2019

Royal Commission into the Victorian Mental Health System

INFANT MENTAL HEALTH
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1 What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

1.1 Create long term goals now

1.1.1 Mental health develops from birth and within relationships. Many of the adolescent and adult patterns of mental health and resilience are formed in the early years. Only a whole of system focus on the beginning of life will create comprehensive long-term commitments to sustainable improvement in understanding what promotes mental health; to what reduces mental illness and the associated stigma and discrimination. We are an adult dominated and adult centric society. All too often our adult orientated response to mental illness obscures the earlier, beginning mental health experiences of infants, children and young people; this is, unless a clearer vision of the young better serves the interests of the old. Ironically, it is our over-emphasis on later-in-life treatment services in dealing with mental illness rather than an 'across the life span', 'across sector response' and 'across our whole community' that has seen little change in how we reduce mental illness.

1.1.2 Whilst the focus on youth mental health and the development of Head Space has been most welcome, we need to start much earlier if we are to prevent as well as reduce mental health difficulties that become more apparent and often increasingly detrimental later in life.

1.1.3 The years from conception to the age of three are the most critical for human development because the foundations for all emotional and physiological systems are established during this period. Human growth and development are hierarchical, trend towards greater complexity and efficiency, and occur in a use-dependent way through bidirectional interactions with the physical and relational environment (Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Schore, 2015; Siegel, 2015).

1.1.4 Three of the most crucial systems that are generated in infancy include:

- the stress-response system
- the capacity to trust others
- emotional and behavioural regulation

1.1.5 These systems form the building blocks of human relational functioning. Because humans are inherently social animals, our entire functioning depends upon our capacity to operate in relationship with others. For example, learning occurs in relationship with teachers and fellow students - many children and adolescents find they struggle in subjects where they don't 'get along' with a specific teacher but will be quite successful with someone else. Virtually all employment involves the need to form collaborative relationships with others. Friendships, family and intimate partnerships are fundamental to health and wellbeing and buffer against life stressors. Having a network of supportive relationships is key to resilience (Hartling, 2008), and having sufficient relational capacity to form a supportive network is the key to good health.

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1.1.6   This research demonstrates that the most powerful interventions that address a diverse range of emotional, psychological, relational, learning and social difficulties are most efficacious during infancy when the crucial systems are forming. Beliefs around the biology and hereditary status of mental health difficulties is being challenged by genetic and epigenetic research which points to the importance of the perinatal environment and its influence on the individuals stress response and health generally (DeSocio, 2019; Meaney, 2010). Yet, the latest Australian Institute of Health and Welfare report on Mental Health makes no mention of infants or young children and only cursory references to children (AIHW, 2018). Infants and their mental health needs, so critical to their evolving development in later life are effectively seen as unimportant.

1.2   Getting in Early

1.2.1   Evidence on what creates and enhances infant mental health is now well established (Zeanah Jr, 2019), as are treatment responses for infants who exhibit early signs of relational and developmental difficulties. The report of the task force of the World Association for Infant Mental Health (Lyons-Ruth et al., 2017) on the worldwide burden of infant mental and emotional disorder noted that:

1.2.2   *"Atypical developmental trajectories can be identified in the first 6 months of life that predict higher risk for later symptomatology (Cote et al., 2009), and, when severe behavior problems are evident in the first few years of life, there is moderate to strong continuity in symptoms that place these children at risk for long-term problems, especially in the context of family dysfunction… There are a number of evidence-based interventions based on randomized controlled trials that are effective in treating infants with mental health problems and disrupted infant–caregiver relationships… Outcomes of these intervention approaches have included improvements in security of parent–child attachment relationships, reductions in child behavior problems, reductions in child and parent symptoms of traumatic stress and depression, improvements in maternal sensitivity, improvements in cortisol regulation, and reductions in failed foster care placements" (p. 698).*

1.3   Reducing stigma and increasing awareness of mental health in infancy

1.3.1   Stigma and discrimination occur as a result of misunderstanding, and the perception of threat. The most effective way to reduce the stigma and discrimination associated with mental illness is through emotionally and personally connecting to the experiences of others. Our ability to develop empathy, insight and capacity for tolerating difference begins in infancy (Iacoboni, 2009; Liddle, Bradley, & McGrath, 2015). What understanding does the general community have in relation to infants and their developing mental health?

1.3.2   The key to reducing stigma and discrimination is education and community awareness, beginning with what contributes to good mental health in infancy, both in indigenous and non-indigenous populations. The key features of successful campaigns include such things as:

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- A focus on the importance of good mental health in the early years as the building blocks for a lifelong mental health (for example go to https://heckmanequation.org/ or https://emergingminds.com.au/).

- Understanding that good parental mental health is crucial to good infant and family mental health, this includes our ability to be as mindful of the mental health issues of fathers as we are of mothers. One powerful example of promoting the mental health of fathers within Aboriginal families has been: Our Men, Our Shields: http://www.first1000daysaustralia.org.au/sites/default/files/position_stat ement/Our_Men_Our_Shields_May19.pdf.

- Culturally sensitive and respectful, strengths-based approaches to infants and their (gender diverse and inclusive) caregiving environments. Recognition also that the child who is yet to be conceived has rights (see http://www.first1000daysaustralia.org.au/sites/default/files/position_stat ement/Charter_for_Children_May19.pdf). This pre-conception approach to creating space to think about what sort of caregiving environment the child has a right to be born into is ground-breaking.

- Trauma informed approaches that have created a compassionate response to distress, asking not 'what is wrong with you', but rather, 'what has happened to you', including the intergenerational and cultural transmission of trauma.

- Victorians have shown they have great compassion and understanding for psychological and emotional difficulties that have been caused by disasters outside the home. If people can be helped to understand that disasters inside people's homes, families and relationships will challenge mental health the community will be more accepting of both people's difficulties and of the service response required.

- Comprehensive and collaborative infant mental health responses across traditional silos support people to identify and respond to difficulties in a timely manner. The RCH infant mental health program trial with maternal and child health services is one such model (contact Megan Chapman on ▮▮▮▮▮▮▮▮▮▮▮▮ for information).

- Recognising that intergenerational trauma has occurred in many families and communities and the consequences need a trauma informed approach to healing. Examples of evidence based approaches for Aboriginal communities can be found here: https://healingfoundation.org.au/healing-portal/

- Moving beyond the idealised response, such as the 'brave' and 'stoic' response to disaster to an acceptance that stressful events cause distress. This needs to be extended to babies and toddlers- that they too experience physiological distress and are capable of holding enduring implicit memories when witnessing stressful events (Rifkin-Graboi, Borelli, & Enlow, 2009; Schechter & Willheim, 2009; Zeanah Jr & Zeahah, 2019).
- Promoting an awareness campaign regarding the difference between mental health and mental illness across the entire lifespan and recognising the need for a continuum of mental health care (see http://siblingsaustralia.org.au/wp-content/uploads/2017/10/aicafmha_pos_paper_final.pdf).

