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Mental
Health
for
the
Young
and
their
Families

Royal Commission into Victoria's Mental Health services

Submission by *Mental Health for the Young and their Families, Victorian Group (MHYF Vic)*

The following submission was compiled by the Committee of Mental Health for the Young and their Families, Victorian Group (MHYF Vic), comprising:

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We dedicate this work to the consumers and carers who have privileged us by allowing us into their lives.

MHYF Vic acknowledges the Aboriginal people of the State of Victoria as the traditional custodians of its lands and waters, and respects the wisdom and leadership of their elders, past, present and emerging

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Executive summary of MHYF Vic's submission

MHYFVic is a not-for-profit community organisation of mental health professionals, consumers, and carers advocating for improvements to mental health services, particularly for young people and their families. This submission summarises our views on the matters covered by the Royal Commission's Terms of Reference and our recommendations for solutions.

Mental Health Services in Victoria are fundamentally flawed because there is no coordinating strategy. Mental disorders are very prevalent, affecting some 15% or more of the population at any one time, with serious social and economic consequences, and therefore requiring considerable resource allocation. The disorders range from mild to severe, with services provided by a multiplicity of agencies that are uncoordinated and piecemeal in their availability, funding and coverage. Public sector specialist services are currently focussed on the most severely mentally-ill 2% of the caseload, whereas the majority of less severe cases are undertreated and find considerable barriers to obtaining specialist services (other than in private practice, if they can afford it). Yet it is that underserviced group which produces the greatest number of suicides, distress and economic loss. This is addressed in Section One of the submission.

MHYF Vic proposes a coordinating strategy for public sector mental health services collaborating with other public and private health service providers to ensure improved access within existing resource allocation and a more planful method of allocating future additional resources.

At the administrative level this involves specialist inpatient Tier One mental health services located in the hospital system, generalist Tier Two mental health services located in Community Health Centres, and Tier Three health, welfare and educational services in the community having access to support from the Tier Two services. The Tier Two services would have specialist staff deployed from Tier One services so as to provide the CAT (Community Assessment and Treatment) Teams and perform Intake assessments and consultancy for all three Tiers. In this way specialist staff would control inpatient admissions and provide consultant support to other service providers. No client would be left without service because the Tier Two intake workers would be responsible for service coordination. This is discussed in Section Two of the submission.

At the professional practice level, services would operate within a family developmental approach. This results in a family-based case plan integrating the various service components necessary for optimal outcomes. Included in our submission are protocols for professional functions related to access, family engagement, multi-disciplinary case planning, and monitoring. This is discussed in Section Three of the submission.

MHYF Vic advocates a set of strategic priorities for service delivery. Section Four of the submission includes commentary on each of these problematic areas. These are:

a Prevention services
b Improved access with family engagement
c Services for aboriginal family mental health

d Services for children in out-of-home care
e Early intervention services for mother and infants
f Services for elderly people and their families
g Services for substance users with mental health needs
h Services for anti-social youth and adults (including adult ADHD)
i Services for those who self-harm.

The closing part of this submission makes further comment on the resource implications of our submission and refers to the questions raised in the Royal Commission's invitation by cross-referencing our views on those topics (Appendices 6 and 7).

SECTION 1: Change needed in philosophy and design of mental health service delivery

1.1 Introduction

MHYF Vic is grateful for the honour and privilege to participate in this Royal Commission. We see it as a great opportunity to change the course of how mental health services are delivered to our communities and to provide a platform for improved service and more efficient service. We endorse the wide-ranging nature of the enquiry such that service provision to adults and children, to special interest groups, and by means of private and public providers should be examined.

We strongly support a root and branch analysis of how the system does not work for many Victorians. Services can be positioned at three levels of provision. The three tiers currently exist but need to be defined and the connections between levels articulated (Section 2). This is where we start our submission.

We believe that service changes are needed at the interface between consumers and providers, but we think that such changes should be nested within a new philosophy of service provision (Section 3). This new philosophy needs mapping onto the existing architecture of service delivery. Two important parts of the existing architecture are the multi-disciplinary team and the idea of consumer healthcare rights; yet, our current system does not always accommodate such principles in actual practice.

Commensurate with this new vision are means for implementation that can be applied by practitioners and by consumers. We present a new model of integrated intervention (Appendix 2) and a range of intervention protocols (Section 4 and Appendix 3), designed to turn these changes into efficient and resource light service delivery. We suggest that the Royal Commission focus innovation upon a set of strategic priorities (Section 4) that will address unmet needs and bring down ongoing costs through prevention and early intervention.

