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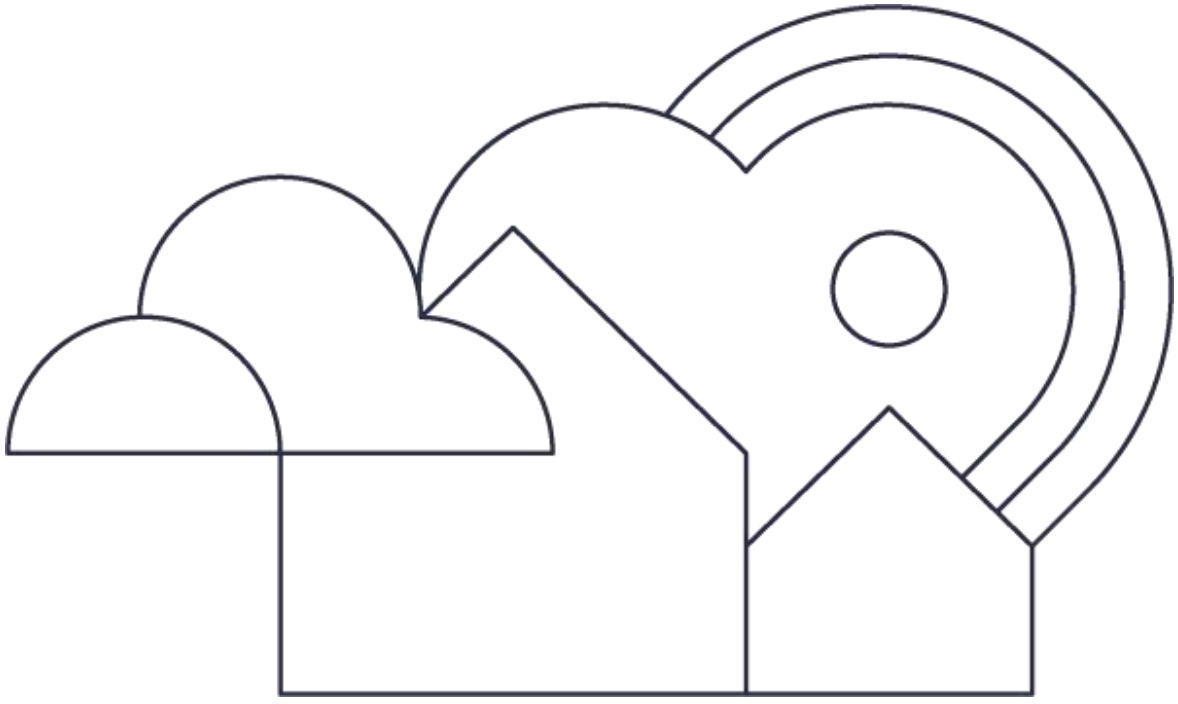
KIDS FIRST AUSTRALIA

Submission to the Royal Commission Inquiry into Victoria's Mental Health System

July 2019



Your information	
Title	Ms
First name	Aileen
Surname	Ashford
Email Address	[redacted]
Preferred Contact Number	9450 0900
Postcode	3081
Preferred method of contact	☑ Email ☐ Telephone
Gender	[redacted]
Age	[redacted]
Do you identify as a member of any of the following groups? Please select all that apply	[redacted]

	[redacted]
Type of submission	☐ Individual ☑ Organisation Please state which organisation: Kids First Australia (refer attachment 4) Please state your position at the organisation: CEO Please state whether you have authority from that organisation to make this submission on its behalf: ☑ Yes ☐ No ☐ Group How many people does your submission represent?
Personal information about others	Does your submission include information which would allow another individual who has experienced mental illness to be identified? ☐ Yes ☑ No
	If yes, are you authorised to provide that information on their behalf, on the basis set out in the document ☐ Yes ☐ No
	Prior to publication, does the submission require redaction to deidentify individuals, apart from the author, to which the submission refers ☐ Yes ☑ No
Please indicate which of the following best represents you or the organisation/body you represent. Please select all that apply	☐ Person living with mental illness ☐ Engagement with mental health services in the past five years ☐ Carer / family member / friend of someone living with mental illness ☐ Support worker ☐ Individual service provider ☐ Individual advocate

	☑ Service provider organisation; Please specify type of provider: Child and Family Welfare Services_____ ☐ Peak body or advocacy group ☐ Researcher, academic, commentator ☐ Government agency ☐ Interested member of the public ☐ Other; Please specify:
Please select the main Terms of Reference topics that are covered in your brief comments. Please select all that apply	☑ Access to Victoria's mental health services ☑ Navigation of Victoria's mental health services ☑ Best practice treatment and care models that are safe and person-centred ☑ Family and carer support needs ☑ Suicide prevention ☑ Mental illness prevention ☐ Mental health workforce ☑ Pathways and interfaces between Victoria's mental health services and other services ☐ Infrastructure, governance, accountability, funding, commissioning and information-sharing arrangements ☐ Data collection and research strategies to advance and monitor reforms ☐ Aboriginal and Torres Islander communities ☐ People living with mental illness and other co-occurring illnesses, disabilities, multiple or dual disabilities ☐ Rural and regional communities ☐ People in contact, or at greater risk of contact, with the forensic mental health system and the justice system ☐ People living with both mental illness and problematic drug and alcohol use

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?
"*People with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people*"[1]. The stigma associated with mental illness is a global problem, and efforts to address it must be informed by evidence on what works well. Stigma is not only external, i.e., the reaction of other people to the person suffering mental illness, it can also be internal, i.e. self-directed by the person with the mental illness, against themselves. Public stigma manifests itself in commonly observed behaviours such as stereotyping, prejudice and discrimination often resulting in avoidance of the person suffering mental illness, withholding help, etc. Research has consistently shown that the most successful strategies for changing public stigma about mental illness are education and contact[2]. Education is a proactive strategy that helps the public make more informed decisions about mental illness thereby reducing negative stereotyping. It is effective for a wide range of audience and for a variety of settings, and research shows that education has the potential to improve the public's attitude towards people suffering mental illness. Contact is another powerful factor that can normalise mental illness in the minds of the public. This is achieved through opportunities for the public to come in contact with a person with mental illness, meeting people with mental illness who are employed, or are active in their communities etc. Interpersonal contact is further enhanced when the general public is able to regularly interact with people with a mental illness[3]. A 1993 study into community tolerance of the mentally ill concluded that the main demographic determinants of tolerance are age, education, occupation and acquaintance with the mentally ill[4]. A similar study in Taiwan concluded direct contact and age were the two most important correlates of community attitudes towards mental illness, with education and occupation also being significant[5]. A meta-analysis of RCTs that studied the effectiveness of existing programs in 2014 concluded that educational interventions were effective in reducing personal stigma, as were interventions incorporating consumer contact[6]. The more people can be encouraged to understand the issues around it, the more we can dispel the stigma associated with mental illness. People need to understand that mental health affects everyone

