Royal Commission into Victoria's Mental Health System

Organisation Name: Emerging Minds

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

There have been a number of mental illness literacy programs in the community with an emphasis on high prevalence mental health conditions in adults and to some extent in adolescents and young people. A parallel body of work in required to expand a focus on improving mental *health* and mental *illness* literacy, with a particular emphasis on infant, child and parent mental health. Some important guidance to improve mental health literacy about infant and child mental health is currently being completed by the Frameworks Institute in partnership with Australian organisations, including a focus on developing communications frameworks for early childhood development and mental health and communications frameworks for health, social and community service providers regarding infant and child mental health.

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?

Emerging Minds recognises that many reform efforts have articulated a commitment to promotion, prevention, early intervention and treatment. However funded service delivery remains focused on responding to the impacts of mental illness on the *individual,* with priority attention being given to adults and (to a growing, but lesser extent) adolescents and young adults.

Data is showing that these investments are not resulting in changes to the mental health of the Australian population. There is a need to balance funding of strategies that support *mental prosperity* as a resource for society alongside current strategies to manage the impact of mental illness on the community.

Emerging Minds recommends a much stronger investment in 'early action' to support the mental health of current and future generations, with a focus on *addressing the prevention and treatment gap in infants and children.* This include**s** reorientation of infant, child, adolescent and adult focused mental health services to :

1. Early action, early in life
2. Early action in the life of mental health problems
    a. Early intervention
    b. Treatment early in life

Early action, early in life

- Due to the brain's heightened sensitivity to its environment, the first years are critically important for brain development and the development of other bodily systems.
- Exposure to high-stress events and environments early in life can alter organ systems which have lasting impacts on mental and physical health.
- The quality of early caregiving relationships plays a critical role in shaping a child's behaviour, mental health, future productivity and future parenting.
- Adverse Childhood Experience (ACE) studies have found that persons exposed to early traumatic experiences in childhood, including child maltreatment, parental mental illness or substance use, domestic violence, parental separation, and incarceration of a household member were at higher risk of:
    - suicide
    - substance use; and
    - mental illness.

    - and comorbid physical illnesses such as cardiac, respiratory and metabolic diseases resulting in reduced lifespan and productivity
- ACE studies have also found that the specific risk factor is less important than the cumulation of adversities in regard to capacity to cope with life's challenges.

A range of investments have been made across governments and services to support early childhood development including prenatal care, child health and development services, family home visitation programs, parenting programs, parental leave, programs for at-risk families, access to quality early childhood education and care, welfare services, and environments that support child/family community participation and engagement.

A number of studies internationally have demonstrated good 'return on investment' for many of these programs and policy responses across a broad range of human development, health and mental health domains.

In practice, the delivery of these programs to support infant and child mental health are challenged by:

- the need to match the outcomes achieved in research trials with real-world service settings
- mismatched intensity of support (e.g. low intensity universal programs being delivered to families with multiple and complex needs)
- coordination of efforts, with many funders funding many different programs and organisations to deliver services
- investment in high-cost packaged programs (often from overseas), rather than translating the evidence into 'core practices' that better reflect their use in local service settings programs outside of the mental health system which do not explicitly pay attention to, or measure, the impact of programs and services on the mental health and resilience of infants and children (e.g. parenting programs tend to focus on 'parenting skills' or on 'child safety' as outcomes); and
- shortages in tertiary services (in mental health and child protection) resulting in many of the primary and secondary prevention and early intervention programs 'holding' and 'responding' to the needs of complex populations.
  This leads to:
    - prevention programs not being delivered to the intended populations
    - children and families with severe presentations being managed by services who cannot offer the intensity or quality of support required to achieve improved mental health outcomes.

Early action in the life of mental health problems

- Half of all lifetime mental health conditions emerge in childhood.
- 1 in 7 Australian children under 12 experience a mental health condition.
- Emotional and behavioural disorders are the leading cause of disability-adjusted life years (DALYs) in Australians aged 5–14 years.
- Prevalence of mental health conditions is not decreasing.
- Mental health problems in childhood contribute to inequalities in health, social, developmental and educational outcomes.
- Mental health difficulties in childhood often persist into mental and physical health conditions that continue through adolescence and into adulthood, increasing health, social, economic and human development inequalities across the lifetime and across generations.
- Mental health promotion and prevention interventions for children and adolescents have been found to be effective, including screening (when there are appropriate and timely responses), psychological intervention and bibliotherapy for the prevention of childhood and adolescent depression, and parenting interventions for the prevention of childhood anxiety and conduct disorders.
- Current allocation of public funding is not designed to respond to the age range during which a majority of mental health problems are likely to emerge (childhood).

