INTERNATIONAL INITIATIVE FOR MENTAL HEALTH LEADERSHIP

MAKING SERVICES WORK FOR CONSUMERS

Summary of key points from the round table discussion on Social Inclusion at the Network Meeting in Brisbane March 2009

Introduction
This summary of responses came from the round table discussion on the last day of the Network Meeting. They were made by leaders from many countries (primarily Australia, Canada, England, New Zealand, Republic of Ireland, Scotland, and the US). People were leaders across and advocates for many areas (e.g. consumer, child and youth, clinical, family, public health, indigenous, government representatives, research and education). In general people came from the mental health, addiction and disability sectors. This is a summary only of many pages of handwritten dialogue and it is hoped that it does justice to the discussions.

1. How did I as a leader achieve social inclusion?

- Haven't done a good job to date!
- Social inclusion as a term is not acceptable to some – what about using "*communityship*"?
- People are often isolated so need opportunities/activities to get people together (e.g. cultural groups, volunteer groups etc). An example from Canada was an elders and youth programme – a journey towards cultural identity. Need ways to connect people back in to their communities.
- By working effectively with others – "*By definition we can't do it alone*"
- Being open and accessible
- Listening to others (e.g. consumers and carers) – Proverb: *"You have two ears and one mouth – use them in that order"*
- Develop a vision – rights based
- By reaching across boundaries among cultures, providers, consumers and others
- By modeling partnership

- By always having the wellbeing of others at the forefront
- By being a strong advocate for it – networks, lobbying; locally and nationally
- By building trusting and respectful relationships
- By being informed and knowledgeable
- By being accountable to the community
- Identifying best practice
- Workforce: use a values-based recruitment programme; support EQ in staff via a leadership programme
- Undertake evaluation of programmes and provide this data to apply for funding (e.g. measure an individual's community contacts/activities over time)
- Remunerate people who work in a socially inclusive way
- Community of choice: "3 C's ": connecting to, competencies for, confidence to

2. What are the leadership attributes that lead to social inclusion?

- *"It's about "us", not "them" – need to be able to model this thinking"*
- Modeling the practice in every interaction, everyday
- The courage to challenge your own value system and others as well
- Recovery is possible for all of us – be able to instill hope
- Willingness to share power and responsibility and investing a sense of responsibility in everyone for everyone
- A willingness to "*engage people who are critical''* – can learn from them
- Ability to articulate the equality agenda
- Find a shared language that models inclusion
- Dignity and respect
- Mindfulness
- Belief that social inclusion is achievable and exhibit that belief
- Be able to champion the value base of respect and integrity
- Courage and resilience – stamina to keep working towards the aim
- Question and explore ways of community participation
- Being prepared to change our behaviours
- Striking a balance between being visionary and being grounded
- Being able to affirm people
- Flexibility
- Reflective practice
- Create welcoming and friendly environments
- Leadership in social inclusion is:
- "*Don't just speak – say something; Don't just listen - hear; Don't just look – see"*

3. What are the barriers to social inclusion?

- Bureaucracy – "Do as I say not what I do"
- Policies – Targets, KPIs etc don't reflect inclusion (instead "bums on seats" are measured)
- Stigma – often unacknowledged by-product of services; and within our services
- Physical environment of services (e.g. seclusion)
- Clinical practices – clinicians are constrained by the system; dominant paradigm still "medical model' but this is changing
- Over reliance on "evidence" – need to also include "promising practices"

4. What strategies make a difference? What works?

- The question itself assumes a state-driven approach – it might not be the right question?