2   What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

2.1   Both mental and physical illness is best prevented by ensuring a safe and nurturing infancy and early childhood (Chapman et al., 2004; Edwards, Holden, Felitti, & Anda, 2003). Further to those initiatives mentioned above, a systematic approach to addressing difficulties early in life as well as early in the presenting of indicated problems is crucial. Key steps to achieving this goal include universal mental health screening for babies and very young children.

2.2   Victoria currently has world class, universal access to Maternal and Child Health (MCH), and when indicated, access to enhanced Maternal and Child Health Nursing services. State-wide staffing shortages are placing this system under considerable strain as are cost cutting (and as a result a decrease in expertise) measures being employed by numerous local councils. This service needs to be protected, further expanded and the workforce to have greater infant mental health literacy and expertise. MCH operates as the first, community accepted entry point for issues impacting infants, including the ability to pick up and intervene at the earliest stages to address potential infant mental health issues.

2.3   However, it is important to accept that not all families will access the universal system and have responses available that target their specific needs. Some Aboriginal families, CALD families and those with a history of involvement with Child Protection Services need a culturally sensitive approach that will understand the impact of intergenerational trauma and abuse by authorities on the capacity to trust services.

2.4   There are tertiary mental health services that ostensibly provide intervention for infants and their families. Very few infants attend Child and Adolescent or Child Youth and Family Mental Health Services. Prevalence rates of mental illness in 18-month olds has been found to be 16%-18%, but 0-4 year olds represent 0.9% of the Child and Adolescent Mental Health Service users.

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2.5 Infants are over-represented in Child Protection Services with 17.1 of 1000 infants under the age of one year being the subject of substantiated abuse or neglect (AIHW, 2019). Research conducted on all child protection clients in a Melbourne metropolitan region entering out of home care showed 33% of infants under the age of three met criteria for a psychiatric diagnosis according to the Diagnostic Criteria:0-3 (Milburn, Lynch, & Jackson, 2008; Zero-to-Three, 1994).

2.6 Infants and very young children make up the highest cohort of children entering Women's Refuges post family violence but receive little to no service response (Bunston, 2018). Preliminary research suggests that infants in Refuge do not enjoy secure attachments with their mothers (Bunston & Glennen, 2008). Attachment difficulties in early childhood increases the potential of later life mental health issues as does unresolved early childhood exposure to traumas such as family violence. The provision of infant mental health support and parent child dyadic work is imperative in Women's Refuges.

2.7 There are limited service system responses to infant and early childhood difficulties and those that are available are not well integrated. There remains a gap in the system between the universal services and the tertiary mental health services. Medicare funded perinatal and infant mental health services are limited in service capacity (number of sessions), availability and quality control.

2.8 Cradle to Kinder, is a targeted intervention offering long term (up to five years) support to infants and their young mothers who have been identified at high risk. This program is an innovative, state-wide an initiative of the Victorian government. It is an exciting concept, and when operating from an infant centred framework produces best practice outcomes, however, there is variability in how it is delivered and lacks a central governance structure. See https://www.ipchealth.com.au/cradle-to-kinder/ or contact Samantha Ware ▮▮▮▮▮▮▮▮▮▮▮▮ for information about a best practice example of the Cradle to Kinder model.

2.9 The Cradle to Kinder model offers the foundation for building other similar programs where young or first-time mothers and/or fathers who are experiencing significant mental health issues and require significant support.

2.10 Early Parenting Centres will be expanded during the current term of the Labor Government, and many more infants and their families will receive secondary and tertiary care than currently. However, the service model currently is limited in terms of the inclusion of mental health services within a multi-disciplinary framework. Significant areas of Victoria will remain without an Early Parenting Centre.

2.11 There is little quality assurance and accountability for outcomes in the infant and toddler services.

2.12 There is little direction and oversight provided by the Department of Health and Human Services in service provision.

2.13 There is significant variability in service delivery depending on region.

2.14 There are no accessible infant mental health services in many regions of Victoria. As such, the availability of support and intervention services with a rapid response capacity will ensure difficulties are addressed in early stages. If not addressed early for infants and very young children, the infant will adapt to the situation and the state of fear or distress is likely to embedded into their rapidly developing brain and will become a trait (Perry et al., 1995; Perry & Linas, 2012). Addressing situations of fear and sadness early will therefore prevent the development of relational disorders such as Personality Disorders, as well as chronic anxiety and depression. This requires the creation and development of specific, state-wide, infant mental health services that are integrated across the continuum of universal and secondary services.

2.15 Funding for training and workforce development being made available. Victoria has a very sophisticated mental health workforce that has been largely upskilled in infant mental health expertise through individual professionals' commitment and self-funding. A systematic approach to workforce development is a cornerstone of good clinical governance and will ensure sustained and high-quality service delivery to families.

2.16 Victoria and Australia have under-invested in research and evaluation of clinical programs. This results in clinical practice that has limited reliability and validity and the practice of taking international evidence-based programs and implementing them in local conditions that do not mirror those in which the evidence has been established, resulting in limited or unknown reliability and validity for local conditions.

2.17 Investing in research and development will ensure that investment in treatment will be targeted to those treatments which provide the best outcomes for families. It is crucial that Australia invest in practice-based evidence models for *Australian* programs that are targeted towards *Australian* conditions.

2.18 Establishing and delivering practice-based evidence and evidence-based practices is expensive and requires a whole of service system commitment.

2.19 Torres Strait Islander and Aboriginal specific infant and family based service responses and research being permanently funded with appropriate workforce development programs supported, (for example the work of the First Thousand Days Australia http://www.first1000daysaustralia.org.au/ and Bubup Wilam https://apps.aifs.gov.au/ipppregister/projects/bubup-wilam-children-s-place-for-early-learning-aboriginal-children-and-family-centre).

2.20 A separate Mental health Strategy for Aboriginal and Torres Strait islander families is needed. Currently there is an opportunity to include this in the 5th iteration of the national plan. https://pmc.gov.au/resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23 whole of family approaches to address social and emotional wellbeing.

2.21 National and State policies and plans need to be integrated.

3 What is already working well and what can be done better to prevent suicide?

3.1 Early intervention, enhancing quality of life and relationships, and adopting a culturally respectful family focus all aids in preventing suicide. Prominent international mental health expert Professor Peter Fonagy from the University College London visited Melbourne last year to speak at the Australian Childhood Conference. Professor Fonagy stressed that across the board, the most effective treatment for those with serious mental health issues is to build relational trust and decrease their social isolation.

