Office of the Public Advocate – Queensland

Submission to the Senate Select Committee Inquiry into Australian Mental Health Services

13 May 2005

I. Preliminaries

1.0 Scope of the inquiry

The Select Committee on Mental Health was appointed by the Australian Senate on 8 March 2005 to inquire into and report on the provision of mental health services in Australia, with particular reference to:

(a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;
(b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;
(c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;
(d) the appropriate role of the private and non-government sectors;
(e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;
(f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;
(g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;
(h) the role of primary health care in promotion, prevention, early detection and chronic care management;
(i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;
(j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;
(k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;
(l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;
(m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;
(n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;
(o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and
(p) the potential for new modes of delivery of mental health care, including e-technology.

Thus the scope of the inquiry is ambitious and wide-ranging. Each reference deals with an important issue, each of which is deserving of its own chapter.

2.0 The Office of the Public Advocate – Queensland

The Office of the Public Advocate was created under chapter 9 of the *Guardianship and Administration Act 2000* (Qld). Unlike other Australian states, the Queensland Public Advocate is charged solely with providing systems advocacy for adults with a decision-making disability. This group includes people with a psychiatric disability, an intellectual disability, an acquired brain injury or some form of dementia. Under the Act, it is the function of the Public Advocate to:

- promote and protect the rights of adults with impaired capacity for a matter
- promote the protection of the adults from neglect, exploitation or abuse
- encourage the development of programs to help the adults to reach the greatest practicable degree of autonomy
- promote the provision of services and facilities for the adults
- monitor and review the delivery of services and facilities to the adults.

3.0 The scope of this submission

The Public Advocate is a Statutory Officer of the Queensland Parliament, appointed by the Governor in Council.

Given the ambitious reach of the terms of reference of the inquiry, and the Office's limited resources, this submission will focus on key matters which the Public Advocate believes, if addressed, would leverage much needed reform in mental health services throughout Australia.

Therefore the purpose of this submission is:

- first to raise issues pertaining to the Commonwealth's role with respect to the inquiry's reference (l), which deals with the stigmatisation of and discrimination against citizens who have a mental illness; and
- second to provide brief comment on other references and where relevant, to draw to the Committee's attention good practice approaches that have been developed in Queensland.

II. Public Advocacy and Mental Health

4.0 The Public Advocate's interest in mental health

Given the Public Advocate's mandate for adult Queenslanders with impaired decision-making capacity, he has taken an active interest in mental health over the past five years. For example:

- In his 2000-01 Annual Report, the Public Advocate recommended strengthening the State's mental health peak body.
- In 2002, the Public Advocate lodged a formal complaint with the Australian Press Council against Queensland Newspapers for its stigmatising and discriminatory reporting on mental health.
- In 2002, the Public Advocate made written and verbal submission to the Mullen-Chettleburgh Review of Queensland Forensic Mental Health Services.
- Since 2001, the Public Advocate has actively monitored the reform of the boarding house industry, which is home to hundreds of Queenslanders with a mental illness.
- The Public Advocate has been a strong supporter of the *Mental Health Act 2000*, widely regarded as among the nation's most progressive mental health legislation.
- The Public Advocate strongly supported the Department of Housing's *Interagency Collaboration Improvement Project*, designed to improve the department's service delivery to clients with a mental illness.
- In his 2002-03 Annual Report, the Public Advocate recommended that Queensland Health apply greater investment in community-based alternatives to acute inpatient care and in the expansion of the non-government mental health sector.
- In his 2002-03 Annual Report, the Public Advocate argued that greater interagency collaboration is needed to better serve vulnerable people – particularly between Queensland Health and Disability Services Queensland. He strongly supported the Queensland Health/Disability Services Queensland *Dual Diagnosis Project*, which aims to improve access to services for people with a coexisting mental illness and intellectual disability.
- The Public Advocate strongly supported a partnership project between Queensland Health and the Queensland Police Service, and acted as a referee for the nomination of this project for a 2003 Queensland Premier's Award.
- In his 2002-03 Annual Report, the Public Advocate drew attention to the highly decentralised nature of Queensland Health, and called for a more consistent application of mental health policies and practices across Queensland's regions.
- The Public Advocate made submission to the Crime and Misconduct Commission Inquiry into Media Access to Police Radio Communications, in support of the position of the Queensland Police Service and Queensland Health.
- In his 2003-04 Annual Report, the Public Advocate commended Queensland Health for a number of initiatives that benefit people with a mental illness, including its partnerships with the Department of Housing, its increase in the number of community-based clinicians, its pilot projects for alternatives to inpatient care, and its increase in spending on non-government services.
- In his 2003-04 Annual Report, the Public Advocate recommended that the Queensland Government pursue a comprehensive and cross-agency Recovery Strategy as the primary

vehicle for delivering interagency collaboration in meeting the needs of people with a mental illness.