Early intervention

Half of all lifetime mental health problems emerge in childhood. See table below with typical age ranges for first presentations of mental health problems.

	Age (yrs)																	
Type of disorder	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**
Attachment																		
Pervasive developmental																		
Disruptive behaviour																		
Mood/anxiety																		
Substance use																		
Psychosis																		

Australia and Victoria in particular, have shown world leadership in early intervention, with significant investments in early intervention for the small group of adolescents who develop psychosis (0.5% of the population).

However, equivalent provisions enabling response to the high prevalence presentations that emerge in childhood (e.g. depression, conduct problems, anxiety and trauma) have not been made. Funding of early intervention should also be made for high prevalence conditions such as conduct disorders and depression that result in individual, family, intergenerational and societal distress and disability.

Treatment early in life

A range of evidence-based interventions and practices exist for many of the mental health conditions experienced in childhood. These interventions can have lasting effects when delivered early in life. Despite this, only one in six children experiencing mental health conditions receive professional help. For the children that do receive help, it is often delayed, insufficient and only received by those with the most severe presentations.

State-funded Child and Adolescent Mental Health Services (CAMHS) or Child and Youth Mental Health Services (CYMHS) provide specialised child and youth treatment and continuing care services for children and young people experiencing mental health problems. In general, these services are intended to cover birth-18 years in most urban and regional areas, and in some rural and remote services across Australia. Services primarily target children and adolescents with severe mental health problems. Infrastructure has been established to support service delivery across most geographical regions in Australia.

Extensive data relevant to mental health outcomes is collected by clinicians in all CAMHS in Australia and programs such as the Australian Mental Health Outcomes and Classification Network help to collate these outcome measures for child and adolescent mental health services.

In general, CAMHS services in Australia (with similar trends internationally) are inadequately resourced to respond to the needs of the population that they are designed for, particularly children under 12. Despite intent to provide broader coverage across childhood, managing severe and acute mental health presentations in adolescent populations is prioritised. This has led to reports of a deskilling of the mental health workforce in non-acute, therapeutic interventions (individual, family focussed and group), that evidence shows improve outcomes for infant, child and parental mental health

In recent years, the Commonwealth has invested significantly in youth mental health services (Headspace) and increasing access to psychological treatment services for children and adolescents through the Access To Allied Psychological Services (ATAPS) and Better Access initiatives through primary health care. These services have been designed to intervene earlier and improve access to evidence-based services for children and adolescents at-risk of or experiencing mild to moderate mental health problems

Recent reviews show that, despite these funded initiatives , *service access and coverage for infants and children remains significantly lower than population need* (see table below). Similarly, data is also showing no change in the mental health status of this population over time, reflecting a likely mismatch between need and the level of intervention allowed/offered.

Age	Prevalence	Multiple risk factors indicative of requiring specialist mental health support (4+)	Current level of access to specialist mental health services
0-4	No current data A range of international studies indicate up to16-18% meet levels of dysfunction highly suggestive of diagnosis	16.1% (0-1 yrs.) 12.1% (2-3 yrs.)	**Commonwealth** MBS Any provider 0.9% (0-4 years) ATAPS 0.3% (0-11 years) **State** Ambulatory 0.4% (0-4 years)
5-11	13.6% meet criteria for diagnosis	19.2% (4-5 yrs.) 25.2% (6-7 yrs.) 28.9% (8-9 yrs.) 32.8% (10-11 yrs.)	**Commonwealth** MBS Any provider 5.7% (5-11 years) ATAPS 0.3% (0-11 years) **State** Ambulatory 1.4% (5-11 years)

Guy, S., Furber, G., Leach, M., & Segal, L. (2016). How many children in Australia are at risk of adult mental illness? *Australian & New Zealand Journal of Psychiatry*, *50*(12), 1146–1160. https://doi.org/10.1177/0004867416640098

The flow on effects of inadequate service coverage for infants and children means that children with moderate to severe mental health presentations are being 'held' by education settings, primary care settings, child protection or social-service settings. Children in these settings are not receiving the evidenced based, multi-disciplinary mental health interventions required to achieve improved mental health outcomes.