3.2 Furthermore, the number of adverse childhood experiences a person endures predicts adult suicidal behaviour. Adults with three or more adverse childhood experiences such as physical, sexual, and emotional abuse, neglect, parental death, incarceration, alcoholism, and family suicidality have been found to be more than three times more likely to consider or attempt suicide as adults (Thompson, Kingree, & Lamis, 2018). These identified adverse childhood events cannot, however, explain away the excessive over-representation of the indigenous community (and particularly children) in Australian suicide rates. Prior to colonisation suicide was believed to be almost non-existent in the indigenous culture (see https://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-natsisps-strat-toc~mental-natsisps-strat-1~mental-natsisps-strat-1-ab). Until our political system acknowledges that white settlers did invade this country, did attempt to eradicate the first nations peoples and did inflict, and still do cause psychological, material and spiritual damage to indigenous Australia, and continue to fail to provide real reparation; these extraordinarily high rates of suicide are likely to remain.

3.3 Early intervention through infant mental health programs within child and adolescent mental health services are often poorly resourced and not connected in with universal services such as maternal child health services. However, examples of best practice, collaborative infant mental health initiatives are currently being trialled within the Infant Mental Health service at the Royal Children's Hospital (contact Dr Megan Chapman: ██████████████████████ also Dr Paul Robertson ████████████████████ who trialled a collaborative Mental Health and Maternal Child Health initiative). Similarly, access to infant mental health services and culturally appropriate support for indigenous and non-indigenous infants and young children is almost non-existent in rural and remote areas. The work of the First 1000 Days Australia (contact Professor Kerry Arabena on █████████████████████████ and see http://www.first1000daysaustralia.org.au/) was one of the first of its kind to begin to address this lack of infant and child focused work within the indigenous community.

4 What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link (education) with each other.

4.1 As already stated, poor early life relationship and caregiving environmental experiences, intergenerational trauma and early childhood difficulties impinge on good mental health. This is often concerned with early problems in mastering affect regulation which leads directly to a poor capacity to exercise reflective functioning which can be at the core of many mental health issues.

4.2 Adverse childhood experiences make it difficult for people to experience good mental health. A history of childhood trauma also makes it difficult for people to be good mothers, fathers, partners and friends. Although it is difficult to eradicate harmful childhood experiences, a community and service system that understands that people will suffer when bad things happen will be more compassionate and responsive to need.

4.3 Once we all accept and understand that White Australia systematically tried to destroy the bonds of Aboriginal families for generations, we may start to address the effects of intergenerational trauma for Aboriginal families.

4.4 Helping families establish a strong bond with, and secure attachment system for, their children will develop the relational capacity that will stop repetitive patterns of intergenerational dysfunction.

4.5 Structurally, our current mental health system fails to successfully integrate familial (in all their diversity) approaches to treatment across the spectrum. Adults with mental health issues often have children, yet these children are seldom considered in adult services treatment plans. That the inclusion of children's voices may be part of powerful treatment approaches needs consideration, not the least to ensure that when parents are particularly unwell infants and children are kept safe from harm. The experience of an only child living with a mother with Schizophrenia has been well described in Justin Heazlewood's book "Get Up Mum".

4.6 As a community it needs to be recognised that infants and children can be exposed to significant harm, can be present or experience significant life trauma where one parent kills the other or there is a murder/suicide. Infants and very young children may even be at risk of filicide where parents are in florid states of psychosis and/or experiencing severe mental health issues (Friedman, Hrouda, Holden, Noffsinger, & Resnick, 2005; Léveillée, Marleau, & Dubé, 2007). Specialist, well-coordinated treatment and service responses need to be quickly activated in such situations and the impact on the emotional, relational and psychological world of the infant duly acknowledged and addressed (Eyer, Milburn, & Bunston, 2019).

4.7 Infant mental health, and CAHMS (as does adult mental health) needs to provide direct service delivery support and reflective supervision opportunities to skill up workers in Women's Refuges.

4.8   All too often the service system is criticised for working in silos. It is beyond doubt that there is a better need for growing an integrated service system that learns from one another. Family violence, for example, is clearly a mental health issue (Bunston, Franich-Ray, & Tatlow, 2017) yet there are all too often poor pathways for entry into one system when case management is being held by another service system. For example, infants and children being referred into Child and Adolescent Mental Health Services by Family Violence and Homelessness services are often denied access as their presenting issues are not seen as being 'mental health' related.

5   What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

5.1   Isolation from family and community.

5.2   Self-imposed isolation- stigma regarding sharing vulnerability and stress.

5.3   Community expectation that people will 'cope' with adversity and stress. Examples include coping with the chronic uncertainty of drought and the expectation that mothers will be able to cope with small children by themselves for long periods. Both of these situations are inherently stressful and should be expected to be so by others. Instead stressed individuals in these situations are sometimes pathologized by the community, contributing to their internal sense of isolation and shame that they somehow aren't coping.

5.4   Poor access to secondary and tertiary therapeutic and/or mental health services throughout Victoria.

5.5   Some communities have a disproportionate number of people who have suffered trauma and/or adversity.

5.6   Whilst it is easy to point out that poverty, the short term focus of services, families who experience homelessness, family violence and marginalisation are all at heightened risk of experiencing mental health difficulties it is harder to identify emotional neglect that can be hidden behind the façade of wealth and privilege. The lack of emotional literacy, the pressure to succeed at all costs, unrealistic expectations on infants and young children can all lead to the wealthiest of families experiencing poor mental health, debilitating depression and poor insight and empathy. A healthy community strives to take care of its own. Simply identifying those with obvious disadvantages as susceptible to greater risks fails to see that those in our community who wield great power, own significant wealth and may unwittingly contribute to the stigmatisation of those less wealthy than themselves may contribute to poorer mental health outcomes for our Victorian community as a whole. Mental health difficulties are not simply the domain of those who are visibly struggling. It is simply better hidden amongst those who enjoy access to greater resources. Destigmatising mental health issues amongst the privileged may lead to a greater capacity to judge less and emotionally and financially enhance greater humility and equality for all.

5.7 As Victoria sets about to undertake another Royal Commission into one of the biggest societal imperatives that threatens the well-being of our community overall, we have the chance to learn from the collective wisdoms garnered through the Royal Commission into Family Violence, and the Australian Royal Commissions into Institutional Abuses into Sexual Abuse; Aboriginal Deaths in Custody., Banking and Aged care. That as a community we face the challenges of placing compassion over profits, respect over relegation and valuing collectivism over individualism. Whilst this may seem like sentimental idealism, the countries and communities in the world that are thriving economically and psychologically appear to have adopted more tolerant, compassionate and egalitarian ways of functioning (Editorial-Board, 2019; Lehmann & Seitz, 2017). New Zealand's well-being budget sets an example for Victoria (https://treasury.govt.nz/sites/default/files/2019-06/b19-wellbeing-budget.pdf).