- In his 2003-04 Annual Report, the Public Advocate examined the low levels of State funding to mental health, the occurrence of "sentinel events" in the mental health system, and the need to both strengthen the "consumer voice" in mental health and to forge a genuine working partnership with the non-government psychiatric disability sector.
- The Public Advocate is about to launch a discussion paper titled "*Preserving Life and Dignity in Distress: responding to critical mental health incidents*". This paper builds on the collaboration between Queensland Health and the Queensland Police Service in proposing a comprehensive interagency strategy for responding to mental health crises.

5.0 Background to this submission

As an Officer of the Queensland Parliament, the Public Advocate works to influence a range of systems that impact on Queensland citizens with impaired decision-making capacity. As such, the Public Advocate directs most of his efforts toward State-based systems that serve, or in some way impact upon, the lives of vulnerable adults.

However, the current Senate Select Committee Inquiry represents a unique opportunity for the Public Advocate to cast a critical light on a range of issues that lie within the Commonwealth's area of responsibility. This is particularly important, given that the locus of energy for the reform of mental health services in Australia lies within the Commonwealth Government.

This is not to overlook the critical role of the Queensland Government with respect to people with a mental illness. In fact, the Public Advocate vigorously engages with agencies of the Queensland Government about various aspects of its service delivery to adults with impaired decision-making. However, the current submission will undertake a closer examination of the Commonwealth's responsibilities in the arena of mental health.

III. A failure of leadership

6.0 Creating a culture of suspicion and exclusion

There is growing evidence that many Australians with a mental illness, and the systems that serve them, appear to subsist in a state of crisis today. This crisis is characterised by the routine inability of mentally ill citizens to access a service, and by their equally routinely shabby treatment once they are exited from whatever service they might be fortunate enough to receive.

However, what is rarely acknowledged is that this crisis is a direct reflection of the position the mentally ill occupy on the social and economic landscape of Australia. This position is one of marginalisation, social exclusion and discrimination.

That citizens with a mental illness barely register on the nation's civic and political agenda is nothing new. It was well documented in the 1993 Burdekin Report of the National Inquiry into the Human Rights of People with Mental Illness. This report led to the establishment of the National Mental Health Strategy, now in its third iteration.

However, it is the concern of the Public Advocate that over the past decade, the actions of the Commonwealth Government have further eroded the already tenuous position of such vulnerable groups in our community. Through the promotion of stigmatising and exclusionary attitudes and practices towards any group considered 'alien' or 'other', the Commonwealth Government has directly contributed to a culture of suspicion and discrimination in Australia.

This thesis was advanced one year ago, when the Queensland Public Advocate delivered a speech entitled *"Mental health and the politics of the white picket fence"*. An edited copy of this speech is attached as an integral part of this submission.

Since the time of this speech further events have come to light.

- It has now been determined that Ms Cornelia Rau, a long-term Australian resident with a mental illness, was wrongly incarcerated – and held without psychiatric treatment – in Commonwealth detention for a period of many months.
- It has also come to light that another woman with a mental illness – this time an Australian citizen of Filipino descent – was in fact deported from Australia.
- The Commonwealth Government has since admitted that over 30 people have thus far been wrongfully detained in Australia's immigration system. The real figure is likely to be much higher, given that this number covers a seven-month period only.
- The devastating impact of such incarceration on people's mental health is by now well established, as evidenced in the more recent work of the Human Rights and Equal Opportunity Commission.

How is it that a country comes to deport one of its own citizens, and to incarcerate many others in refugee detention camps? How is it that having a mental illness, or being of a different ethnic background, has so easily become criminalised? Why has such inhumane treatment continued, despite the demonstrable evidence of its psychological harm, particularly where the presence of a mental illness is neither recognised nor treated?

These cases are marked by the intersection of disturbing forces: racial hatred, the stigmatisation of the mentally ill, and an irrational fear of the 'other'. For people with a mental illness this also

is nothing new: consumers have long reported on the stigma they face on a daily basis, stigma which can be worse than the illness itself, and which extends even to the professionals who are paid to support them.

The intersection of race and mental illness is no accident. Our treatment of refugees and our treatment of citizens with mental illness are linked by an encompassing prejudice promoted by the Commonwealth Government. The public discourse promoted by this government has become increasingly self-interested and exclusionary since 1996. The collective loss of a narrative of compassion – which once underpinned the iconic notion of the 'fair go' and support for the underdog – has been to the detriment of every marginalised group in our community.