[1] Corrigan PW, Watson AC, *Understanding the impact of stigma on people with mental illness*, World Psychiatry 2002 Feb; 1(1): 16:20
[2] Corrigan PW et al, *Three Strategies for Changing Attributions about Severe Mental Illness,* Schizophrenia Bulletin 2001; 27(2):187-95
[3] Corrigan & Watson (2002)
[4] Brockington IF, Hall P, Levings J, Murphy C, *The Community's tolerance of the mentally ill*, British Journal of Psychiatry, 1993 Jan; 162:93-9
[5] Song LY, Chang LY, Shih CY, Lin CY, Yang MJ, *Community attitudes towards the mentally ill: the results of a national survey of the Taiwanese population*, The International Journal of Social Psychiatry, 2005 June; 51(2):162-76
[6] Griffiths et al, *Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomised controlled trials*, World Psychiatry, 2014 June; 13(2):161-75

Given the strong evidence from research discussed above, and our own experience on the ground with successful community education campaigns about preventing violence against women, Kids First strongly recommends that the Government should focus its efforts on community education and contact. Universal settings such as schools provide a great opportunity to educate children about mental illness early, removing misconceptions and teaching children to normalise it, talk about mental illness and seek help early. An Information Paper published by Beyond Blue in 2015 found that for adolescents, educational approaches may be more effective – this may be because their beliefs are not as firmly developed as adults, and they may therefore be more likely to respond to the messages in educational programs[7].

It must be noted that most Primary and Secondary Schools around the state are already heavily invested in educating their students early about recognising and preventing family violence. The 'Respectful Relationships' platform that is currently utilised for family violence education can be extended or adapted to raise awareness about mental illness and reduce stigma.

Schools can also provide a non-threatening universal platform to raise awareness about mental health within the wider school community, and the supports that are available to people with a mental illness.

Broader community education campaigns that challenge the stereotyping of mental illness should also be undertaken, using different media to reach a wider audience. This campaign needs to include education around acute and chronic mental illnesses, in addition to other mental illnesses such as depression, etc.

In addition to community education, community organisations such as Kids First have a role to play in addressing the stigma associated with mental illness. Family Support Services work with a lot of families who may have a family member who is affected by mental illness. By providing family members information in a respectful and non-stigmatising language, workers can improve the family's understanding of the illness and support services that are available to them.

Community services sector staff themselves need Education/Training in challenging their own stereotyping and understanding mental illness and the connections between mental illness and other issues such as family violence, drug and alcohol dependence etc.

The media has also got a vital role to play when reporting traumatic incidents in the community and has a responsibility to ensure that their reporting of the incident particularly where mental health is a major factor, does not further stigmatise people suffering mental ill health.

Contact is another strategy that has been found to be successful in reducing stigma. The Beyond Blue Information Paper (2015) considers this to be particularly effective with adults, when it is done in a face-to-face in local settings, with targeted groups of people. Other success factors indicated in this paper include **credibility**, i.e. the contact being with a person who is in recovery who can tell their story, preferably from similar a socioeconomic background and ethnic group, and **continuity**, with multiple contacts occurring and multiple messages at various opportunities being presented. The paper makes the following recommendations for contact based on the lived experiences of its

[7] Beyond Blue, *Information paper: Stigma and discrimination associated with depression and anxiety,* August 2015, p16

constituents[8]:

- To be heard and understood, the message about living with mental illness needs to concentrate on the positive possibilities for individuals and communities where there is support and engagement as opposed to negatives.
- It needs to be emphasised that normal everyday well-adapted people suffer from mental illness and are capable of leading normal productive lives.
- The experience has to come from 'like' people, e.g., solicitor to solicitor, to combat the attitude that "it doesn't happen to people like me".

The Beyond Blue Information Paper also sets out the Global Anti-Stigma Alliance's recommended key approaches for stigma reduction[9] which Kids First believes should form the basis of an education/contact campaign in Victoria to reduce stigma associated with mental illness.

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?

"Prevention in mental health aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. Preventive interventions are based on modifying risk exposure and strengthening the coping mechanism of the individual"[10]

Modifying risk exposure requires a system that is directed towards identifying mental health risks early for people at every life stage, and intervening early to mitigate the risk. In practice, this will require an agile system with a tiered response that has an equal emphasis on prevention as it has on cure. As with any social, community or health service system, the tiered system for the prevention of mental health can be addressed at three levels:

- Primary Prevention, which is aimed at stopping mental health problems from occurring in the first place, using whole-of-population approaches;
- Secondary Prevention, where the system intervenes as early as possible, picking up the early signs of mental illness and ensuring an intervention is provided to prevent it from progressing to a more acute mental health problem;
- Tertiary prevention, where the system works with people with established mental illness and ensures a sustainable recovery pathway is in place, and also makes available appropriate community support measures to help their transition back into the community, to their jobs and social networks.

All available literature on the current state of mental health services in Victoria present a picture of a system that is weighted towards the tertiary system, to the exclusion of the primary and secondary

[8] Beyond Blue, *Information paper: Stigma and discrimination associated with depression and anxiety,* August 2015, p17
[9] Ibid, p 18
[10] Breedvelt J, *Preventing Mental health problems: what can we do?* The Mental Elf, www.nationalelfservice.net/treatment/mental-illness-prevention/preventing-mental-health-problems-what-can-we-do

tiers, of under investment in community-based services and early intervention and misalignment of resources. The following data has been extracted from Mental Health Victoria's report calling for better investment in mental health[11] and its submission to the Productivity Commission Inquiry[12] in April 2019:

- 45% of Victoria's nearly 5 million adults experience mental illness in their lifetime
    - 11% of these adults (43,634) experience mild mental illness
    - 6% (296,528) experience moderate mental illness, and
    - 3% (148,264) experience severe mental illness.
- Victoria spends 13% below national average expenditure per capita on mental health services and has 40% below national average access to mental health services;
- From 2009 to 2016, acute admissions on mental health conditions increased 19% while admissions to community mental health services decreased 17%.
- In the same period, expenditure on non-secondary care (primary and community care) rather than secondary (acute/hospital care) has been increasing to a greater level nationally.
- The Government's funding for acute mental health services is sufficient to provide for 1.2% of the State's population, when the demand is 3.1%. This underspending has a flow on effect for services upstream, i.e., in the secondary and primary prevention space.
- Each year, 296,528 adults experiencing moderate mental health issues will struggle to access services because of the concentration of resources on more acute presentations.