5.8 It takes very little forward thinking to realize that at some juncture in the future a royal commission into the treatment of children in detention will be necessary. The long-term mental, health and social consequences for infants, children and their asylum-seeking parents who are left to remain in detention for extended periods will rival the consequences of the decision to remove Aboriginal Children from their parents and the institutional sexual abuse of children.

6 What are the needs of family members and carers and what can be done better to support them?

6.1 It is perhaps the obvious to cite increases in funding support, access to material aid and respite services. However, less established but equally critical are re-engineering the system to be centred on relationships. Relationships matter, crucially in our early years, childhood and youth, but remain the most powerful motivator for engagement, change and growth throughout our entire life.

6.2 Individualist approaches that fail to support the relational system that supports the person who is struggling with mental health issues will fail to provide sustainable outcomes. This involves the provision of access to external services such as Carers Victoria but also building in intensive therapeutic, and support-based group work programs within existing mental health programs. Building resilience within families, communities and for carers involves providing them with support, emotionally and relationally. Prioritising opportunities for family members and carers to meet with, support and sustain other family members and carers offers a rich vein of emotional and psychological sustenance that can build networks of ongoing support well beyond that which agencies could ever truly provide. This will ultimately lead to greater community support and a reduced need for service involvement.

7   What can be done to attract, retain and better support the mental health workforce, including peer support workers?

7.1   The provision of regular, reflective individual and group supervision with external, experienced supervisors offer what pioneering Infant Mental Health clinician Janet Dean, the founding Director of the Boulder Colorado Community Infant Mental Health Program, argues is "the guarantee and insurance policy" to help us sustain thoughtful and effective work (Stone, Jones, & Bunston, 2019). Reflective practice enables those working with complex issues in highly stressful, human services environments to access emotionally regulated and thoughtful responses to clients and situations that are often highly dysregulated, high risk and can evoke reactive, unthoughtful and ill-considered service responses. Regular access to reflective supervision also minimises burnt-out and worker dissatisfaction (Eaves Simpson, Robinson, & Brown, 2018).

7.2   Managers within the mental health workforce also require access to and the support of reflective supervision. All too often those higher up in services exclude themselves from the need to attend reflective supervision whilst they are the ones who inevitably set the tone and culture for the workplace. Perhaps infant mental health, with its strong commitment to reflective supervision (O'Rourke, 2011; Tomlin, Weatherston, & Pavkov, 2014), the use of observation (Rustin, 2014; Trowell & Miles, 2004) and recognition of the worker being supported to manage their own dysregulated emotional states when working with emotionally challenging cases can offer adult mental health services a model of practice that can maximise worker retention and improve client outcomes.

7.3   Post-graduate training in mental health other than Psychiatry is not funded which limits selection of trainees. Removing funding barriers and discrimination against non-medical training in mental health is a must.

7.4   Funding for continuing professional development for the mental health workforce does not match expectations of continued best practice.

8 What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

8.1 Supporting innovation within the mental health sector in sourcing out community initiatives and projects that build opportunities for those living with mental health issues to participate in employment opportunities, projects within the arts, and media programs (for example, the ABC program "Employable Me") that promote awareness.

9 Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

9.1 In 2011 the Australian Infant, Child, Adolescent and Family Mental Health Association wrote a comprehensive position paper that offered a propose model for "Improving the mental health of infants, children and adolescents" (http://siblingsaustralia.org.au/wp-content/uploads/2017/10/aicafmha_pos_paper_final.pdf). This would be an excellent starting point in bring in an integrated, across the life span model of care, as would engaging with the Victorian Branch of Australian Infant Mental Health Association ███████████████ and appropriate indigenous early years initiatives such as The Frist 1000 Days ████████████████

9.2 Switch the system from an adult oriented pathology focused system to a relationship focused developmental and collaborative system. This means investing primarily in early in life and early in problem services to develop good mental health from the beginning of life. Much mental health treatment is seeking to undo damage that was done early in life when crucial brain systems were developing.

9.3 In practice this requires a large investment in babies and toddlers and their families. It should be accompanied by high quality research that will track return on investment. This can be established through a Centre for Excellence or Institute for Early in Life Mental Health that would oversee research and evaluation, training and service system models to ensure an integrated approach to supporting good mental health and development in the first three years of life. This includes parenting support and development as well as therapeutic offerings to ensure robust parental mental health and the establishment of secure attachment systems for babies and toddlers.

10 What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

10.1 Engaging with experts and organisations across the spectrum, from infant, child, young people, adult and the elderly mental health services to meet and hold round table discussions about how to work together and to invite other key stake holder organisations within Family Violence, Homelessness, Drug and Alcohol to participate. To involve the indigenous community fully in such discussions and to also invite consumers themselves to be fully present and respected participants in such discussions.

10.2 The establishment of robust governance frameworks across the breadth of mental health and therapeutic services.

10.3 Include the breadth of therapeutic services in the mental health system framework to assist integration and improve quality and governance of service delivery. This is mainly referring to the therapeutic services that are provided outside of the mental health budget, being through family services, school-based services and the like.

11 Is there anything else you would like to share with the Royal Commission?

11.1 The answers to good mental health are in establishing good social and emotional functioning so that people grow the capacity to trust that others will be there when they need help, that they can ask for help when needed, and the relational capacity to share their difficulties when they arise. These skills are developed during the first three years of life.

11.2 Babies and toddlers have the right for their difficulties to be recognised and addressed in a timely manner. An eight-week waiting time for the rapidly developing infant is too long. Infant mental health work is urgent, with an eight week wait equating to what would be comparable to a year long wait for an adult.

11.3 It is shameful that babies are over-represented in Child Protection services, (meaning that by definition they have suffered harm from the people they are most dependent upon) and they are under-represented in mental health services (showing that the consequences of harm for emotional and psychological functioning is not addressed).

11.4 The evidence is clear that investing in the early years pays dividends for society for years. It is baffling that this has not been embedded in the service system responses.

11.5 The Royal Commission provides a unique opportunity to build a world class, comprehensive, across the life span response to building wellness within Victoria. The integration of learnings from this Royal Commission, on the back of other recent Royal Commission findings lends itself to creating rather than replicating a raft of recommendations which can provide something sustainable.

<p align="center">Please do not let us down.</p>

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Dr Nicole Milburn is a Clinical Psychologist and Infant Mental Health Professional who has specialised in the mental health and development of high-risk infants involved with or on the cusp of involvement with the Child Protection System. She has worked across the state in private and public capacities, providing expert testimony to the Children's Court. She has also been a member of the Board of Management of Tweddle Child and Family Health Service for 12 years and stood as Chair of the Board for six years.