While the Public Advocate does not argue that widespread stigmatising attitudes and behaviours are easily reversed by governments, he does assert that our national leadership has an overriding duty to develop narratives that support social cohesion, rather than undermine what is a complex and increasingly fragile sense of national community. The current national government has manifestly failed to fulfil this duty and the consequences for citizens with a mental illness have been overwhelmingly negative.

7.0 Structural elements of mental health reform

7.1 The stigmatisation of the mental health sector

Even after accounting for the failure in leadership of the current national government, stigma and discrimination underlie other key issues that confront the mental health sector. It is often not appreciated that the agencies which provide services to marginalised groups are themselves stigmatised, and suffer low status in the pecking order of and within government departments.

Thus the mental health program in every health department in the Commonwealth is likely to be marginalised in terms of funding, policy clout and capacity to influence the broader health agenda. Given that national spending on mental health services accounts for only 6.4% of total gross recurrent expenditure on health, it is unlikely that any State's mental health program achieves funding levels commensurate with the real need. This need is evidenced by two key indicators. First, 20% of the nation's population will at some time experience a mental illness. Second, mental illness accounts for almost 30% of the nation's non-fatal burden of disease.

Again, this deficiency of funding and policy direction will only be overcome by exemplary national leadership and long term resolve. Clearly the Commonwealth has a considerable stake in addressing this crisis. The priorities for the national agenda were established by the Commonwealth Government. The Commonwealth initiated, and continues to drive, the reform of services through the National Mental Health Strategy. While services are delivered by the States, federal funding still accounts for almost 40% of the nation's mental health resource base.

Given this shared responsibility, the role of the Commonwealth in mental health reform is critical. Many pundits applaud the policy intention of the national strategy, while lamenting the failure of its implementation by the States. However, little benefit accrues to vulnerable people with a mental illness by merely condemning the States' performance. Nor would the handover of responsibility for mental health to the Commonwealth guarantee the results that consumer advocates have long hoped for.

What is needed instead from the Commonwealth is a commitment to leadership and dialogue with the States. Its efforts are best directed towards assisting the States to realign their health

priorities, so that mental health programs are empowered to fully implement the vision of the national strategy, and to apply the necessary policy leverage and funding reallocation they require.

Commonwealth leadership is needed to elevate mental health beyond the policy and funding wasteland where it currently resides. Until this happens, the low priority that States place on mental health will persist, a reflection of the low priority it has on the national policy agenda relative to nearly every other area of health.

7.2 Interdependency and the recovery model

The terms of reference of the inquiry correctly imply that no single service system is capable of delivering that which vulnerable citizens need in order to live a full and productive life.

Yet regrettably, the mental health program in each jurisdiction is unreasonably expected to do so. This is a primary reason why each mental health service is perceived to be in a state of ongoing crisis.

This situation becomes apparent when we examine the complex life experiences of people with a mental illness, as substantiated by the large body of empirical evidence. For many consumers, the reality of life is characterised by any combination of the following:

- poor housing
- long-term or periodic homelessness
- low income
- discrimination
- unemployment
- low labour force participation and loss of vocational capacity
- substance abuse
- poor social networks
- frequent interaction with the criminal justice system.

Neither the national strategy nor the States' mental health programs can address these issues alone. What is required is a broad framework that identifies the essential stakeholders and aligns them in a way that ensures their accountability for specific outcomes.

To date, the most useful framework for this task derives from the concept of Recovery. As described by consumers themselves, Recovery is both a process and an outcome. It is essential for promoting hope and improving well-being and self-determination for people who live with a mental illness. Importantly, Recovery from a mental illness requires more than just psychiatric treatment and access to mental health services – it takes people beyond the role of 'consumer'. As articulated in the most recent National Mental Health Plan, Recovery means once again living a hopeful, satisfying and contributing life. This may include:

- having a secure, stable home – and the support necessary to sustain this tenancy in the community
- enjoying close and mutual relationships
- having meaningful work – and the necessary training and support to sustain employment
- being able to purposefully contribute to the wider community
- having seamless access to both mental health and substance use services
- being able to interact with a variety of open community systems without fear of discrimination or stigma

- being diverted from the criminal justice system into appropriate treatment.

Recovery represents an holistic vision for a person's life, one that goes far beyond the simple provision of mental health services. A comprehensive framework built around the concept of Recovery can therefore act as the vehicle for the necessary whole-of-government reform, a reform that also includes the Commonwealth.

In fact, it is the Public Advocate's view that this whole-of-government reform for mental health should be led by the Commonwealth. It is incongruous to expect that a federal *health* reform strategy could produce a coherent *whole-of-government* delivery at the State level. A whole-of-government approach to mental health policy and funding should emerge from the Commonwealth, in order to see the same level of integration in the States' delivery of services.

7.3 Interagency collaboration

Similarly, the terms of reference of the inquiry also beg the question as to the extent to which resources could be better utilised if various silos of government were to develop more effective collaborative arrangements.