In its 2018 budget submission to the Victorian Government, VICSERV, the peak body for mental health service providers in Victoria highlights the need for investment in community-based mental health services to reduce the growing pressure on other parts of the service system such as hospitals, ambulance, justice and prisons.

Kids First practitioners who work with families experiencing a range of challenges see evidence of this chronic under-investment in community-based mental health services in their day-to-day practice. Many of Kids First clients who require support from mental health services are unable to access the support until they reach crisis mode. Consultations with our staff in preparation for this submission highlighted the following:

Lack of community awareness

A big part of preventing mental illness and helping people to get support early is awareness about mental illness, recognising the symptoms early, knowing what supports are available, where to access them, and overcoming personal and external stigma to seek support. It is important for the government to initiate information and education campaigns using diverse media platforms, to reduce the stigma associated with mental illness, and encourage people to seek help early.

Difficulty in accessing services early

[11] Mental Health Victoria, *Saving Lives, Saving Money: A case for better investment in Victorian Mental Health,* June 2018, p10

[12] Mental Health Victoria, *Initial Submission: Productivity Commission Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth,* April 2019 p8-9

In general, our practitioners working with young people are able to access secondary consultations with the Child and Adolescent Mental Health Services Team (CAMHS) where there is a need for hospitalisation or more intensive treatment required for the client. However, at a lower scale that does not meet the CAMHS threshold, it is difficult for the client to get access.

There are several instances where parents who have taken their children for emergency assessment have been unable to access services because their child's condition was not considered as acute. Psychiatric beds in hospitals are difficult to find for children, and parents are forced to deal with the child's issues at home, placing enormous stress on the family unit. Several parents familiar with the system do not even take their children when they experience mental health episodes, because they know they will not get services anyway.

The adult mental health system is also not easily accessed, with the gateway into the system tricky to navigate, and our practitioners find engaging with the mental health system challenging.

Another area highlighted during our consultations is the difficulty in accessing mental health support for our clients who are already engaged with other services and the expectations of the workers in the mental health system. For example, if a Kids First client receiving Family Support Services is in need of acute mental health services, there is a push back from the CAT teams, or if they are able to access support, the expectation is that the client will continue to be managed by their Case Worker.

It appears that in a very stretched mental health system, the workers are compelled to prioritise the needs of people who have no support from any other program/service, over ones who are engaged with at least another service such as family support. While our staff can and do support families to some extent with their mental health problems, they are not trained mental health professionals who can offer the level of support that the client requires.

This shifting of the care from the mental health system to other community and health systems is evident in the following figures published by Mental Health Victoria[13]:

- the number of Emergency Department presentations relating to mental health increased by 19% over the last four reporting years;
- Ambulance Victoria responded to approximately 132 mental-health related cases per day;
- 2078 cases that Ambulance Victoria responded to in 2015 were children aged 15 years and under.

The general consensus from our on-the-ground experience of the mental health system is that early intervention is not happening to the extent it needs to. Clients are bounced around the system, and integrated practice across service systems, such as child and family support, CAMS, family violence and drug and alcohol services, is virtually non-existent. Further when the statutory systems such as Child Protection become involved, the response from the mental health system is seen to improve at this stage, however it is often too late, and the opportunity to intervene early and help client's recover from their illness and children to remain in their parent's care is missed.

Our practitioners also identified that parents who have a mental illness find it difficult to navigate a system that is responsive to their need as and due to this lack of support they are managing their mental illness on their own, due to a lack of appropriate services being available or access to the

[13] Mental Health Victoria, *Saving Lives. Saving Money: The case for better investment in Victorian Mental Health,* June 2018.

waiting list. In many instances the support required for a family may be something as simple as respite, review and reset of their medication or transport for their children to get to and from school, which can allow them the time to focus on themselves and their recovery.

Cost of private services

Unfortunately, the issues highlighted above leads to the only other option that people have when the public mental health system is unable to provide them with the support they need - accessing the, the private system. Private mental health support is prohibitively expensive for many families that Kids First works with, the 6 to 10 sessions that are available through the Medicare Mental Health Care Plan, with a referral from a GP, does not provide enough interventions doses for many clients, and additional sessions that many people may need are unaffordable at the cost of up to $250 per hour. This is a situation where a mental health intervention only partially meets the needs of an individual, with the risk of escalating into more deeply entrenched mental illness over a period of time – a situation that can be avoided if the system is geared to provide the level of mental health support a person needs in the first instance.

Gaps in the system across age groups

A large proportion of Kids First's clients are children and young people. One of the significant gaps in the mental health system that our practitioners have encountered, is services for children in the primary school and pre-primary age group. This observation is corroborated by data from Mental Health Victoria[14] that the largest discrepancy between Australians receiving clinical mental health services (national average) and Victorians receiving clinical mental health services is in the younger age brackets. As a proportion of the population receiving clinical mental health care, Victorians aged under 15 years received 50% less service than the national average, those aged between 15-24 received 45% less and those aged 25-34 received 43% less.

Services in the youth sector such as the Head Space program support early engagement of youth experiencing mental illness. Kids First also believes that the Head Space program, which is currently centre-based, can be extended to provide outreach support to young people who are unable to access it. Young people who currently do not meet the criteria for the Head Space program also fall through the cracks in the system. Kids First clients have mental health issues but they are not acute enough to get services in CAMHS services.

There are no comparable targeted early intervention programs that engage with younger children from birth to five. This is a highly specialised area that is currently a gap in our mental health service system, and currently, the only option available to them is through the Mental Health Care Plan subsidised by Medicare.

However, Kids First has recently trialled an early years' program that has the potential to bridge this gap, and provide an "intensive care response" for children and families. Kids First recommends this program for the consideration of the Commission.

The Kids First Early Years Education Program (EYEP), is an Australian first model of early years' education and care designed to meet the educational and developmental needs of infants and

[14]Ibid.

toddlers living with significant family stress and social disadvantage. With a strong focus on **infant mental health**, and addressing the trauma experienced by children, this program is being evaluated by Melbourne University through a Randomised Controlled Trial (RCT) which is the first RCT of an early years' education and care program in Australia.