Professor Kerry Arabena is the Executive Director of First 1000 Days Australia. A descendant of the Meriam people of the Torres Strait, she has a Doctorate in Human Ecology and an extensive background in public health, administration, community development and research. Kerry's work has made significant contributions across many States and Territories in areas such as gender issues, social justice, human rights, access and equity, service provision, harm minimisation, and citizenship rights and responsibilities. Kerry is leading the development of the First 1000 Days Australia initiative and is Chair of the Council.

The three authors share a passionate commitment to improving the recognition and response to the difficulties that babies and toddlers face in their everyday lives and to re-engineering the system to promote better life functioning from the bottom up.

2019 Submission - Royal Commission into Victoria's Mental Health System

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N/A

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?

"1.1Create long term goals now 1.1.1Mental health develops from birth and within relationships. Many of the adolescent and adult patterns of mental health and resilience are formed in the early years. Only a whole of system focus on the beginning of life will create comprehensive long-term commitments to sustainable improvement in understanding what promotes mental health; to what reduces mental illness and the associated stigma and discrimination. We are an adult dominated and adult centric society. All too often our adult orientated response to mental illness obscures the earlier, beginning mental health experiences of infants, children and young people; this is, unless a clearer vision of the young better serves the interests of the old. Ironically, it is our over-emphasis on later-in-life treatment services in dealing with mental illness rather than an across the life span', across sector response' and across our whole community' that has seen little change in how we reduce mental illness. 1.1.2Whilst the focus on youth mental health and the development of Head Space has been most welcome, we need to start much earlier if we are to prevent as well as reduce mental health difficulties that become more apparent and often increasingly detrimental later in life. 1.1.3The years from conception to the age of three are the most critical for human development because the foundations for all emotional and physiological systems are established during this period. Human growth and development are hierarchical, trend towards greater complexity and efficiency, and occur in a use-dependent way through bidirectional interactions with the physical and relational environment (Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Schore, 2015; Siegel, 2015). 1.1.4Three of the most crucial systems that are generated in infancy include: the stress-response system the capacity to trust others emotional and behavioural regulation 1.1.5These systems form the building blocks of human relational functioning. Because humans are inherently social animals, our entire functioning depends upon our capacity to operate in relationship with others. For example, learning occurs in relationship with teachers and fellow students - many children and adolescents find they struggle in subjects where they don't get along' with a specific teacher but will be quite successful with someone else. Virtually all employment involves the need to form collaborative relationships with others. Friendships, family and intimate partnerships are fundamental to health and wellbeing and buffer against life stressors. Having a network of supportive relationships is key to resilience (Hartling, 2008), and having sufficient relational capacity to form a supportive network is the key to good health.   1.1.6This research demonstrates that the most powerful interventions that address a diverse range of emotional, psychological, relational, learning and social difficulties are most efficacious during infancy when the crucial systems are forming. Beliefs around the biology and hereditary status of mental health difficulties is being challenged by genetic and epigenetic research which points to the importance of the perinatal environment and its influence on the individuals stress response and health generally (DeSocio, 2019; Meaney, 2010). Yet, the latest Australian Institute of Health and Welfare report on Mental Health makes no mention of infants or young children and only cursory references to children (AIHW, 2018). Infants and their mental health needs, so critical to their

evolving development in later life are effectively seen as unimportant. 1.2 Getting in Early 1.2.1 Evidence on what creates and enhances infant mental health is now well established (Zeanah Jr, 2019), as are treatment responses for infants who exhibit early signs of relational and developmental difficulties. The report of the task force of the World Association for Infant Mental Health (Lyons-Ruth et al., 2017) on the worldwide burden of infant mental and emotional disorder noted that: 1.2.2 Atypical developmental trajectories can be identified in the first 6 months of life that predict higher risk for later symptomatology (Cote et al., 2009), and, when severe behavior problems are evident in the first few years of life, there is moderate to strong continuity in symptoms that place these children at risk for long-term problems, especially in the context of family dysfunction There are a number of evidence-based interventions based on randomized controlled trials that are effective in treating infants with mental health problems and disrupted infant?caregiver relationships Outcomes of these intervention approaches have included improvements in security of parent?child attachment relationships, reductions in child behavior problems, reductions in child and parent symptoms of traumatic stress and depression, improvements in maternal sensitivity, improvements in cortisol regulation, and reductions in failed foster care placements (p. 698). 1.3 Reducing stigma and increasing awareness of mental health in infancy 1.3.1 Stigma and discrimination occur as a result of misunderstanding, and the perception of threat. The most effective way to reduce the stigma and discrimination associated with mental illness is through emotionally and personally connecting to the experiences of others. Our ability to develop empathy, insight and capacity for tolerating difference begins in infancy (Iacoboni, 2009; Liddle, Bradley, & McGrath, 2015). What understanding does the general community have in relation to infants and their developing mental health? 1.3.2 The key to reducing stigma and discrimination is education and community awareness, beginning with what contributes to good mental health in infancy, both in indigenous and non-indigenous populations. The key features of successful campaigns include such things as: A focus on the importance of good mental health in the early years as the building blocks for a lifelong mental health (for example go to https://heckmanequation.org/ or https://emergingminds.com.au/). Understanding that good parental mental health is crucial to good infant and family mental health, this includes our ability to be as mindful of the mental health issues of fathers as we are of mothers. One powerful example of promoting the mental health of fathers within Aboriginal families has been: Our Men, Our Shields: http://www.first1000daysaustralia.org.au/sites/default/files/position_statement/Our_Men_Our_Shields_May19.pdf. Culturally sensitive and respectful, strengths-based approaches to infants and their (gender diverse and inclusive) caregiving environments. Recognition also that the child who is yet to be conceived has rights (see http://www.first1000daysaustralia.org.au/sites/default/files/position_statement/Charter_for_Children_May19.pdf). This pre-conception approach to creating space to think about what sort of caregiving environment the child has a right to be born into is ground-breaking. Trauma informed approaches that have created a compassionate response to distress, asking not what is wrong with you', but rather, what has happened to you', including the intergenerational and cultural transmission of trauma. Victorians have shown they have great compassion and understanding for psychological and emotional difficulties that have been caused by disasters outside the home. If people can be helped to understand that disasters inside people's homes, families and relationships will challenge mental health the community will be more accepting of both people's difficulties and of the service response required. Comprehensive and collaborative infant mental health responses across traditional silos support people to identify and respond to difficulties in a timely manner. The RCH infant mental health program trial with maternal and child health services is one such model (contact Megan Chapman ███████████████████████ for information).