The prerequisite to achieving this is that the policy dialogue moves away from what have become traditional notions of 'core business' beyond which an agency will accept no responsibility, towards a 'without prejudice' discussion of those issues which no single agency can hope to resolve and which are therefore 'everybody's business'.

The Public Advocate has campaigned for a number of years in Queensland for significantly improved collaboration between key human service agencies, in particular the mental health, disability and public housing programs. While there is still substantial room for improvement, a number of key agencies have responded with innovative service models that could be usefully adopted in other Australian jurisdictions. Three of these projects are discussed below.

7.3.1 Dual diagnosis project
(mental health and disability programs; references (c) and (f))

A two year strategy was undertaken to improve access to services and support to people with a dual diagnosis of mental illness and intellectual disability. This was a joint project by Queensland Health and Disability Services Queensland. The model included the development of Guidelines for service provision between both government agencies and community-based organisations, as well as training to develop specialist skills for frontline staff. This model has been implemented in 15 sites across the State where there is a high prevalence of intellectual disability.

As part of this project, Queensland Health and Disability Services Queensland were the first agencies in the country to jointly adopt the use of the Psychiatric Assessment Schedule for Adults with Developmental Disability (PAS-ADD). Further, the Queensland Centre for Intellectual and Developmental Disability is the only accredited PASS-ADD trainer in Australia, and could be usefully engaged to deliver training to other jurisdictions.

It is the hope of the Public Advocate that a similar model of collaboration and innovation might be successfully applied to the problem of dual mental illness and substance use disorders, given the high rates of this form of dual diagnosis.

7.3.2 Critical incident response

(mental health and police services; references (b) (c) (f) (j) and (m))
An innovative partnership project has been developed by Queensland Health and the Queensland Police Service to better serve the needs of vulnerable mental health consumers who come into contact with law enforcement. A State-wide Memorandum of Understanding has been in place for a number of years and Local Protocol Agreements exist in most districts.

More recently, crisis intervention protocols between the two services have been developed and a model for crisis intervention has been endorsed. This has been given strong support by the Public Advocate in his publication of a Discussion Paper, *Preserving life and dignity in distress: responding to critical mental health incidents*. In this Paper, the Public Advocate proposes a comprehensive strategy for police-mental health collaboration, and a coherent framework for more integrated and humane responses to mental health crisis situations. A copy of the discussion paper is attached, and forms part of this submission.

7.3.3 Housing and psychiatric disability project
(mental health and public housing programs; references (b) (c) (e) and (m))
There is now overwhelming evidence of the link between housing stability and mental health. Research indicates that an appropriate housing response – one that makes having a real home possible – fosters recovery, stability and hope, and reduces hospital readmissions.

There is growing collaboration between Queensland Health and the Queensland Department of Housing, which aims to sustain tenancies and improve outcomes for public housing residents who have a mental illness. Based on the Department of Housing's *Interagency Collaboration Improvement Project*, several local partnership agreements now exist between mental health services and area housing offices, and work is underway towards the endorsement of a corporate-level agreement between the two departments. Joint research work on the housing needs of people with a psychiatric disability is planned as part of this agreement.

7.3.4 Project 300
The Public Advocate has been arguing for some time that State and Commonwealth Governments should look to Queensland's *Project 300* as a model for further reform in both mental health and disability.

Project 300 has assisted the transition of some 260 people with psychiatric disabilities from long-term institutionalisation in Queensland Health facilities to a real life in the community. It is the most successful example to date of interagency collaboration in Queensland for people with a decision-making disability. This project has significantly enhanced the quality of life of highly vulnerable people, often against the odds and in the face of some entrenched scepticism.

What sets Project 300 apart from other service responses in Queensland?

- Project 300 was devised to meet the needs of a group of people who had suffered a long period of systemic neglect, during which time it was generally believed that no other option existed for their care, other than long-term/permanent institutionalisation.
- Project 300 was a collaborative response by Queensland Health, Disability Services Queensland and the Department of Housing.
- There was in-built accountability to ensure that all three government departments delivered tangible outcomes.
- Dedicated and recurrent funds were set aside for Project 300.
- Project targets were established with respect to the number of people to be served.

- An holistic vision was developed for people, one that encompasses their health, disability support, community integration and housing needs.
- Both government and non-government agencies provide integrated service responses as part of Project 300.
- Some years after the project's inception, vulnerable people continue to benefit from Project 300. (Negotiations are currently underway for the movement of more people from long-term institutionalisation under Project 300).
- Queensland Health reports that in some cases Project 300 has been so successful that a number of support packages were no longer required, enabling reallocation of funds to assist additional people.