There is a very high need for a parallel focus on increasing coverage *and* quality of services where the burden is highest.

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

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 with each other.

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

a. Social Determinants driving poorer mental health outcomes

Substantial evidence exists regarding the impacts that inequality, poverty, disadvantage and discrimination have on mental health. These issues increase the likelihood of exposure to adverse childhood experiences and flow on impacts to human development, mental and physical health, across generations. Actions on these issues require whole of Government responses.

While the mental health outcomes of a number of specific communities in Victoria are affected by social, historical and environmental circumstances and carry significant degree of intergenerational burden, two groups, namely communities affected by disaster or traumatic events and Aboriginal and Torres Strait Islander peoples accessing mainstream services have been prioritised by Emerging Minds within the first phase of our work.

Emerging Minds has recently produced co-designed resources for the workforce and local communities in relation to the cycle of intergenerational trauma and disadvantage experienced by these two communities notably largely consisting of regional, rural and remote locations.

In the workforces that support them acknowledgement of the need to address intergenerational cycle of mental distress and ill-health through appropriate trauma informed approaches has inconsistent and not universally integrated into service design or local action plans.

The following links take you to examples of how evidence-based sector specific resource development can assist in addressing the gaps contributing to poorer mental health outcomes.

Working with Aboriginal and Torres Strait Islander Families and Children Toolkit

Downloadable A4 Summary:
https://emergingminds.com.au/resources/toolkits/working-with-aboriginal-and-torres-strait-islander-families-and-children/
The Online Toolkit via:
https://d2p3kdr0nr4o3z.cloudfront.net/content/uploads/2019/05/31124514/Aboriginal-and-Torres-Strait-Islander-families-and-children-toolkit-summary.pdf
Video: The Whole Child
https://vimeo.com/327656419 (3 min)

Community Trauma Toolkit
Video: How to use the community trauma toolkit (1 min):
https://vimeo.com/326494044
Video: Trauma and adversity (2:30min)
https://vimeo.com/243599162
Downloadable A4 Summary:
https://d2p3kdr0nr4o3z.cloudfront.net/content/uploads/2019/04/03145025/Community-Trauma-Toolkit-Summary-Final-interactive.pdf
The Online Toolkit:
https://emergingminds.com.au/resources/toolkits/community-trauma-toolkit/

Emerging Minds is committed to producing professional resources to assist communities where poorer mental health outcomes for children birth to 12 have been identified. We are currently developing similar resources focusing on the cohort of children with predisposing individual risk factors such as intellectual disability and family circumstances such as those involving parental AOD and physical illness adversities.

b. Addressing social determinants systemically

Given actions on the range of issues influencing inequitable mental health outcomes require whole of Government responses, Emerging Minds would recommend adapting and implementing a 'Mental Health in all Policies' Framework, building on the World Health Organisation's 'Health in All Policies' Framework.

Our organisation is in the initial stages of scoping a 'Child Mental Health in all Policies' Framework and would welcome and invite partnership with the Victorian Government, initially via this Commission, in the development of this systemic reform strategy.

Further information on the 'Health in all Policies' Framework is available from:

Word Health Organisation:
https://www.who.int/healthpromotion/frameworkforcountryaction/en/

Local examples of implementation for other health concerns are available from:

South Australian Government: Health in All Policies:
https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+in+all+policies/south+australias+hiap+approach

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

Emerging Minds has a long and well-recognised history of engaging and partnering with family members and carers of people experiencing mental illness who are parents. Under the banner of the Children of Parents with Mental Illness COPMI National initiative hundred (2001-2016) over 150 individuals were active on our lived experience pool. A smaller group the COPMI National Lived Experience Forum provided consultation and advice on a regular basis, while the remainder made themselves available for specific consultation, review, interview, filming, public speaking and product co-development opportunities that arose across a 15-year period.

Family members and carers both as individuals and members of peak advocacy bodies would regularly express frustration at repeated requests from government and researchers asking for their involvement to clarify what their needs were and what could be done better to support them. Their message to us clearly paralleled the frequently stated consumer frustration of having to repeat their stories when seeking support.

There have been a myriad of State and National reviews, initiatives, needs assessments, trials, discussion papers and policy developed or conducted over the last 20 years to establish family member and carers needs. This exists for governments, policymakers, organisations and researchers to read and inform themselves through.

We need to stop asking the same questions as though they haven't been answered.

This is not valuing lived experience. It does not it constitute inclusion and participation if the history and wealth of documented analysis of needs continues to be ignored or revisited.