Recognising that intergenerational trauma has occurred in many families and communities and the consequences need a trauma informed approach to healing. Examples of evidence based approaches for Aboriginal communities can be found here: https://healingfoundation.org.au/healing-portal/ Moving beyond the idealised response, such as the brave' and stoic' response to disaster to an acceptance that stressful events cause distress. This needs to be extended to babies and toddlers- that they too experience physiological distress and are capable of holding enduring implicit memories when witnessing stressful events (Rifkin-Graboi, Borelli, & Enlow, 2009; Schechter & Willheim, 2009; Zeanah Jr & Zeahah, 2019). Promoting an awareness campaign regarding the difference between mental health and mental illness across the entire lifespan and recognising the need for a continuum of mental health care (see http://siblingsaustralia.org.au/wp-content/uploads/2017/10/aicafmha_pos_paper_final.pdf). "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"2.1Both mental and physical illness is best prevented by ensuring a safe and nurturing infancy and early childhood (Chapman et al., 2004; Edwards, Holden, Felitti, & Anda, 2003). Further to those initiatives mentioned above, a systematic approach to addressing difficulties early in life as well as early in the presenting of indicated problems is crucial. Key steps to achieving this goal include universal mental health screening for babies and very young children. 2.2Victoria currently has world class, universal access to Maternal and Child Health (MCH), and when indicated, access to enhanced Maternal and Child Health Nursing services. State-wide staffing shortages are placing this system under considerable strain as are cost cutting (and as a result a decrease in expertise) measures being employed by numerous local councils. This service needs to be protected, further expanded and the workforce to have greater infant mental health literacy and expertise. MCH operates as the first, community accepted entry point for issues impacting infants, including the ability to pick up and intervene at the earliest stages to address potential infant mental health issues. 2.3However, it is important to accept that not all families will access the universal system and have responses available that target their specific needs. Some Aboriginal families, CALD families and those with a history of involvement with Child Protection Services need a culturally sensitive approach that will understand the impact of intergenerational trauma and abuse by authorities on the capacity to trust services. 2.4There are tertiary mental health services that ostensibly provide intervention for infants and their families. Very few infants attend Child and Adolescent or Child Youth and Family Mental Health Services. Prevalence rates of mental illness in 18-month olds has been found to be 16%-18%, but 0-4 year olds represent 0.9% of the Child and Adolescent Mental Health Service users. 2.5Infants are over-represented in Child Protection Services with 17.1 of 1000 infants under the age of one year being the subject of substantiated abuse or neglect (AIHW, 2019). Research conducted on all child protection clients in a Melbourne metropolitan region entering out of home care showed 33% of infants under the age of three met criteria for a psychiatric diagnosis according to the Diagnostic Criteria:0-3 (Milburn, Lynch, & Jackson, 2008; Zero-to-Three, 1994). 2.6Infants and very young children make up the highest cohort of children entering Women's Refuges post family violence but receive little to no service response (Bunston, 2018). Preliminary research suggests that infants in Refuge do not enjoy secure attachments with their mothers (Bunston & Glennen, 2008). Attachment difficulties in early childhood increases the potential of later life mental health issues as does unresolved early childhood exposure to traumas such as family violence. The provision of infant mental health support and parent child dyadic work is imperative in Women's Refuges. 2.7There are limited service system responses to infant and early childhood difficulties and those that are available are not well integrated. There remains a gap in the system between the universal services and the

tertiary mental health services. Medicare funded perinatal and infant mental health services are limited in service capacity (number of sessions), availability and quality control. 2.8Cradle to Kinder, is a targeted intervention offering long term (up to five years) support to infants and their young mothers who have been identified at high risk. This program is an innovative, state-wide an initiative of the Victorian government. It is an exciting concept, and when operating from an infant centred framework produces best practice outcomes, however, there is variability in how it is delivered and lacks a central governance structure. See https://www.ipchealth.com.au/cradle-to-kinder/ or contact Samantha Ware ████████████████ for information about a best practice example of the Cradle to Kinder model. 2.9The Cradle to Kinder model offers the foundation for building other similar programs where young or first-time mothers and/or fathers who are experiencing significant mental health issues and require significant support. 2.10Early Parenting Centres will be expanded during the current term of the Labor Government, and many more infants and their families will receive secondary and tertiary care than currently. However, the service model currently is limited in terms of the inclusion of mental health services within a multi-disciplinary framework. Significant areas of Victoria will remain without an Early Parenting Centre. 2.11There is little quality assurance and accountability for outcomes in the infant and toddler services. 2.12There is little direction and oversight provided by the Department of Health and Human Services in service provision. 2.13There is significant variability in service delivery depending on region. 2.14There are no accessible infant mental health services in many regions of Victoria. As such, the availability of support and intervention services with a rapid response capacity will ensure difficulties are addressed in early stages. If not addressed early for infants and very young children, the infant will adapt to the situation and the state of fear or distress is likely to embedded into their rapidly developing brain and will become a trait (Perry et al., 1995; Perry & Linas, 2012). Addressing situations of fear and sadness early will therefore prevent the development of relational disorders such as Personality Disorders, as well as chronic anxiety and depression. This requires the creation and development of specific, state-wide, infant mental health services that are integrated across the continuum of universal and secondary services. 2.15Funding for training and workforce development being made available. Victoria has a very sophisticated mental health workforce that has been largely upskilled in infant mental health expertise through individual professionals' commitment and self-funding. A systematic approach to workforce development is a cornerstone of good clinical governance and will ensure sustained and high-quality service delivery to families. 2.16Victoria and Australia have under-invested in research and evaluation of clinical programs. This results in clinical practice that has limited reliability and validity and the practice of taking international evidence-based programs and implementing them in local conditions that do not mirror those in which the evidence has been established, resulting in limited or unknown reliability and validity for local conditions. 2.17Investing in research and development will ensure that investment in treatment will be targeted to those treatments which provide the best outcomes for families. It is crucial that Australia invest in practice-based evidence models for Australian programs that are targeted towards Australian conditions. 2.18Establishing and delivering practice-based evidence and evidence-based practices is expensive and requires a whole of service system commitment. 2.19Torres Strait Islander and Aboriginal specific infant and family based service responses and research being permanently funded with appropriate workforce development programs supported, (for example the work of the First Thousand Days Australia http://www.first1000daysaustralia.org.au/ and Bubup Wilam https://apps.aifs.gov.au/ipppregister/projects/bubup-wilam-children-s-place-for-early-learning-aboriginal-children-and-family-centre). 2.20A separate Mental health Strategy for Aboriginal and Torres Strait islander families is needed. Currently there is an opportunity to include this in the 5th iteration of the national plan. https://pmc.gov.au/resource-centre/indigenous-affairs/national-

strategic-framework-mental-health-social-emotional-wellbeing-2017-23 whole of family approaches to address social and emotional wellbeing. 2.21National and State policies and plans need to be integrated. "