While Project 300 is far from a perfect service response, the above elements have been brought together successfully in Queensland to holistically meet the needs of a highly vulnerable group of people in innovative ways.

7.4 Commonwealth funding

The regrettable habit of our national leadership of using funding issues as weapons in its ideological battles with state and territory jurisdictions tends to mask the degree to which the national government must accept responsibility.

This is relevant first to mental health funding. Although the Commonwealth Government has significantly increased funding to mental health over the past decade, the inequity persists. While federal funding to mental health was around $1.146 billion in 2001-02, this represents only a fraction of the Commonwealth's entire health expenditure (in excess of $30 billion in the same year). Clearly the funding inequities in mental health at the State level are an expression of federal priorities.

However, the funding issues reach beyond mental health. Over successive years, the national government has severely eroded the resource base that is available to build and maintain public and social housing, of which citizens with mental illness are regular users. As discussed in section 7.3.3 above, housing is one of the critical factors in a person's recovery process. A wealth of empirical evidence now attests to the fact that poor, unsuitable, substandard and/or unaffordable housing has a direct impact on the emotional and social well-being of mental health consumers. Simply put, good mental health requires good housing.

Meanwhile, the Commonwealth's diminishing support for social housing and its preference for private sector investments (through Commonwealth Rent Assistance), along with an increasingly unaffordable private rental market, has put the prospect of long-term, decent housing out of reach for the majority of vulnerable Australians who live with a mental illness. The stress this places not only on the housing system but also on the mental health system, and other community-based infrastructure, cannot be underestimated.

Similarly, the national government speaks eloquently about disability issues – arguing that business services (formerly sheltered workshops) must become more business-minded in order to pay their disabled workers a fair wage; and that the states must accept responsibility for young people with disability who are currently residing in aged care facilities. However, the Commonwealth fails to take account of the new and emerging requirement that disability programs are now expected to meet the needs of a very much expanded client base, in particular people who have a psychiatric disability.

8.0 A National Commission for Mental Health?

The Queensland Public Advocate supports the establishment of a permanent and independent national commission on mental health, as previously recommended by the Mental Health Council of Australia and SANE Australia, to report on the progress of mental health reform in Australia and investigate abuse and neglect within mental health settings.

There are distinct advantages in Australia having such a commission.

- It would be a credible, competent, high level body to advise the Commonwealth and State Governments on mental health, and to provide the necessary leadership to maintain the momentum of the national strategy.
- It would provide the capacity for independent reporting on mental health, operating at arm's length from Commonwealth Government.
- It would work collaboratively with the States to influence the implementation of mental health reform.
- It would identify gaps in service provision to people with a mental illness.
- It would be directly informed by consumer and carer experience, and be evidence-based.

Importantly, such a Commission would not become just another critic of the State and Commonwealth Governments, publicly lamenting the lack of progress in mental health. In the minds of its architects, it would be "constructive, positive and programmatic, promoting optimal services and resourcing, providing a practical vision and agenda for the development of mental health services nationally." A high level, reputable Commission which pursues a positive, practical agenda with Government is far preferable to the current situation, in which we hear regular demands for state or national inquiries into mental health. The example provided by the New Zealand Mental Health Commission is worthy of serious examination.

9.0 Medicare Issues

General Practitioners are important partners in caring for the needs of Australians who live with a mental illness or mental health problem. For many people, particularly those in regional or rural areas of the country, GPs are the only/main form of mental health support they receive.

To its credit, the national government has invested in several projects to strengthen GPs' capacity to serve the needs of people with a mental illness. These include: *Better Outcomes in Mental Health Care*, the *More Allied Health Services* scheme, and the *Enhanced Primary Care Allied Health* program. However, funding for these programs urgently needs to be boosted. Further, the government should ensure that other mental health programs link effectively to these programs, to enable seamless referrals and mental health care by GPs for people living in the community.

ATTACHMENT TO SUBMISSION TO SENATE SELECT COMMITTEE INQUIRY INTO MENTAL HEALTH SERVICES

Mental Health and the Politics of the White Picket Fence

Speech by Ian Boardman
Public Advocate - Queensland
at
Public Advocate's Mental Health Forum
Brisbane, 1 June 2004

Welcome & acknowledgement

I am very pleased to welcome you all here today. I am hopeful that we can have a useful conversation about the many vexing issues that confront Queenslanders who live with a mental illness or resulting psychiatric disability, and those issues that confront their families, loved ones and allies.

Let me begin by acknowledging the traditional custodians of the land on which we meet today. It is fitting that I do so, and not just because of what Aboriginal people have lost over many years. But also because of what Australians of European stock have lost. Some have described the damage wrought to our own sense of humanity through our various acts of colonisation and dispossession. What is often forgotten is the loss to our collective sense of spirit or soul. And this, I believe, speaks directly to the issue of mental health and well-being.

