

A number of examples of place-based approaches were identified by stakeholders, including localised suicide prevention action plans.

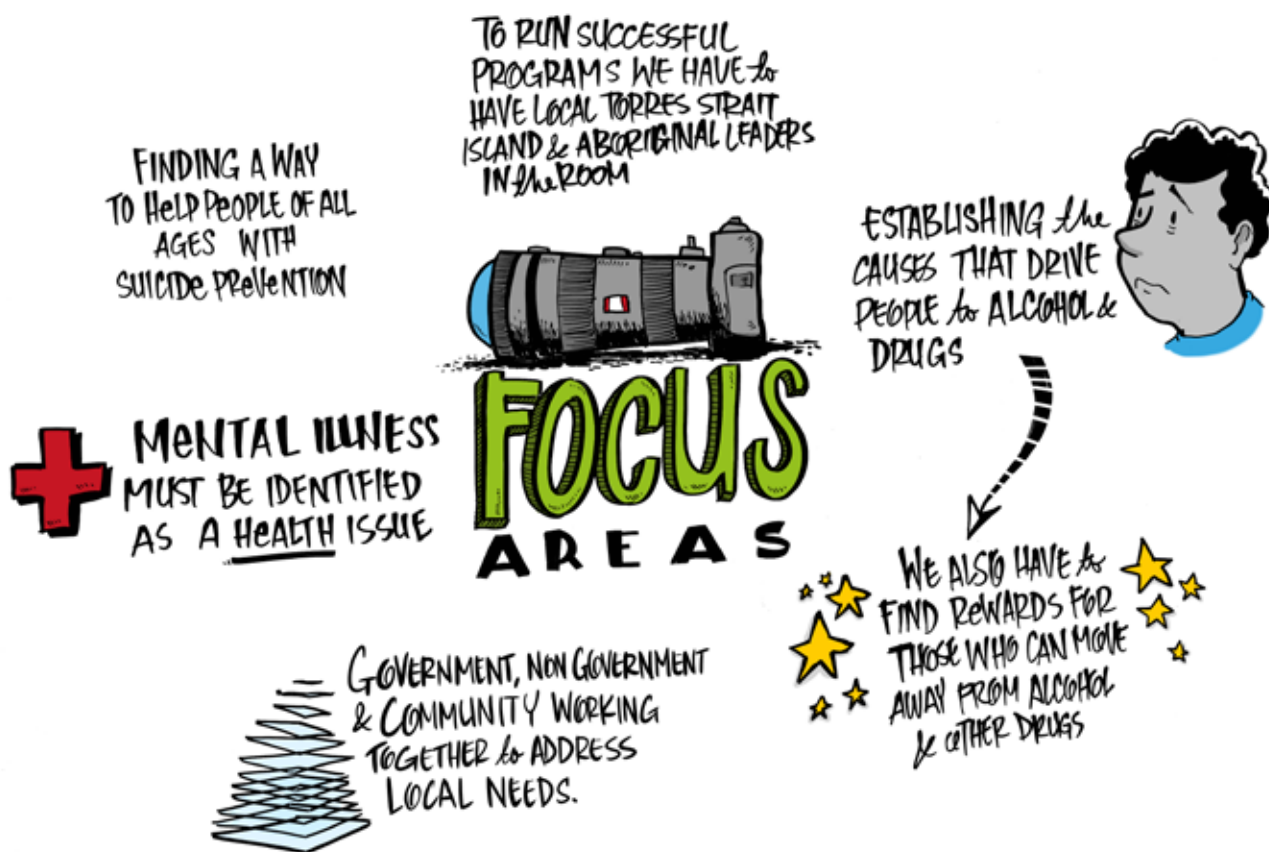


WHAT IS NEEDED

Reducing suicide and its impact

To prevent and reduce the impact of suicide on Queenslanders, we need to:

- Improve the coordination between suicide prevention strategies and activities occurring at the national, state and local levels.
- Implement suicide prevention strategies that are based on contemporary data and evidence, and are informed by people with lived experience.
- Address the full range of individual, social and structural factors that contribute to suicide, including mental health, relationships, economic factors and the impact of adverse events and hardship.
- Ensure individuals, groups and services have the knowledge and skills they need to identify and respond to those who may be at risk of suicide.
- Make it easier for people at risk of suicide to access support services, including after-hours, crisis, clinical and non-clinical supports.
- Ensure people receive a sensitive and positive experience of care when seeking assistance for suicide and self-harm.
- Provide a range of clinical and non-clinical options to better meet the needs of people with complex suicide and self-harm behaviours.
- Provide timely follow-up care and pathways to ongoing support for people presenting to health and other services following a suicide attempt.
- Improve support for families, communities and frontline staff who are bereaved or impacted by suicide.
- Support localised approaches to suicide prevention as part of a well-coordinated strategy.



Our next steps

Since consultation commenced, the Commission has heard from a wide range of Queenslanders. This includes people with a lived experience, their families, carers and support people. The Commission also heard from service providers and representatives from the government and non-government sector.

The Commission will ensure that these views are used to inform the strategic direction and actions stakeholders take to improve the mental health and wellbeing of all Queenslanders, with a particular focus on people who are living with mental illness, problematic alcohol and other drug issues and those who have been affected by suicide.

This will be reflected in the renewed Strategic Plan, which will be released in 2018.

Importantly, the Commission will continue to work collaboratively with government, non-government and the private sector to ensure reforms and investment strategies are aligned to what works. This will include:

- placing greater focus on prevention and early intervention
- reducing stigma and discrimination
- being centred on the diverse and changing needs of Queenslanders

- enabling flexibility and removing access barriers
- providing stepped care options that are linked to other support services as required
- supporting recovery and people to live lives with purpose
- ensuring meaningful engagement with the community and people with a lived experience
- tailoring policies, programs and services to more effectively respond to the needs and goals of Queenslanders
- coordinating programs and funding to ensure equitable access to services and better outcomes for people
- promoting and supporting coordination, collaboration and integration within and across services and sectors.

The Commission commits to regular and meaningful engagement to ensure we remain abreast of contemporary and emerging issues and to work together to develop innovative solutions.



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Appendix 1

Submissions received

In total, 32 submissions to the review of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* were received: 12 from individual members of the community and people providing services; and 20 from service providers, researchers and other organisations. Outlined below is a list of written submissions received from service providers^d.

Alcohol and Drug Foundation	North Burnett Regional Council
<i>beyondblue</i>	Public Health Association of Australia
Brisbane City Council	Queensland Advocacy Incorporated
Children’s Health Queensland Hospital and Health Service	Queensland Family and Child Commission
Department of Education and Training	Queensland Health
Department of State Development	Queensland Network of Alcohol and other Drug Agencies
Heart Foundation	Queensland Police Service
Inner City Referral Team – Institute for Urban Indigenous Health	Royal Australian and New Zealand College of Psychiatrists
Micah Projects	Suicide Prevention Australia
MOVE muscle, bone and joint health	

^d To preserve the anonymity of submissions received from individual members of the community, the Commission will only publish the names of organisations that submitted to the review of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*.

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Feedback

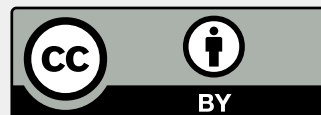
We value the views of our readers and invite your feedback on this report.

Please contact the Queensland Mental Health Commission on telephone 1300 855 945, fax (07) 3405 9780 or via email at **info@qmhc.qld.gov.au**.



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