What is already working well and what can be done better to prevent suicide?
"3.1Early intervention, enhancing quality of life and relationships, and adopting a culturally respectful family focus all aids in preventing suicide. Prominent international mental health expert Professor Peter Fonagy from the University College London visited Melbourne last year to speak at the Australian Childhood Conference. Professor Fonagy stressed that across the board, the most effective treatment for those with serious mental health issues is to build relational trust and decrease their social isolation. 3.2Furthermore, the number of adverse childhood experiences a person endures predicts adult suicidal behaviour. Adults with three or more adverse childhood experiences such as physical, sexual, and emotional abuse, neglect, parental death, incarceration, alcoholism, and family suicidality have been found to be more than three times more likely to consider or attempt suicide as adults (Thompson, Kingree, & Lamis, 2018). These identified adverse childhood events cannot, however, explain away the excessive over-representation of the indigenous community (and particularly children) in Australian suicide rates. Prior to colonisation suicide was believed to be almost non-existent in the indigenous culture (see https://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-natsisps-strat-toc~mental-natsisps-strat-1~mental-natsisps-strat-1-ab). Until our political system acknowledges that white settlers did invade this country, did attempt to eradicate the first nations peoples and did inflict, and still do cause psychological, material and spiritual damage to indigenous Australia, and continue to fail to provide real reparation; these extraordinarily high rates of suicide are likely to remain. 3.3Early intervention through infant mental health programs within child and adolescent mental health services are often poorly resourced and not connected in with universal services such as maternal child health services. However, examples of best practice, collaborative infant mental health initiatives are currently being trialled within the Infant Mental Health service at the Royal Children's Hospital (contact Dr Megan Chapman: ███████████████████████ also Dr Paul Robertson ██████████████████ who trialled a collaborative Mental Health and Maternal Child Health initiative). Similarly, access to infant mental health services and culturally appropriate support for indigenous and non-indigenous infants and young children is almost non-existent in rural and remote areas. The work of the First 1000 Days Australia (contact Professor Kerry Arabena on ████████████████████████ and see http://www.first1000daysaustralia.org.au/) was one of the first of its kind to begin to address this lack of infant and child focused work within the indigenous community. "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"4.1As already stated, poor early life relationship and caregiving environmental experiences, intergenerational trauma and early childhood difficulties impinge on good mental health. This is often concerned with early problems in mastering affect regulation which leads directly to a poor capacity to exercise reflective functioning which can be at the core of many mental health issues. 4.2Adverse childhood experiences make it difficult for people to experience good mental health. A history of childhood trauma also makes it difficult for people to be good mothers, fathers, partners and friends. Although it is difficult to eradicate harmful childhood experiences, a community and service system that understands that people will suffer when bad things happen will be more

compassionate and responsive to need. 4.3Once we all accept and understand that White Australia systematically tried to destroy the bonds of Aboriginal families for generations, we may start to address the effects of intergenerational trauma for Aboriginal families. 4.4Helping families establish a strong bond with, and secure attachment system for, their children will develop the relational capacity that will stop repetitive patterns of intergenerational dysfunction. 4.5Structurally, our current mental health system fails to successfully integrate familial (in all their diversity) approaches to treatment across the spectrum. Adults with mental health issues often have children, yet these children are seldom considered in adult services treatment plans. That the inclusion of children's voices may be part of powerful treatment approaches needs consideration, not the least to ensure that when parents are particularly unwell infants and children are kept safe from harm. The experience of an only child living with a mother with Schizophrenia has been well described in Justin Heazlewood's book Get Up Mum. 4.6As a community it needs to be recognised that infants and children can be exposed to significant harm, can be present or experience significant life trauma where one parent kills the other or there is a murder/suicide. Infants and very young children may even be at risk of filicide where parents are in florid states of psychosis and/or experiencing severe mental health issues (Friedman, Hrouda, Holden, Noffsinger, & Resnick, 2005; Lveille, Marleau, & Dub, 2007). Specialist, well-coordinated treatment and service responses need to be quickly activated in such situations and the impact on the emotional, relational and psychological world of the infant duly acknowledged and addressed (Eyer, Milburn, & Bunston, 2019). 4.7Infant mental health, and CAHMS (as does adult mental health) needs to provide direct service delivery support and reflective supervision opportunities to skill up workers in Women's Refuges.   4.8All too often the service system is criticised for working in silos. It is beyond doubt that there is a better need for growing an integrated service system that learns from one another. Family violence, for example, is clearly a mental health issue (Bunston, Franich-Ray, & Tatlow, 2017) yet there are all too often poor pathways for entry into one system when case management is being held by another service system. For example, infants and children being referred into Child and Adolescent Mental Health Services by Family Violence and Homelessness services are often denied access as their presenting issues are not seen as being mental health' related. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"5.1Isolation from family and community. 5.2Self-imposed isolation- stigma regarding sharing vulnerability and stress. 5.3Community expectation that people will cope' with adversity and stress. Examples include coping with the chronic uncertainty of drought and the expectation that mothers will be able to cope with small children by themselves for long periods. Both of these situations are inherently stressful and should be expected to be so by others. Instead stressed individuals in these situations are sometimes pathologized by the community, contributing to their internal sense of isolation and shame that they somehow aren't coping.   5.4Poor access to secondary and tertiary therapeutic and/or mental health services throughout Victoria. 5.5Some communities have a disproportionate number of people who have suffered trauma and/or adversity. 5.6Whilst it is easy to point out that poverty, the short term focus of services, families who experience homelessness, family violence and marginalisation are all at heightened risk of experiencing mental health difficulties it is harder to identify emotional neglect that can be hidden behind the faade of wealth and privilege. The lack of emotional literacy, the pressure to succeed at all costs, unrealistic expectations on infants and young children can all lead to the wealthiest of families experiencing poor mental health, debilitating depression and poor insight and empathy. A healthy community strives to take care of its own. Simply identifying those with obvious

disadvantages as susceptible to greater risks fails to see that those in our community who wield great power, own significant wealth and may unwittingly contribute to the stigmatisation of those less wealthy than themselves may contribute to poorer mental health outcomes for our Victorian community as a whole. Mental health difficulties are not simply the domain of those who are visibly struggling. It is simply better hidden amongst those who enjoy access to greater resources. Destigmatising mental health issues amongst the privileged may lead to a greater capacity to judge less and emotionally and financially enhance greater humility and equality for all. 5.7As Victoria sets about to undertake another Royal Commission into one of the biggest societal imperatives that threatens the well-being of our community overall, we have the chance to learn from the collective wisdoms garnered through the Royal Commission into Family Violence, and the Australian Royal Commissions into Institutional Abuses into Sexual Abuse; Aboriginal Deaths in Custody., Banking and Aged care. That as a community we face the challenges of placing compassion over profits, respect over relegation and valuing collectivism over individualism. Whilst this may seem like sentimental idealism, the countries and communities in the world that are thriving economically and psychologically appear to have adopted more tolerant, compassionate and egalitarian ways of functioning (Editorial-Board, 2019; Lehmann & Seitz, 2017). New Zealand's well-being budget sets an example for Victoria (https://treasury.govt.nz/sites/default/files/2019-06/b19-wellbeing-budget.pdf). 5.8It takes very little forward thinking to realize that at some juncture in the future a royal commission into the treatment of children in detention will be necessary. The long-term mental, health and social consequences for infants, children and their asylum-seeking parents who are left to remain in detention for extended periods will rival the consequences of the decision to remove Aboriginal Children from their parents and the institutional sexual abuse of children. "