Here I am indebted to the work of Aboriginal writer Miriam Rose Ungunmerr, who eloquently wrote on the Aboriginal concept of Dadirri. Dadirri is the word used to symbolise a mystical and contemplative approach to life, and refers to a deep spring of silence that lives inside us. From Dadirri flows renewal, peace, and a profound connection to the earth and to each other. Through Dadirri, we are said to be like a tree surrounded by a raging bushfire. Its bark is scorched and its leaves burnt, yet its roots still survive underground and its sap still flows deep inside. When the fire is over the tree will be reborn. So it waits patiently, silently. In Ungunmerr's words, Dadirri – the gift of deep listening – is the gift of Aboriginal people to all people.

I have borrowed Miriam Rose Ungunmerr's words because when I think of the course of mental health policy and program development in recent years, and the much longer tribulation that is the centuries' long history of the treatment of people who live with mental illness, I am reminded that there is only so much that can be achieved because so little of what happens is within our power to influence. What we can change is how we approach the world, how we think about things and how we conduct ourselves. Ungunmerr's admonition to inner silence and patience seems apt to me, and a good starting point for what I have to say.

Perhaps our closest approximation to Dadirri is the concept of "resilience" which, along with "recovery", is now receiving vigorous attention in mental health circles, including the recent work of prominent Australian and mental health advocate Anne Deveson.

So, in welcome, may the spirit of Dadirri – of both resilience and deep listening – inform our discussion today?

Stigma and discrimination

The title of this talk is “Mental health and the politics of the white picket fence”. Its subject is the stigma and discrimination faced by many people who live with a mental illness. I want to explore this issue because it seems to me that, of all the pressing and perplexing mental health issues that confront us, this is the one that has the most debilitating and insidious effect, and yet is the issue that it is most difficult to do anything about. I want to examine the nature of that discrimination – what we can do about it, what we cannot do, and why.

The argument that I want to develop today is that stigma and discrimination against people with a mental illness is not an isolated and inexplicable event, but rather an inevitable consequence of a larger human and social phenomenon – what I call the fear of the “alien other”.

It seems that sometimes the index of fear in the community is very high indeed, whereas at other times people are much more relaxed and comfortable with their life. At the present time the fear index is moving towards its upper levels, and it is important to understand what consequences that is likely to have for vulnerable groups of people, and what type of leadership is needed to reduce it, not just nationally, but in the local communities in which we live. For it is true that fear itself is the single most frightening phenomenon we confront. When fear grips a community there can be every type of scapegoating and stigmatisation and discrimination, an uncaring and dehumanising tendency that shames us all.

It is my contention that this is what we confront in Australia today. Which brings me to the image of the white picket fence.

Mr Howard and the psychology of fear

Australia’s current Prime Minister, the Honourable John Winston Howard, was photographed standing with his family in front of a white picket fence during one of his early failed attempts to win the Prime Ministership. It is an image that has stuck in many people’s minds.

In exploring the issue of stigma and discrimination I am going to talk about Mr Howard rather than some other well known parliamentarian or community leader, not because I do not like him, but because I am hoping it is safer for me and more useful for you if I do so. It is, I hope, safe for me to use Mr Howard as my example because he is a national figure rather than a Queensland parliamentarian. For you see, my Office operates under Queensland rather than national legislation. It should be evident therefore, that while I am talking about things that have an inevitable political dimension, I am not seeking to have an influence in the political sphere.

Equally, it is useful to take Mr Howard as my example because he is well known to everyone in the audience, and therefore the meaning of what I have to say will be more readily apparent.

I want to examine the meaning of the white picket fence in Mr Howard’s psychology and his political worldview, and how that worldview has applied itself in the world to the detriment or the betterment of people, including people who live with a mental illness. This is important, because it is my contention that stigma and discrimination arises from perceptions and attitudes, that attitude formation occurs very early in our psychological development (some say as young as six years), and that the phenomenon of stigma, while essentially psychological in its origins, is regularly and most destructively played out in the political realm.

Community and political leaders can help to moderate stigmatising attitudes and behaviour to some degree, but only if their own approach to life allows sufficient psychological space for the so-called "alien other" to co-exist.

How does Mr Howard approach life? He is respected as tough, determined and wily, a stubborn defender of the values to which he adheres. But what lies behind this? It is important to know because Mr Howard is not all that much different from any number of Australian parliamentarians. And, much as we like to resent and revile them, Australian parliamentarians are not all that much different from the Australian people they have been elected to represent. It follows that if we can understand Mr Howard's approach to "otherness", we can begin to understand ourselves a little better – and our fellow citizens, and the source of the stigma and discrimination that is such a blight on our national psyche.