Ensuring the voice of people with lived experience, particularly of the mental health service system, should by now be embedded in governance processes at all levels. Consultants and peer support workers are the emerging workforce that need security of funding to be integrated.

Emerging Minds believes that the work done by the Victorian government in progressively supporting this emerging workforce is essential to continue so that genuine ongoing participatory structures are standard, consistent and permanent.

The area of potential blindness and deafness in this domain is the voice of children. As family members whose lives and primary relationships are affected by this circumstance and who are involved in, informally as part of normal family caring but also often formally supporting their parent, they have a right to be considered and have their voice and concerns heard.

This is developmental work Emerging Minds is pursuing to improve the capacity of services and systems to appropriately support and better hear the voice of children as family members of those experiencing mental ill health in their own right.

While Recovery is a framework that the Victorian mental health system has embraced, Mike Slade one of its pioneers, has recently noted it is in the process of evolving itself to address some of the areas of omission and limitation in its original conception. The concept of Relational Recovery is one Emerging Minds has promoted and made contributions to at a National and International level. It enhances the person-centred approach by acknowledging the relational context in which we all exist are impacted by and impact on. It also defuses the disenfranchising binary of 'consumer' and 'family' as though the consumer is not a family member, often with the most critical responsibility of raising children.

We have attached an article to further elaborate on this.

Relational Recovery - Beyond individuali

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

Emerging Minds conducts specific sector workforce needs analysis as part of a quality process in resource development. We also receive continued feedback from a broad range of professionals, including from the mental health workforce, who access our online material, face to face events and via regular evaluation surveys.

To date feedback, including from organisational leadership groups, consistently indicates *work satisfaction* as a priority for the well-being and continued commitment and retention of front-line workers. Within increasing levels of service complexity, demand and diminishing time to collaborate with others in consumer/family support and shared care, they find it extremely difficult to prioritise and maintain their own professional development. The priority of responding to acuity, crisis and short-term involvement creates narrow practice parameters, reinforces silo disconnection (across the age spectrum) and ultimately, adoption of survival strategies to maintain self-care, burn out, and loss of hope and attachment to the motivating factors that lead them into this work.

Hence, long-term support for the continued development, refinement, implementation and evaluation of strategies to improve mental health outcomes inclusive of training and development needs is core to addressing issues of recruitment and retention. Staff wish to feel confident and supported in their day to day work both in managing pressure and providing quality, humane, evidence based holistic treatment. The ability to see opportunities for contributing to prevention and early intervention regardless of their work role and remit are key to maintaining hope.

However, a number of implementation barriers to effective prevention and early intervention work that impact on staff satisfaction have been identified:

- Health and social service professionals are being restricted by funding and/or organisational systems requiring them to focus on individual, rather than child, family or multi-generational centred care.
- Multi-generational and family focussed interventions are not included in or supported by the MBS/NDIS.
- Services for adults and services for children rarely work together to provide wraparound support for the whole family due to a range of professional, organisational and systemic barriers.
- Most health and social service professionals are trained to react to presenting issues, rather than integrate pro-active or preventative responses.
- Data and client management systems are not designed for family or multi- generational focused practices and interventions.
- Access during workhours to regular practice refreshers and advanced practice and development training has diminished as organisational mandatory training schedules (largely safety-focussed) have expanded.
- Suboptimal information technology systems within health and social service settings, not only limit efficient care recording and communication but also compromise access to readily available free, online professional development and practice resources for staff and local educators .

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?

a. Service delivery models to integrate a focus on mental health and adversity

The relationship between experiences of adversity and poor mental health is well established. However, most service models assume adversity and complexity is only expected in the most 'severe' presentations.

An example of this is the recently introduced 'stepped care' model, which uses symptom severity to inform the service mix/response. For example, current recommendations indicate that a low severity presentation = low intensity intervention. When applied to an infant or child population, this approach does not take into account:

- high developmental/lifetime risks for future mental health difficulties that are predicted by exposure to adversity/risk factors, but may not yet present in symptoms
- intergenerational needs (e.g. parallel complexities in parents and children and their impacts on each other and treatment effectiveness)
- current adversity and what this means for different levels of intensity of intervention across the promotion, prevention, early intervention and treatment continuum. For example, prevention interventions can be costly/intense in the short term, but cost- benefits are demonstrated longitudinally in relation to reduced welfare dependence, crime and illness.