What are the needs of family members and carers and what can be done better to support them?

"6.1It is perhaps the obvious to cite increases in funding support, access to material aid and respite services. However, less established but equally critical are re-engineering the system to be centred on relationships. Relationships matter, crucially in our early years, childhood and youth, but remain the most powerful motivator for engagement, change and growth throughout our entire life. 6.2Individualist approaches that fail to support the relational system that supports the person who is struggling with mental health issues will fail to provide sustainable outcomes. This involves the provision of access to external services such as Carers Victoria but also building in intensive therapeutic, and support-based group work programs within existing mental health programs. Building resilience within families, communities and for carers involves providing them with support, emotionally and relationally. Prioritising opportunities for family members and carers to meet with, support and sustain other family members and carers offers a rich vein of emotional and psychological sustenance that can build networks of ongoing support well beyond that which agencies could ever truly provide. This will ultimately lead to greater community support and a reduced need for service involvement. "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"7.1The provision of regular, reflective individual and group supervision with external, experienced supervisors offer what pioneering Infant Mental Health clinician Janet Dean, the founding Director of the Boulder Colorado Community Infant Mental Health Program, argues is the guarantee and insurance policy to help us sustain thoughtful and effective work (Stone, Jones, & Bunston, 2019).

Reflective practice enables those working with complex issues in highly stressful, human services environments to access emotionally regulated and thoughtful responses to clients and situations that are often highly dysregulated, high risk and can evoke reactive, unthoughtful and ill-considered service responses. Regular access to reflective supervision also minimises burnt-out and worker dissatisfaction (Eaves Simpson, Robinson, & Brown, 2018). 7.2Managers within the mental health workforce also require access to and the support of reflective supervision. All too often those higher up in services exclude themselves from the need to attend reflective supervision whilst they are the ones who inevitably set the tone and culture for the workplace. Perhaps infant mental health, with its strong commitment to reflective supervision (O'Rourke, 2011; Tomlin, Weatherston, & Pavkov, 2014), the use of observation (Rustin, 2014; Trowell & Miles, 2004) and recognition of the worker being supported to manage their own dysregulated emotional states when working with emotionally challenging cases can offer adult mental health services a model of practice that can maximise worker retention and improve client outcomes. 7.3Post-graduate training in mental health other than Psychiatry is not funded which limits selection of trainees. Removing funding barriers and discrimination against non-medical training in mental health is a must. 7.4Funding for continuing professional development for the mental health workforce does not match expectations of continued best practice. "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
"8.1Supporting innovation within the mental health sector in sourcing out community initiatives and projects that build opportunities for those living with mental health issues to participate in employment opportunities, projects within the arts, and media programs (for example, the ABC program Employable Me) that promote awareness. "

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"9.1In 2011 the Australian Infant, Child, Adolescent and Family Mental Health Association wrote a comprehensive position paper that offered a propose model for Improving the mental health of infants, children and adolescents (http://siblingsaustralia.org.au/wp-content/uploads/2017/10/aicafmha_pos_paper_final.pdf). This would be an excellent starting point in bring in an integrated, across the life span model of care, as would engaging with the Victorian Branch of Australian Infant Mental Health Association ████████████████ and appropriate indigenous early years initiatives such as The Frist 1000 Days ██████████████████ 9.2Switch the system from an adult oriented pathology focused system to a relationship focused developmental and collaborative system. This means investing primarily in early in life and early in problem services to develop good mental health from the beginning of life. Much mental health treatment is seeking to undo damage that was done early in life when crucial brain systems were developing. 9.3In practice this requires a large investment in babies and toddlers and their families. It should be accompanied by high quality research that will track return on investment. This can be established through a Centre for Excellence or Institute for Early in Life Mental Health that would oversee research and evaluation, training and service system models to ensure an integrated approach to supporting good mental health and development in the first three years of life. This includes parenting support and development as well as therapeutic offerings to ensure robust parental mental health and the establishment of secure attachment systems for babies and

toddlers. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"10.1Engaging with experts and organisations across the spectrum, from infant, child, young people, adult and the elderly mental health services to meet and hold round table discussions about how to work together and to invite other key stake holder organisations within Family Violence, Homelessness, Drug and Alcohol to participate. To involve the indigenous community fully in such discussions and to also invite consumers themselves to be fully present and respected participants in such discussions. 10.2The establishment of robust governance frameworks across the breadth of mental health and therapeutic services. 10.3Include the breadth of therapeutic services in the mental health system framework to assist integration and improve quality and governance of service delivery. This is mainly referring to the therapeutic services that are provided outside of the mental health budget, being through family services, school-based services and the like. "

Is there anything else you would like to share with the Royal Commission?
"11.1The answers to good mental health are in establishing good social and emotional functioning so that people grow the capacity to trust that others will be there when they need help, that they can ask for help when needed, and the relational capacity to share their difficulties when they arise. These skills are developed during the first three years of life. 11.2Babies and toddlers have the right for their difficulties to be recognised and addressed in a timely manner. An eight-week waiting time for the rapidly developing infant is too long. Infant mental health work is urgent, with an eight week wait equating to what would be comparable to a year long wait for an adult. 11.3It is shameful that babies are over-represented in Child Protection services, (meaning that by definition they have suffered harm from the people they are most dependent upon) and they are under-represented in mental health services (showing that the consequences of harm for emotional and psychological functioning is not addressed). 11.4The evidence is clear that investing in the early years pays dividends for society for years. It is baffling that this has not been embedded in the service system responses. 11.5The Royal Commission provides a unique opportunity to build a world class, comprehensive, across the life span response to building wellness within Victoria. The integration of learnings from this Royal Commission, on the back of other recent Royal Commission findings lends itself to creating rather than replicating a raft of recommendations which can provide something sustainable. Please do not let us down.
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