The list of strategic priorities has been developed having observed the history of legislation in the state of Victoria (Appendix 1), observing the changes in the social fabric of our state, to knowledge about mental health, and to technology, in the context of the combined experience of our committee and our knowledge of the evidence about mental health. We list these changes, shortly.

Among our many activities, MHYF Vic sponsors a yearly oration on matters relating to Mental Health and Families, the Winston Rickards Memorial Oration, which was provided by one of the Royal Commissioners, Dr Allan Fels, in 2013, as we have sought to access opinions across the range of interests that bear upon the provision of mental health services to families. In parallel, under the leadership of former Chief Child Psychiatrist, Dr Allan Mawdsley (another Orator, in 2018), we have been assembling an atlas of best practice within our field, such that professionals can access the latest practice research with respect to any particular disorder or presentation. This is a vast project, but it has started generating for us evidence-based policy statements. It is from this wealth of evidence that our submission has been constructed.

The Royal Commission into Victoria's Mental Health system has described six questions for investigation and six terms of reference. We provide two tables at the end of this submission that cross-references our submission with these six areas (Appendices 6 and 7).

1.2 Changes in mental health service provision and society since the 1986 Act

The 1986 Act was regarded by many at the time as a radical and refreshing re-allocation of resources to the most vulnerable and the most mentally ill members of our community; and away from the "worried well". This had many advantages for those very ill persons receiving services, but there have been many social and procedural changes which warrant change to how mental health services are delivered as we enter the third decade of the third millennium. We note the following forty-two pertinent changes, under eight headings. We are unsure which of the changes are the most significant or if the list is complete, but wish for all such changes to be reflected in any new model of service delivery; we note that the classes of change are hard to prioritize relative to each other.

1. **Policy changes**
   a. Aboriginal dispossession and reconciliation
   b. Sexual assault
   c. Domestic violence
   d. Adolescent and youth mental health
   e. Child protection and out-of-home care
   f. Other policies that affect service delivery and undermine a coordinated policy perspective on mental health service delivery
   g. Establishment of the Australian Charter of Healthcare Rights
2. **Changes to perception of mental health**
   a. Recognition of the role and rights of consumers and carers
   b. Advocacy by consumers and professionals
   c. Acceptance of family-based practice
   d. Better understanding of how the perception of stigma excludes potential consumers
3. **Changes to the field**
   a. Closure and demolition of Psychiatric Asylums, without replacement
   b. Increased availability of private services due to Medicare
   c. Increased numbers of well-trained mental health professionals
   d. Decreased integration and coordination of services
   e. Improved understanding of the role of prevention in mental health services
   f. Improved understanding of the role of early intervention in mental health services
   g. Improved understanding of the mental health needs of elderly persons and their families
4. **Changes due to drugs**
   a. Greater availability of illicit drugs
   b. Greater variety of illicit drugs
   c. Higher rates of consumption of illicit drugs and of alcohol
   d. Uncertainty about the interaction between drug use and mental health
5. **Changes due to rates of diagnosis**
   a. Rise in suicide rate in general population

b. Rise in diagnosis of personality disorders (especially BPD and NPD)
c. Rise in incidents of non-lethal self-harm
d. Rise in diagnosis of trauma related mental health problems

6. Changes due to procedures

a. Improved risk assessment procedures
b. Higher criteria for acceptance of consumers to tertiary mental health services
c. Greater rates of exclusion of vulnerable and needy potential consumers
d. Better understanding of how to conduct access procedures to mental health services
e. Shift in focus of tertiary services away from treatment toward crisis response
f. Acceptance of the multi-disciplinary team approach in many agencies and among many practitioners

7. Changes due to research

a. Formulated protocols for therapeutic action (some of which may not be easily applied to mental health consumers and their families)
b. Better measures of psychological state and psychosocial change
c. More effective psychopharmacology
d. Better understanding of effects of trauma upon personal and family mental health
e. Better understanding of brain development and the early infantile period

8. Changes due to technology

a. Increased survival rate of premature babies
b. Availability of online material; especially pornography and violence
c. Cyber-bullying and sexting
d. Availability of online technology to improve access for rural and remote consumers
e. Improved technology for record keeping, case-based research, and professional liaison

These changes permeate mental health service delivery, as will a family/developmental philosophy. While most of the changes are beneficial and in line with developments in research and practice in mental health, one notable exception is the closure of places of asylum. Royal Park and Larundel hospitals, among others, were closed and sold in the 1990s and as a result we have lost inpatient facilities where people with psychiatric illnesses who are at risk of harming themselves and others can be housed and treated on a long-term basis. In respect to those who are at risk of harming others this means that a crime has to be committed and persons charged for them to be imprisoned, thereby increasing the risk of harm to the population and reducing or eliminating the opportunity for rehabilitation and treatment. It is our view that the wards in public hospitals are unable and inappropriate to offer the service that would be possible if specialist facilities were available.