The focus of stepped care requires further refinement for infants and children, and more broadly, needs to incorporate both the severity of symptoms and the number/severity of psychosocial adversities predicting short and long-term mental health risks. This could inform the intensity of care, support and service coordination between mental health, health, social and education/care environments. Further refinement of this to incorporate the cost- benefit of interventions would provide a strong foundation for informing investments in mental health.

The table below provides a 'work in progress', narrative description of how this model currently being developed by Emerging Minds could be applied to describe the focus of interventions at different levels of need.

	Level of Adversity		
	Low (0-1)	Moderate (2-3)	High (>4)
Normal	**Family intervention:** A preventive intervention directed to parents of shy, temperamentally inhibited pre-schoolers reduces the prevalence of childhood anxiety during the primary school years and also adolescent depression. **Population intervention:** A child with normal psychological functioning and no/low exposure to adversities is likely to benefit from universal programs such as	**Family/community intervention:** A low-key early intervention supporting active expansion of informal and formal supports for parents and the development of children's social support network to combat the isolation and reduction of access that occurs when families face multiple adversities.	An infant with normal psychological functioning, but very high levels of adversity, would benefit from high intensity prevention interventions such as 'Intensive Family Home Visitation' to reduce lifetime developmental and mental health risks. Cost benefit studies have shown that high cost/high intensity prevention interventions have cumulative cost benefits due to lifelong reductions in costs associated with welfare, health and crime.

	social and emotional learning programs in schools.		
Moderate Distress	A school-aged child with raised anxiety symptoms might benefit from low intensity CBT programs delivered in the classroom, online or in a family mental health support service.	A family living through prolonged drought, resulting in high psychosocial stress/depression in parents would benefit from family prevention intervention delivered in a primary care setting, supplemented with access to Peer Support Programs for Parents, Children and Families in similar situations.	
High Psychological Distress	A child with very high psychological distress and severe mental health symptoms would benefit from multidisciplinary and specialist mental health support provided by CAMHS.		A child with very high psychological distress and symptoms in an out-of-home care arrangement would benefit from multidisciplinary and multi-generational specialist support involving specialists in multi-systems family interventions, with collaboration between specialist adult and child-focused services.

b. Reform leading to a responsive service system that is grounded in effective prevention and early intervention.

1. That at each stage of individual and life development phase
   (e.g. Perinatal, Infant, Pre-school, Primary School Age, Adolescent, Young Adult, Adult, Older & Aged person)
   the complete continuum of service is considered, accessible and available.
   (e.g. health promotion, prevention, early intervention, specialist intervention, continuing care, recovery support, crisis and acute response, acute and specialist inpatient service)

2. That the individual consumer, *their relational and familial roles and responsibilities*

and the needs of their significant others and family members are **equally** attended to rather than a narrow individual treatment, recovery or support focus alone *(e.g. relational and family recovery as well as personal and clinical recovery)*

3. Whatever service/sector configuration is funded, that they are required to reflect this continuum and relational emphasis, regardless of their delivery mandate and remit *(e.g. adult or child focussed, clinical treatment, outreach support, consumer and family peer support)*

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?

a. Plan ahead for improved measurement to better inform future service design

Most Australian population mental health measures focus on measuring the *prevalence* of mental health conditions in the population. Recognising the evidence of clear links between exposure to adversity and mental health, Emerging Minds recommends that in addition to prevalence, population measures of mental health should incorporate a focus on measures of psychological functioning alongside levels of exposure to adversity at each age and stage.

This would assist in:

- understanding population health needs across a mental health continuum
- estimating population health needs at each age and stage, and designing service responses accordingly
- predicting future mental health needs based on accumulation of exposure to adverse childhood experiences and risk factors
- identifying target groups for interventions
- identifying which interventions are most cost-effective for long-term outcomes in identified cohorts (e.g. whole of population interventions, multi-generational/family interventions or individual interventions);
- improving understanding of different levels of intensity and systems of care needed across the continuum of interventions (e.g. children with normal psychological functioning but living with high adversity are likely to benefit from high intensity prevention interventions).

The table below is a very simple/developing example of this approach being applied to a sample of Australian children aged 4-5 years, using data from the Longitudinal Study of Australian Children.