The EYEP is designed for children under three years of age at enrolment who are at heightened risk of, or who have experienced, abuse and neglect and are already demonstrating problems in emotional and behavioural regulation, delays in development, and whose families struggle to participate in universal early education and care services.

The EYEP model is designed to provide vulnerable infants and toddlers with a predictable, nurturing and responsive interpersonal environment that will facilitate all facets of their development and learning—cognitive, language, emotional, social and physical—to build the children's capacity for full participation in society. The model is designed to address the impacts of toxic stress on the developing brain and to provide high quality pedagogy in an enriched early learning and care environment. The model can therefore be considered a tertiary level intervention, equivalent to intensive care in the health services' sector.

The key elements of EYEP are relational pedagogy, **infant mental health**, attachment theory, nutrition, parent engagement and the interface with family support services. The unique features and the level of intensity and duration of the EYEP model, including the employment of full-time, qualified educators, with an embedded infant mental health clinician/consultant and family services practitioner as part of the staff team; a rigorous relationship-based curriculum informed by trauma and attachment theories; individualised case planning in consultation with parents and other agencies, and the ongoing training, professional development, and reflective supervision for staff, contrasts clearly with universal education and care services in Australia

The second-year research report[15] of this trial program identifies large and statistically significant impacts at 24 months for several outcomes for children:

- IQ;
- protective factors related to resilience; and
- social-emotional development.

Evidence that EYEP is having an impact on the stress experienced by primary caregivers is also emerging.

More details of this unique model supporting and enhancing the mental health and development of very young children experiencing toxic levels of stress, that has the potential to become a successful early intervention program is provided in **Attachment 3**.

The other gap in the current mental health system is that the services for children and young people do not work in an all-of-family way. A lot of the professional work is focussed on the children but not incorporating their families and providing an all of family response and recovery plan in order for parents to understand and support their children at home.

[15] Tseng, Y.P. et al, *Changing the Life Trajectories of Australia's Most Vulnerable Children: Report No. 4*, University of Melbourne, Kids First Australia, May 2019. (available at www.kidsfirstaustralia.org.au/news/56/earlyyearseducationchanginglives)

What is working well

Kids First practitioners have identified the following programs/support that work well in providing them and their clients with support:

Y-Flex

This program provides mental health support to young people aged 12 – 25 years, who face barriers to accessing mental health services. It is a tailored program that provides support to young people who are experiencing complex mental health issues, at risk of developing them, or are experiencing emerging mental health issues and have difficulty accessing other mainstream mental health supports. This program is currently offered by Neami in the Northern Region.

YETI

The Youth Engagement and Training Initiative (YETI) developed by Orygen, the National Centre for Excellence in Youth Mental Health, the University of Melbourne and the Australian Catholic University is a space for young people in Australia to communicate, engage in online training on advocacy and youth mental health programs and share information about youth mental health.

Emerging Minds

Emerging Minds develops mental health policy, services, interventions, training, programs and resources in response to the needs of health care professionals, children and their families. These include online resources, practical books, DVDs, online and Face-Face training.

Kids First Early Years Education Program

A targeted and intensive intervention delivered by a highly trained team of educators, infant mental health specialists and family services practitioners, through the early years' platform that is demonstrating immense potential to address the gap in early intervention mental health support services for infants and families. (Described earlier in this section and in Attachment 3).

Other programs/services

Other services that Kids First staff have accessed for their clients offered at the Austin Hospital include:

- Adolescent Intensive Management team, which works with harder to engage children and young people and accessed currently through CAMHS
- Youth Brief Intervention Service, an early intervention program providing a three-session assessment for children who do not have an acute mental illness.

However, the team at the Austin is so stretched with the demand for these services, that it is not widely publicised within the community services sector.

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

During 2017, 621 people were lost to suicide. This number is down from 624 in 2016 and 654 in 2015. Victoria now has the lowest suicide rate of all Australian states and territories. Suicide remains the leading cause death for Australians aged 15-44 years and the second leading cause of death among

Australians aged 45-54 years[16].

A range of initiatives such as HOPE (Hospital Outreach Post-suicidal Engagement) which is offered in 12 hospitals currently, place-based suicide prevention trials in 12 locations across the State, the National Suicide Prevention Implementation Strategy, and programs and support offered by organisations such as Beyond Blue, have created greater awareness in the community about suicide. Powerful education and awareness raising campaigns in Victoria have helped in addressing to some extent the stigma that was associated with suicide, encouraging many to identify the symptoms and access supports early.

Kids First practitioners report seeing a shift in community attitudes to suicide over the past 20 years, with more people openly talking about suicide ideation, and seeking support and advice. Suicide ideation is taken seriously, and people are able to get a good response from CAT teams, and are able to better access services.

It is commonly known that men are at greatest risk of suicide but least likely to seek help. Other groups that are at greatest risk of suicide include Indigenous Australians, LGBTI community, people in rural and remote areas and children[17]. A more targeted and coordinated response to these communities that are particularly vulnerable to suicide is required. Suicide and self-harm rates among youth has also increased. With the advent of online digital communication mediums, people who are vulnerable are exposed to an increased risk of cyber bullying leading to suicide ideation.

On the other hand, families and friends of people who have disclosed their suicide ideations, or who have attempted suicide lack appropriate skills and knowledge on how to cope themselves, but to also talk to the person making such disclosure and persuade them to access appropriate support. In particular, children of primary and secondary school age who become the confidants of friends who disclose to them need education and support on how to support their friends. The same goes for children who read online posts from their friends confessing suicide ideation. There is a need for information campaigns targeted at this cohort, guiding them on how to approach the person, the range of services that are available to them, who to contact etc. to support them during this critical time.

A more general information and education campaign on how to respond to a person confessing their suicide ideation to them, the warning symptoms to look out for, and how to support them access services will also assist in raising awareness levels.

Professionals in the community services sector also require training to identify symptoms to help them support people with suicide ideation with a basic "first-aid" kind of response before referring them to specialist services. Parents also need education and training on how to cope if their child exhibits suicidal tendencies.

[16]State of Victoria, *Victoria's Mental Health Services Annual Report 2017-18,* Department of Health and Human Services, October 2018

[17] Black Dog Institute, *Keeping health in mind: Facts and Figures about Mental Health*, Fact sheet.