- Indigenous communities start with family and community – connectedness and culture is essential to mental health. We need to protect and respect this value and be strengths and resilience-based (not deficit) *"Start with what's strong, not what's wrong"*. The loss of connectedness is a risk factor in mental health. Need to build on and collaborate with these supports so flexibility of policy and programmes is so important

- Recognise the value of the lived experience and use this to change attitudes and behavior

- Need a vision: *"a belief in possibilities combined with creativity and risk taking"*. Also need to generate action in line with the vision

- Communication is key - The effective use of language is critical – no jargon, clear, accessible, simple, meaningful words

- **Values** of all staff and stakeholders to be articulated as a prerequisite to policy and service design, reinforce these in concrete ways: **modeling**: being inclusive in the organisation structure, practice what we preach, allow internal challenge to our practices; **networking**: encourage staff to have their own networks, create a diversity of networks – consumers, peers, NGO, government etc

- **Commitment: to social justice:** in all aspects of an organisation, have lived experience shaping the service and workforce development; **fostering connections**: attention to reducing the social isolations of individuals and families through activities, the web local media; **working with communities:** social marketing campaigns, different approaches for different communities and cultures – *"no – one size fits all"*, acknowledge and respect diversity; **celebration of**

progress: evaluate progress and celebrate with public events, celebrate the courage of individuals and families who are willing to share their narratives of recovery.

- Look at the physical environment - Minimise "exclusion" (e.g. locking people up in seclusion!) This reinforces the idea that mentally ill people need exclusion. Instead have a range of options in the community). In addition by its nature treatment in a "psychiatric hospital" models exclusion. So are "staff restrooms' where clients cannot access.

- Need "whole of government" approach and intersectoral commitment in addressing inequalities in mental health, addiction and disability sectors

- As well as the physical environment - review the language of policies, clinical practice, training, education, HR practices etc – needs to all be inclusive

- Need to take people with us: meaningful involvement, whole of life perspective; listening, communication and education; all cultures

- *"Use measures to ensure we are going where we want to be"*. Take note of "promising practices" as well as best practice. Fund services on "effectiveness' from the point of view of the consumer. The best evidence is the individual's/families self report of wellness

- Encourage independent champions, advocacy

- Change the Hippocratic oath from duty of care to duty of social inclusion

- Youth are the leaders of the future therefore invest in them now (e.g. shape understanding in schools re inclusion, community, well being)

- Strengthen known protective factors

- Use language that is inclusive: "*social and emotional wellbeing'* is used by Australian indigenous people (not "mental" – which instills fear and stigma)

- Strengthen role of the NGO sector

- Build stronger primary care linkages – consumers and families prefer services through GPs – less stigma

- "*Work with; not for or to them*" and build on strengths of people, families, communities, services

- Become more "*customer focused*" in our approaches to serving and supporting individuals and families. Borrow training models and culture change models that work from other industries

- Build a social movement around the creation of caring and supportive communities

- Need a change in attitude around mental health – both the public and the mental health sector. Need more options in mental health: massage, traditional healing practices, aromatherapy etc alongside clinical services - Clinicians as "enablers' towards recovery)

- A social marketing initiative that highlights that there is "*No health without mental health*"

- Explicitly address consumer leadership within workforce development strategies

- Advocate a social determinants policy approach to health with needs based funding

- Use a chronic disease management model which incorporates many components of care along a continuum – not just a clinical focus

- Build an evidence base about how social inclusion works.

- Need to better integrate research into service delivery environments

- Peer support is the most powerful tool for transformation – need to build this evidence base

- Support networking of communities of interest and intersectoral linkages

- Improve help-seeking rates through: stigma reduction initiatives; early identification of people at risk; and improve community knowledge – mental health literacy

- Dismantle barriers (e.g. legislation for disability, insurance issues for people with mental health problems)

- Staff exchanges make a difference- staff learn new ways of being and working

- Education
  - Challenging stigma
  - Community involvement
  - Providing choices, options

- Leadership
  - Consultative
  - Collaborative
  - Solution focused
- Connectedness
  - Holistic across the lifespan
  - Mind
  - Body
  - Spiritual
  - Family
  - Housing, employment, poverty, education

- Build capacity of consumers and carers to inform us of needs and experiences across all ages – young to old

- Work – "secure a job" is exclusive of children and older adults. "Meaningful social role" fits better

- Accept ambiguity and differences – bring known and unknown together to facilitate change

Janet Peters August 2009