	Level of Adversity		
	Low (0-1)	Moderate (2-3)	High (>4)
Normal	46.9%	27.7%	6.6%
Slightly Raised	3.1%	4.3%	2.1%
High Psychological Distress	1.5%	2.3%	1.5%
Very High Psychological Distress	.7%	1.6%	1.7%

Data in the table informed by:
Segal, L., Guy, S., & Furber, G. (2018). High levels of adversities in children and adolescents experiencing psychological distress: the rule rather than the exception. Manuscript submitted for publication

b. Plan ahead for improved child and family sensitive built environments

Frequently explored but rarely implemented as a permanent feature are dedicated spaces for family meetings and children's visits. This infrastructure has long been acknowledged as essential to successful child aware and family sensitive practice across adult focused mental health services.

Given capital works expenditure is largely determined at the state departmental level, government has a distinct opportunity to future-proof current and proposed developments of the physical environment where services are delivered to ensure this well-known enabler is permanently secured and not left to the vagaries of local planning or central budgetary negotiation. In the future development of any new or expanded state-funded facilities this dedicated space should be considered mandatory as part of design and construction contractual arrangements. In any expansion or premise leasing arrangements this dedicated space should also be considered mandatory as part of selection and contractual priorities.

Acute Inpatient Settings (IPU)

- The family room external but immediately adjacent to the inpatient ward incorporated within the expansion of the Northern Psychiatric Unit in Epping in 2011 is a good example of enabling and supporting practice change consistent with trauma-informed recovery focused , child aware and family sensitive practice principles. The lesson from this experience is that an 'officially designated' multi-purpose visiting space (originally this was designated as an ECT suite waiting room/family room) inevitably reverts to use by staff for meetings and supervision despite being consciously set up as a child friendly space.

Residential and recovery settings (PARCS & CCU's)

- PARC settings in particular are well suited to the quarantining of quiet space. Some facilities have incorporated sensory modulation environments that have been and are well suited to doubling as family and child visiting space.

Community mental health services (Both clinical and community-managed NGOs).

- Despite being a service setting where children and family members are most likely to regularly attend with consumers, the ability of services to quarantine and maintain appropriate child and family friendly meeting spaces (of sufficient size for a group of people and enabling setup play space) has consistently proven to be difficult despite good intentions. Consideration should be given to including this provision within the scope of a work safe/child safe requirements.

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

We would like to share two short videos with the commission as our final contribution.

The Invisible Child is a 2-minute video summarising the 'why of our work' and its importance in improving mental health outcomes across generations and systems.
https://vimeo.com/256522580

The Trauma Lens video provides a brief example (3 mins) of the online workforce development material developed by Emerging Minds to support practice change towards a child-aware, parent-sensitive and relational recovery approach.
https://vimeo.com/263812043

Emerging Minds would welcome the opportunity to provide further input and detail in relation to the responses provided in this report.

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

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

About Emerging Minds:
Emerging Minds is a national organisation dedicated to advancing the mental health of Australian infants, children, adolescents and families. Emerging Minds develops innovative education and training materials, knowledge translation strategies, health promotion programs and implementation/change management resources for organisations, professionals, children, young people and their families. We provide advice to government, to monitor, support and deliver continuous improvement in this area and partner with family members, state and territory, national and international organisations to implement evidence-informed practice in the Australian context.

Emerging Minds is funded by the Department of Health to lead a consortium in delivering the **National Workforce Centre for Child Mental Health.**

Through this program, Emerging Minds is developing workforce support resources for health, social and community services to:

- improve mental health literacy around child mental health, trauma and adversity
- apply a continuum of promotion, prevention and early intervention supports for children at risk of or experiencing mental health conditions and trauma; and
- advance multi-generation focused practices and interventions for children and families.

These resources are targeted at:

- child health and development services
- child mental health services
- adult mental health services
- alcohol and other drug (AOD) services
- services working with families experiencing family and domestic violence
- child wellbeing and protection services
- primary care setting
- services responding to community trauma incidents (e.g. natural disaster or man-made incidents)
- services supporting parents experiencing severe or chronic health difficulties
- social services for children and families
- Family Relationship Services
- Disability Services

Our Victorian and Tasmanian Child Mental Health Workforce Consultants and other staff are co-located in Melbourne. Our online resources are also conveniently accessible to the broader mental health workforce through the Victorian Centre for Mental Health Learning website, as well as through our own national web hub. This brief 4-minute video introduces our organisation, our work and establishes our interest in providing input to a critical opportunity for mental health reform in the State of Victoria. https://vimeo.com/239731845	
Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☒ Yes ☐ No