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.

Mental health is an integral component of the overall health of a person and is organically connected with the structure and function of our psychosocial and physical environments. There are certain times in people's lives when their mental health is more vulnerable. These are typically around transition phases in one's life such as graduating from school, entering the workforce, moving out of home, becoming a parent, retiring from work etc. They can also be around life events such as experiencing the death or loss of a loved one, losing a job, major physical illness etc. Not everyone will experience vulnerability during these times, but for those that do, targeted support services at an early stage can improve their mental health. By taking care of mental health early, in the same way people take care of their physical health, the risk of developing mental illness can be avoided.

There are several structural and social barriers to experiencing good mental health. In addition to lack of access to/availability of appropriate mental health services, structural barriers include other external factors such as unemployment, homelessness etc. Social barriers include lack of opportunities for community participation, lack of social networks, interactions with people etc. Recommendations for strategies that governments can implement to ensure that people enjoy good mental health are discussed in the Guidelines for building up good mental health[18] . Grouped into eight domains, the strategies address both structural and social determinants in the following manner:

- Enhancing mental health through comprehensive mental health policy, including contemporary legislation, mental health programs at all levels of government, a coordinated approach to service delivery through collaboration between various sectors, robust human resource policy, inclusion of carers and users in designing their care, outcome and impact assessment, and most importantly, appropriate funding.
- Building mentally healthy communities, through improved participation in the community by its members, enhancing equity and social justice, ensuring easy access to mental health services, and post recovery support systems.
- Developing the physical environment by building mentally healthy housing environments and green spaces, playgrounds for children, securing public safety etc.
- Providing opportunities for leisure activities including sport and recreation, cultural activities, activity centres for children, youth, families and elders.
- Enhancing the mental health of young children including post-natal care for mothers, accessible quality early education for children, early support for parents at risk, parenting education etc.
- Fostering the development of mentally healthy schools, that provide psychological support for students, supports teachers, involves parents in the child's education, and implements health-promoting programs.
- Enhancing a mentally healthy work life through a comprehensive employment policy, anti-

[18] Lehtinen V, *Building up good mental health: Guidelines based on existing knowledge*, STAKES, 2008, p 7-8

discrimination provisions, skills training, balance between work and life, supporting those who are unemployed, providing supported employment for people with mental illness etc.

- Enhancing the mental health of older people by providing greater opportunities for participating in social life, supporting them overcome isolation, providing opportunities for independent living, and providing appropriate health, social and mental health services.

At a practice level, Kids First practitioners observe a number of barriers to good mental health in their client group including homelessness, unemployment, and poverty manifesting themselves in negative behaviours such as family violence, alcohol and drug addiction perpetrating the cycle of poor mental health. Not all of our clients who experience poor mental health are mentally ill, however, if the underlying factors contributing to poor mental health are not addressed in a timely manner, the risk of mental illness at a later stage increases.

Knowing what services are available, and where to go to access those services is another barrier for many people. For our clients who require mental health support, services are very hard to access when they need them. Our practitioners observe quite a lot of people in their practice that are always sitting on the fence, have significant mental health issues but not acute enough for tertiary services. Some of these access barriers are discussed in section 2 of this submission.

Kids First also believes that there are several aspects that are glaringly missing from the current mental health system:

- An integrated systemic response to mental health and mental illness with a more 'care-team' approach to working with clients. The integrated approach taken by the Victorian Government to providing family support and family violence services over the past few years provides a sound evidence base to structure such a response.
- Therapeutic work in groups.
- Colocation of mental health services within services such as the Orange Door to provide the gateway into the system, so that people can access service voluntarily rather than involuntarily.

Kids First practitioners who have several years' experience in the sector also believe that the mental health system has over a period of time moved away from a psychotherapy model towards a medical model. Clients had the ability to access psycho-social interventions and group work with both the Psychiatrist and the Psychologist being involved, but such services are not available any more. With the advent of the NDIS, practitioners are observing a significant reduction/non-availability of psycho-social services.

Treatment approaches also rely heavily on medication (which can have side effects and get in the way of people's lives) with not a lot of focus on therapies to address the problem. Over-medicating children and young people, mis-diagnosing trauma for mental illness, and defiance behaviours being treated with medication are all symptomatic of a system that is in need of a thorough review of its practices and injection of more contemporary and evidence-based interventions to support people experiencing mental health issues and mental illness.

Several of Kids First's clients come are refugees and asylum seekers, who find it very hard to access mental health services. A lot of these migrants have experienced trauma in their native countries and have sought asylum in Australia to escape persecution and genocide. The treatment options available to them do not take trauma into consideration. Our practitioners believe that Psychiatry is only now

touching upon trauma informed practice.

The clinical environment in which some of the acute mental health services are delivered can also be a significant barrier for people wanting to access support for their mental health. The system needs to introduce different modalities of treatment for various mental health issues and make it accessible early for people.

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

Some of the drivers behind some communities in Victoria experiencing poorer mental health include:

- Geographical – for example there are very few services providing limited choice in Country Victoria, with long wait lists, long distances to travel etc.
- Cultural – several culturally and linguistically diverse communities do not access mental health services due to lack of knowledge about mental health, cultural barriers, language barriers, mistrust of the system, and stigma. Many Aboriginal communities may not access service because of cultural barriers, and the trauma of the Stolen Generations.
- Socio-economic factors – income, employment, housing etc.
- Discrimination based on ethnicity, race, sex, gender identity, or sexuality

Family violence and dependence on drug and alcohol and other substances also contributes to poor mental health in some sections of the Victorian population. Educating people about the importance of mental health and minimising/removing the stigma attached to seeking help is the first step in addressing poor mental health in some communities. This must be supported by realistic investment in addressing some of the systemic, social and socio-economic barriers listed above along with a realistic investment in enhancing the system to respond early to people who seek support.

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

Mental illness or poor mental health has an impact on family members of the person suffering the illness and different family members may be affected in different ways, and can bring about big changes in how people live their lives. Research shows that many forms of mental illness are first noticed when the person is in their late teens or early twenties, an age where most Australians are still living at home with their family.

In many instances, families may take on the role of day-to-day carers for the person, and in most instances do so without any training or very little support, and without acknowledgement of their own respite of mental health needs.