The simplest explanations of human behaviour are summed up in various ways. Some refer to the pleasure/pain principle: we avoid pain and seek pleasure. Others say much the same thing by arguing that we are largely motivated by fear and greed.

This is a fairly desolate view of human nature, yet much of our own experience suggests that it is true. And to the extent that it is, it has some very curious consequences for mental health services in Australia today.

Mr Howard may be tough and he may have demonstrated courage in changing our gun laws, but I would contend that the bullet-proof vest he wore at the time was essentially a psychological mantle of fear. He isn't any different to the rest of us and he didn't want to get shot.

Now how has that played out in Mr Howard's Prime Ministership, and what has become of the white picket fence by which at one point in his political life, he attempted to symbolise his values?

Australia's white picket fence

The white picket fence that was originally meant to represent suburban stability and respectability has become any number of different fences now, including the barbed wire fences that surround containment camps located in the Australian desert.

These fences are designed to detain would-be refugees who have been demonised – in other words, stigmatised and discriminated against – into "potential terrorists" and "illegal immigrants".

We sit here today while our country incarcerates children and young people who, together with their parents, are experiencing all the hopelessness and isolation that are known to be the precursors to emotional breakdown, mental illness, and suicide.

We have constructed another white picket fence, one that surrounds our entire country, and hence our minds, our hearts and our communities. This fence is designed to keep the "alien other" out, and our known and respectable selves safely inside. Having constructed this fence, we have now begun a new process of colonisation that we declare to be brave, ethical and righteous. Mr Howard has supported foreign wars ever since Vietnam, so it is no surprise that he still does, and that the people he represents – you and me – largely support him.

For we all live our lives, for the most part, from this motivational basis of fear and greed: fear of the other, fear of loss, fear that we will not get what we want before we die. The colonising tendency is our response to that fear, a response that seeks to shape the world into a reality that makes us feel safe.

Fear-based colonialism does not simply seek to dominate other nations, it operates within a country to dominate its institutions, its cultural life, and ultimately the way we think and live. From among many examples from which I could choose, Mr Howard's colonising of the community sector is the most relevant to us today.

The colonisation of the community sector

Of course government and its political leadership invariably have a tendency towards wanting to dominate and control the community sector – sometimes it happens overtly, sometimes under the guise of "engagement" or as the prescribed antidote to inefficient government services. Thus while government rhetoric often supports community development and empowerment; the reality tells us otherwise.

Over the past eight years there has been an extraordinary shift in service delivery in Australia – a shift from the public to the community sector. And with this outsourcing there has been a vastly increased accountability of community organisations back to government and, I would argue, a corresponding loss of control, vision and leadership. Eight years ago the largest employment service in Australia was the Commonwealth Employment Service. Today it is the Salvation Army, followed by Mission Australia.

Some are arguing that the heart is rapidly being ripped out of public education and our public health systems, to be replaced by church and community-based not-for-profits, or for-profit providers. Certainly the trends would seem to support such claims.

Yet many people might wonder, "who cares?" And for those who can afford it, this brave new world is no doubt a simpler and more prosperous place. But what about those who cannot afford it?

Think for instance, about the people on whose behalf I advocate? Are they typically wealthy enough to have private medical insurance? Did they get the opportunity to receive a decent education? After the accident that led to their brain injury, were they well served by the public

health system or, if that system failed them, did a private provider step into the breach? Is the average job network provider working hard to find jobs for people with a mental illness and providing the personal support they need to keep the job?

For the most part, the answer to these questions is "no". The people I serve are, for the most part, poor and marginalised, reliant on the goodwill of others to have any sort of decent life and to avoid abuse or exploitation. Many of them live in hostels and boarding houses. A few of these hostels are excellent, some of them are good, others are okay. Too many others are dangerous, flea-ridden and exploitative.

People live out their lives without enough money to catch a bus, let alone enough to access what limited community services are available. For fifteen years now the quintessential cartoon that sums up the availability of mental health in-patient care is that of the consumer desperately climbing the asylum wall to get in, rather than trying to get out. Deinstitutionalisation was supposed to include the adequate resourcing of community-based services. Instead in some States it became the means whereby government treasuries saved money rather than funding what should have been a liberating process of community inclusion.

So if I speak strongly in terms of social justice and am critical of what Mr Howard has accomplished in his now lengthy term as our national leader, it is because I know of its effect. Hugh McKay, the social researcher, has tracked the trends over recent years, and those trends are unambiguous – the rich are getting richer, the poor are getting poorer, and the middle class is shrinking. Almost all of the people for whom I advocate are poor. I cannot help but be critical.