In Kids First's experience, it is difficult for parents to get support from the mental health system, so that they can support them in turn, at home. Mental Health Services do have family consultants, but there are not enough of them to meet the need on the ground. Many parents, particularly of young children feel burnt out before they can get access to services, and find they need to be really vocal

advocates for their children. As the Kids First Early Years Education Program[19] demonstrates, the lack of support for parents is particularly noticeable in universal early years settings, especially where children are vulnerable in one or more developmental domains.

Our practitioners also find that given their caseloads, case managers also do not allocate sufficient time for the families, and include them in the care planning of their child in a tokenistic manner. In some instances, mental health professionals also do not listen to families on the grounds of 'patient confidentiality'. In many counselling sessions parents/carers are brought in tokenistically for the last two minutes of the consultation.

Brokerage funding is not accessible in the mental health system in the same way as the family support service system to put in practical support measures in place for the family. The limited brokerage funding may go some way in covering petrol costs or paying a bill, but does not cover activities or therapies for children.

Families with a child with mental illness also find it difficult to access respite care to provide a break from their caring duties. Kids First works with children experiencing high levels of trauma and related mental health issues, but there are not many services available to support families of these children. Our family support service practitioners spend a lot of time with the families helping them navigate through the mental health system to access support.

Organisations such as SANE Australia, and Carers Link offer programs that support parents and families of people with a mental illness, as do programs such as the state-wide FaPMI Program (Families of People with Mental Illness), and the Federally funded COPMI (Children of Parents with a Mental Illness) Programs, with a range of online resources and training. These support programs need to be extended more across Victoria to meet the demand, and made easily accessible to a wider range of families who are carers for a person with a mental illness.

The mental health system also needs to strengthen its capacity to do outreach support work for families. It needs to have a range of programs to support people with mental health issues and mental illnesses in an integrated setting, alongside their professional colleagues experienced in family support.

[19] Described in more detail in section 2 of this submission and Attachment 3

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A
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 research report into barriers that employers face in employing a person with a disability, published by the Commonwealth Department of Social Services in 2017[20] shows that while an overwhelming majority of employers show a willingness to employ people with a disability, only around a third of the businesses show a commitment to doing so. Medium to large employers are likely to be more committed than small businesses. The principal motivators for employers to hire people with a disability include: • A moral conviction at an individual level, and to some extent a sense of self-gratification; • Support for the concept of inclusion, and to some extent enhancing the 'corporate image' and reputation, and the benefits to the bottom-line as a result; and • Belief that people with disability can bring valuable attributes to the workplace. The report found that the key attitudes that pose a barrier include: • Low levels of confidence around the process of employing disabled people, the adjustments within the workplace, both in terms of management approaches, and the physical working environment; • Suitability and fit of the person, and their integration into the workforce; • Greater supervision and support responsibilities, and increased safety risk associated with their employment. Recent research undertaken by the University of Sydney, La Trobe University and Neami National[21] shows that "effective employment support for people with mental illness in Australia is challenged by differences between mental health and employment support systems; in relation to funding structures, practitioner skills, cultures, outcomes and incentives to achieve these. As a result, it has been difficult to get these two systems working together effectively to meet people's employment support needs". There are a range of job networks funded by the Commonwealth Government that work with people with disabilities including a mental illness and help them find employment. Services provided by these networks include training to get employment and support once in the job. Victoria has very recently developed a *Lived Experience Workforce Development Initiative* to meet the workforce needs of

[20]Australian Government Department of Social Services, *Building Employer Demand, Research Report*, October 2017

[21] Scanlan, J.N, Feder, K., Ennals, P., Hancock, N., *Outcomes of an individual placement and support program incorporating principles of the collaborative recovery model,* Australian Occupational Therapy Journal, 2019

family/carers and consumers.

The barriers faced by these organisations supporting people with mental illness gain employment are typically one of capacity to support demand, and as the Neami report articulates, getting the mental health and employment support systems working together to meet people's needs.

Suggestions from Kids First practitioners to improve the social and economic participation of people with mental illness are provided below:

- Training people with mental illness and getting them job ready takes a long time, and requires a commitment of resources. Alongside training people to become job-ready, there is a need to educate employers about the need to be more inclusive and address their concerns.
- Wind-back funding cuts for community activities for mentally ill people offered by organisations such as NEAMI to increase social connectedness and engage with educational and vocational opportunities.
- Employers must be prepared to offer a lot of protection in the workplace to ensure there is no discrimination or marginalisation if people disclose mental health problems, or mental illness.
- People with mental health problems require a lot of support in the workplace to sustain employment and employers must be prepared to be flexible with the employee during acute periods of poor mental health. This might include part-time work arrangements periodically, additional time off work for recovery etc.
- Government needs to support people with mental health issues access meaningful activities to be socially connected such as membership in a gym, sports club etc. Unemployment as a result of the mental illness can place such activities outside their reach.
- Employers need to be educated to support workers with a mental health issue at the workplace. They need to understand that employing a such a person should not be a tokenistic gesture, rather a well thought out move with full awareness of the additional responsibilities involved to sustain the employment.
- Opportunities for workplace training for young people with mental illness need to be made available.

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?

Kids First believes that the Royal Commission Inquiry presents a great opportunity for a complete overhaul of the Victorian mental health system. What is required is a system that addresses the psychosocial and structural determinants to promote positive mental health in all Victorians as a starting point, with the built-in capacity (matched with appropriate funding) to provide tailored intervention and support across the range from primary prevention, early intervention to tertiary services, to those who require it.

Kids First's vision for what Victoria's mental health system should look like is articulated below:

- There should be a 'no-wrong-door' approach to mental health similar to the current approach to delivering family violence services. This means, no matter how severe or mild a problem is, people who need mental health support will be able to access services that they require, when they require it. People requiring service are able to access them regardless of where they live, i.e., there are no catchment-based limitations on people accessing services.
- The system should recognise the intersections between mental health, homelessness, alcohol and drug use, family violence, unemployment etc., and develop a framework similar to the Multi-Agency Risk Assessment and Management Framework (MARAM) that has been developed in the family violence support services system to ensure services are effectively identifying, assessing and managing mental health risks and people do not work in isolation.
- A service similar to the Orange Door - which is the access point for women, children and young people who are experiencing family violence or families who need assistance with the care and wellbeing of their children to access the services they need to be safe and supported – is required in the mental health system to help people with mental health problems access support early before they become an entrenched illness.
- The system's focus on primary prevention and early intervention is increased and there is adequate funding for innovative interventions to support all Victorians requiring mental health services early. The system is strong in the early engagement phase, and services for very young children is considered a priority.
- Targeted, intensive interventions such as the Kids First EYEP are available across the State to support the mental health and wellness of infants growing up in highly toxic and stressful environments.
- Universal early childhood educators are trained in infant mental health and are able to support infants early with their mental health.
- There is a tiered continuum of services available for everyone who needs it that works on the principles of proportionate universalism – i.e., services are available universally but with a scale and intensity that is proportionate to the level of identified need.
- Services focus on therapeutic restoration rather than medication.
- Services are affordable for families on low incomes, and people with mental illness who are unemployed.

- The funding that has been steadily cut from the Victorian system is restored, and future funding is a collaborative effort between both State and Federal Governments, that is realistic and adequate to meet the projected demand for services.
- Government takes into consideration the recommendations arising from this Royal Commission Inquiry with the same seriousness that it did the Royal Commission Inquiry into Family Violence a few years ago, accepting the recommendations, but more importantly committing realistic funding to implement them.
- Hospitals and community-based mental health services have more workers to meet the demand for services. Mental health professionals are located in medical clinics, schools etc., and other such universal facilities to enable a seamless and early entry into the mental health system for people requiring support.
- There are no waiting lists for people who want to access services, and the service is bulk-billed or the gap is reduced to make it more affordable.
- There are more services to support families and carers who care for a family member with mental illness. Brokerage dollars are made available to ensure that non-medical support services are able to be purchased to support the family.
- Assertive outreach support targeting hard-to-reach vulnerable groups and families becomes an integral part of the mental health system.
- Staff across the community services system work in partnership with the mental health staff, and are trained in early identification of mental illness. Mental health workers and community services support workers are co-located, share information and work together as a care team in an integrated manner. Training in recognising and responding to suicide ideation becomes mandatory for family support workers to enable them to identify the signs and help people seek treatment early.
- There is a cohort of people with mental illness who will require support always. The service system is flexible in such instances, allowing for more longer-term engagement (rather than episodic engagement, with flexibility move in and out of the treatment as the need arises. To support such engagement, the system has an in-built, proactive follow-up pro cess at regular intervals to ensure people are tracking with their recovery.
- There are a range of after-care follow up services for people who have been discharged from hospitals including connecting them with housing services, and programs and activities within their community. People who are isolated and have no family to support them are connect with community-based mentors who can link them to social opportunities and be there for them.

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

Attachment 1 - Case Study 1

Background

Susan* and her husband are parents of [redacted] have been separated for the previous [redacted] years. The children are in a 50/50 care arrangement with their parents. Susan has significant mental health issues (severe depression).

Current situation

The [redacted] child disclosed sexual abuse by her father. The father did not deny or confirm that something may have happened when the daughter was asleep in his bed. A report has been made, following which all further contact with the father has been suspended until such time that all information has been gathered and further consultation has occurred with Child Protection.

This has placed a considerable amount of stress, financial pressure and responsibility on Susan whom has advised that she feels that her mental health is declining and requires some extra support and assistance since she has very limited social supports that can assist her.

Prior to the report being made, Susan and her husband worked well together to co-parent the children with the father assuming primary care when Susan became unwell and was unable to care of the children. The father is currently only allowed to have supervised access while the investigation occurs.

The children also report they are worried about their mother's mental health. The children's mental health has also declined. The mother has advised that her [redacted] can sometimes become suicidal, and present with self-harming behaviours and the [redacted] has felt very stressed, is attention seeking and having disturbed visons of a sexual nature. Both girls are working with CAMHS due to concerns for their mental health (anxiety) and also for self-harm for the [redacted]. After the sexual abuse disclosure was made, the [redacted] was referred to the Kids First Sexual Abuse Counselling and Prevention Program for sexual abuse counselling.

What would be helpful in this situation

Without much support with the care of the girls, Susan is struggling to cope, and her mental health has deteriorated. She has contacted her Family Services worker at Kids First to ask for respite so that she can have a break to focus on improving her mental health. There are currently no services that can be of assistance to provide respite for children who live with their family. They are only available for children in out of home care. Support that would help Susan with caring for her children when her mental health deteriorates are assistance to transport the children to school, grocery shopping, house cleaning etc.

Outcomes that additional support will achieve for the family and for the Mental health system

This additional support would prevent the children from being removed from Susan's care as a result of the deterioration in her mental health. In this situation, if the disclosure is not substantiated on investigation, the children are more likely to be returned to the father's full-time care because of the Susan's mental health condition.

*Name changed

Attachment 2 - Case Study 2

Background

Jane* is living with her [redacted] children – [redacted]s. The father was living outside of the family home, however had frequent contact with the children and Jane.

The family was referred to the Kids First Integrated Family Services (IFS) team by Child Protection intake. There have been several previous reports to Child Protection for the children, and there have been multiple referrals for this family through Child FIRST. The family has been supported by the Kids First IFS team for 17 months.

The main presenting concern at intake and throughout IFS involvement related to concerns for Jane's poor mental health and the impact that this has on the parenting relationship and the impact on the children. In addition, there were also home environment concerns and lack of school attendance.

Historically, Jane was diagnosed with Borderline Personality Disorder and Bi-polar Disorder and had a history of self-harming. She has had involvement with Crisis Assessment Treatment Team (CAT) on several occasions however she was not linked with consistent and or appropriate mental health support.

When Jane's mental health reached crisis point, she made contact with CAT who provided a brief intervention. Child Protection would often be notified of when this would occur due to the impact and concern for the children's wellbeing. Child Protection would then ensure that IFS are involved, and leave it to the IFS team to support the family with this concern.

Throughout the IFS team's involvement, there have been numerous creative attempts to engage Jane and the father, however the engagement was inconsistent and many appointments were missed. Jane declined to be linked in with mental health support and there was limited progress towards achieving goals.

Kids First IFS had to close the case due to the lack of engagement from Jane and the father, and concerns regarding Jane's mental health and other contributing factors impacting on the children's health, development and wellbeing.

At closure, the IFS team consulted with Child Protection who commenced an investigation and recommended more intensive support is provide to the parents.

Additional measures could have helped in this case

- having one access point for the Jane (and the IFS team) to contact when seeking support for her mental health (e.g./ similar to The Orange Door, but for mental health services);
- Mental health services including the father in their safety planning;
- Mental health services including the Kids First IFS team in their case and safety planning;
- Follow up phone calls (e.g./ at 3months, 6months) post contact with CAT to facilitate proactive engagement and ensure that the appropriate supports were in place for Jane.