Stigma and the white picket fence

Yet I have not even touched on the worst aspect of the colonising mind – its capacity to colonise itself. Propaganda served up as education is nothing new. At the present time Australians are being educated to accept the incarceration of young innocents behind barbed wire in our own homeland. We are being educated to accept that our nearest neighbour is yet another reason to be afraid – whether that neighbour is on our own street or the country to our north. We would also be educated by some in our community that people with a mental illness represent a danger to our community's safety and way of life – and that we should wind back the humane and innovative mental health legislation we have in place.

We are being educated that we must do all these things and many others as well. Implicit in our "education" is the notion that if we don't learn our "lessons" well, there will be no room for us inside the safety of the white picket fence.

Yet people with a mental illness do not live behind the white picket fence. Nor do people with intellectual disability, nor do Aboriginal people, nor the impoverished elderly with dementia, nor refugees who fled here looking for safe haven.

None of these groups has ever had a place behind the white picket fence because they have been associated with things that the fear-based mind does not wish to contemplate – foreign "otherness", social disorder, loss of control, unpredictability or, god forbid, the possibility that they or their loved ones might become subject to a disability, the nature of which terrifies them.

Thus for the fear-based person, such as most of us and the Prime Minister we vote for, it starts to seem natural that we should stigmatise others, so natural that we do not even realise we are doing it. Rather, we construct narratives that justify what we do. We pretend to ourselves that we are not fearful. We feel sorry for the "other", even as we secretly and not so secretly revile them. We turn fences into prisons, oftentimes physical prisons for the "other", but just as surely into psychological prisons for ourselves.

From within this self imposed imprisonment of the mind we continue what becomes a self fulfilling cycle as we plan policies, programs and occasionally pogroms, always in the name of what is right, but with the primary purpose of remaking an unpredictable and frightening world in our own safe image.

And so it goes.

From fear to love

How then can people with a mental illness and their family, friends and allies respond to this centuries' long lock-in? How can we do anything to change this deeply entrenched fear of the "alien other", be it someone of different race, or different religion, or someone with any of a range of disabilities that makes them vulnerable to the stigmatising instinct?

We can vote one politician out and another in, and indeed times of change can sometimes provide opportunities. But there remains the certainty that, while the replacement may be better or may be worse, the fundamental fear-based psychology that causes and supports stigma and discrimination against vulnerable groups will not so easily disappear.

We can fight passionately for change, as I know a number of you here today have done over the decades. But we do so at the risk of exhausting ourselves and giving way to the bitterness of eventual defeat, as we come to appreciate that our early hopes for a changed attitude towards people with mental illness have yet to be realised.

We can ignore the reality of stigma and discrimination as best we can, and get on with our lives as best we can.

Or we can do all three, without exhausting ourselves, without becoming bitter, without losing hope.

How so?

Here what I have to say comes full circle, for it is to the words of Miriam Rose Ungunmerr that I return. What might happen if we were to inwardly examine our own motivation, if we were to study the consequences for ourselves of living our life controlled by a fearful mind, and if we were to commit to something other than fear as our guiding light? What if we were to develop that inner silence about which Ungunmerr speaks, and the patient resilience that accompanies that silence?

It seems impossible to break out of the fear/greed nexus that Western psychology teaches is the fundamental building block of human motivation. Yet it is essential that we do so if our own actions are not to contribute to ever more aggression and hate.

Most of us think that hate is the opposite to love, but I do not agree. To me, hatred is a secondary emotion that usually arises when our fear has been provoked. So to me, the opposite, the antidote to fear, is love.

This has been the essential message of many of the great spiritual teachers over the millennia, and who am I to contest their wisdom?

The essential issue for those of us who are ordinary human beings dealing with sometimes extraordinarily difficult personal and family circumstances, is how to live a compassionate life when the community of which we are a part offers so little compassion to us or our loved one when we need it?

I am not in a position to provide an answer to my own question, for I am sometimes as bereft as many of you must be when the latest mishap or crisis or social rebuff has just shattered the fragile sense of well being that I have struggled to create.

Yet I know unequivocally that the compassionate life is needed today more than ever, when so many of our so-called leaders reflect back to us a smorgasbord of security concerns ranging from terrorist alerts to supposed crime waves to new and improved superannuation regimes.

What I know, is that if we can harness this silent energy of compassion, using whatever paradigm or framework or set of beliefs that best suits us, then we can work hard, fight hard, and always find refreshment, until the day we die.

That’s about all I have to say for the time being. I can only hope that I have not offended any of you or even worse, bored you. My job is to ask difficult questions even if there are no definitive answers. My job is to provoke thought and discussion, and sometimes the task requires that I say things that are controversial or unpalatable.

Please understand that I do not claim what I am saying is right. My purpose in saying the things that I do, is to help all of us to move for a time at least, out of our comfort zone, so that we can take a second look at old problems, and reconsider what might be done about them.

I thank you for listening.
ENDS