Outcomes that could have been achieved

- Jane would have received support for her mental health problems earlier and would have had follow up phone calls to re-assess her mental health, which could have prevented future crisis;

- If there was ongoing assertive mental health outreach to the mother, this would have ensured that she was linked with appropriate supports in a timely manner;
- The Father would be involved in the safety planning for Jane's mental health to ensure that respite is provided to her when she identified a decline in her mental health;
- The home environment would have been less chaotic for the children;
- The children would have a well-structured routine which allowed them to engage in education;
- The mother would have been more emotionally and mentally available for the children.

*Name changed

Attachment 3

Key findings from the research report "Changing the Life Trajectories of Australia's Most Vulnerable Children, Report No. 4: *24 months in the Early Years Education Program: Assessment of the impact on children and their primary Caregivers, May 2019"*

(Available at www.kidsfirstaustralia.org.au/news/56/earlyyearseducationchanginglives)

The Kids First Early Years Education Program (EYEP), is an Australian first model of early years' education and care designed to meet the educational and developmental needs of infants and toddlers living with significant family stress and social disadvantage. With a strong focus on **infant mental health**, and addressing the trauma experienced by children, this program is being evaluated by Melbourne University through a Randomised Controlled Trial (RCT) which is the first RCT of an early years' education and care program in Australia.

The EYEP is designed for children under three years of age at enrolment who are at heightened risk of, or who have experienced, abuse and neglect and are already demonstrating problems in emotional and behavioural regulation, delays in development, and whose families struggle to participate in universal early education and care services.

The EYEP model is designed to provide vulnerable infants and toddlers with a predictable, nurturing and responsive interpersonal environment that will facilitate all facets of their development and learning—cognitive, language, emotional, social and physical—to build the children's capacity for full participation in society. The model is designed to address the impacts of toxic stress on the developing brain and to provide high quality pedagogy in an enriched early learning and care environment. The model can therefore be considered a tertiary level intervention, equivalent to intensive care in the health services' sector.

The EYEP model transcends traditional professional knowledge silos and utilises multi-disciplinary professional knowledge, skills and expertise. Qualified and experienced professionals in early education, infant mental health, and family support services work collaboratively with families and children to implement the model.

The research report describing EYEP participants shows that the children in the study were, on average, living with significantly more disadvantage compared with children living in low socioeconomic status (SES) households who participated in the Longitudinal Study of Australian Children. They had lower birth weights, and at the time of enrolment into the trial when aged between birth and three years, they had compromised language, motor skills and adaptive behaviour development. Their parents were much more likely to be jobless, young parents, with less financial resources and higher likelihood of suffering severe psychological distress having experienced an extraordinary number of stressful life events beyond their control.

The main objective of the EYEP trial is to test whether the program is meeting its goal to improve children's cognitive and non-cognitive skills. Outcomes relating to children's cognitive skills (IQ and language skills) and their non-cognitive skills (within-child protective factors related to resilience and social-emotional development) are therefore examined. Possible impacts of EYEP on primary caregivers are evaluated using outcomes relating to perceptions of the level of stress they are experiencing and the quality of home environment.

The second-year research report identifies large and statistically significant impacts at 24 months for several outcomes for children:

- IQ;
- protective factors related to resilience; and
- social-emotional development. There is also a relatively large impact on children's language skills, but this estimate has limited statistical significance.

The estimated impact on IQ is one-third to one-half of a standard deviation. This compares with average impacts on IQ from early years demonstration programs in the United States of about one-quarter of a standard deviation. The estimated impact on within-child protective factors related to resilience is about one-third of a standard deviation. The proportion of children enrolled in EYEP who are classified in the clinical range for social-emotional development is lower by 30 percentage points compared with the control group, a substantial impact.

Evidence that EYEP is having an impact on the stress experienced by primary caregivers is also emerging. Primary caregivers of children in EYEP show a reduced level of distress on the Kessler Psychological Distress K6 Scale (K6) of about 1.5 points (on a zero to 30 points scale), which is marginally statistically significant. Participation in EYEP is also estimated to be associated with small decreases in the frequency (one point on zero to 80 points scale) and in intensity (three points on zero to 100 points scale) of parenting daily hassles, but these estimates are not statistically significant. The estimated impact of EYEP on the home environment is small and not statistically significant.

Major differences are apparent in the impact of EYEP on boys and girls – especially for non-cognitive skills. For children's IQ and language skills the estimated impacts are larger and have higher levels of statistical significance for boys than girls. For protective factors related to resilience a large and highly significant impact is found for boys, compared to a zero impact for girls. By contrast, the estimated impact of EYEP on social-emotional development exhibits the opposite pattern, with a much larger impact for girls than boys. Impacts on outcomes for primary caregivers at 24 months are confined to families with girls enrolled in EYEP. For the primary caregivers of girls there is a decrease in psychological distress and in the frequency of parenting hassles. There is, however, no evidence of an impact on these outcomes for the primary caregivers of boys.

The timing of the impact of EYEP over the first 24 months has varied across outcomes. The impact of EYEP on children's IQ appears to have been concentrated in the initial twelve months of the program, as the estimated impact size does not change appreciably between twelve months and 24 months. This result is consistent with evidence from previous trials of early years demonstration programs in the United States. Other outcomes for children show a more pronounced impact from EYEP after the second year of being enrolled in the program. The estimated impact on children's language skills increases from zero after twelve months to about three to four points after 24 months. For protective factors related to resilience the estimated impact size after 24 months is two to three times larger than after twelve months. While distinguishing the exact timing of impact on social-emotional development is difficult, there does seem to have been a positive impact spread across both the first and second years of the program. Where there have been positive outcomes for primary caregivers, these have been concentrated in the second year of their child's enrolment in EYEP.

The key elements of EYEP are relational pedagogy, **infant mental health**, attachment theory, nutrition, parent engagement and the interface with family support services. The unique features and the level

of intensity and duration of the EYEP model, including the employment of full-time, qualified educators, with an embedded infant mental health clinician/consultant and family services practitioner as part of the staff team; a rigorous relationship-based curriculum informed by trauma and attachment theories; individualised case planning in consultation with parents and other agencies, and the ongoing training, professional development, and reflective supervision for staff, contrasts clearly with universal education and care services in Australia.

The final report of this RCT is due in early 2020.

Attachment 4

About Kids First Australia

Annual Report available at: https://www.kidsfirstaustralia.org.au/page/156/annual-reports