A further implication and sequela of the absence of places of asylum is the significant stress placed on families of people with mental health disorders. Physical and sexual violence, and threats, are constant in the lives of these families, they often report that they have little if any access to help and the family members themselves report significant anxiety, depression, inability to work or sleep, or attend school. They also report being unable to speak with the treating professionals of the unwell family member due to citing of confidentiality, again, creating a situation where the families have the care responsibility, the stress associated with this, but the treating professionals do not engage with them to assist them.

Families also report emotional and financial stress associated with being on “suicide watch” for family members who are at risk and “medication watch” for family members who tend to stop taking medication because they “feel OK”, “it's not doing any good, “it will harm me its toxic” etc. Again, with the individually centred bio-medical model of psychiatric care, families who give shelter and support need to have access to effective psychoeducation, strategies for managing the demands, and possible financial assistance if they are unable to work while caring for their unwell family member.

We have spent some time considering how to shape intervention planning that provides the consumer with sufficient confidence that treatment might be successful, or at least worth participation. Again, we have looked at longstanding practices, and the development of the field of mental health service provision and of its professions across the past century, to articulate a model of intervention that is relatively simple to implement and allows for accountability to consumers and others, and that generates coordinated and integrated intervention (see Appendix 2 and the case study explorations of the new model). No such model has previously existed in mental health services, as far as we know. It is an innovation that requires review and thinking through. Nevertheless, we think that this model fills a gap in service delivery that needs to be filled.

1.3 Pattern of services and disorders

The recommendations for service delivery that emerge from the Royal Commission need to address the needs and unmet needs of those who require mental health intervention. These recommendations needs to reflect an understanding of the current structure of services and service delivery and how existing services can be updated and better coordinated in helping those in need. Further, the recommendations need to be resource sensitive. At MHYF Vic we believe that there are things that need to be done that do not require extra money, but if extra money is found it should be applied planfully. We hope that by moving to prevention and early intervention, funds can be saved that can be used for innovation.

Poverty is by far the most important factor negatively correlated with mental health. Improvement in safety, housing, food and welfare is the single most important universal intervention in the relief of mental disorders.

What is the minimum income for a family to lead a healthy life? We note that data from the Social Policy Research Centre at the University of NSW in 2017 calculated that a single adult would need $600pw. A couple with no children would need $830pw. Add a child of 6 and that rises to $970. Add a second child and it is $1170. Of that, one third would go on rent and the remainder to cover all other costs. Current Social Security benefits fall short by at least $100 pw of the minimum wage and does not allow for time for nurturance of children. Best Practice requires housing and income support for all families to live at better than the abovementioned standard. The level of support needs to be regularly updated.

Best Practice models for prevention of mental disorders include universal programs that address a) Safety, housing, food, welfare, b) Family functioning, parenting, and pro-social functioning (human capital), c) Education to potential, and d) Reduction of toxic factors.

Marginalisation, social isolation, and stigma of specific communities are other significant drivers of poor mental health outcomes. Three examples of identified community groupings faced with marginalisation, social isolation, and stigma in Australian society and identified as disadvantaged by poverty and poor mental health outcomes are the Aboriginal community, Refugees, and the LGBTI community. There is significant research supporting these claims and publicity across the board pointing to research into mental health outcomes for these communities has led to the recognition that political intervention at the highest level has been and is required.

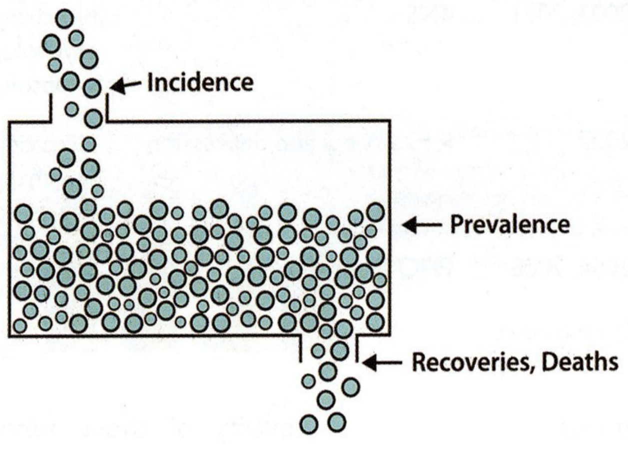
Mental health disorders result in high rates of premature death and serious losses in economic productivity. The disorders are widespread and frequent but under-recognized and often ignored. Compared to the management of physical health problems, the mental health services have serious difficulties with resourcing, efficient utilization of the available resources, and inequitable access to appropriate care.

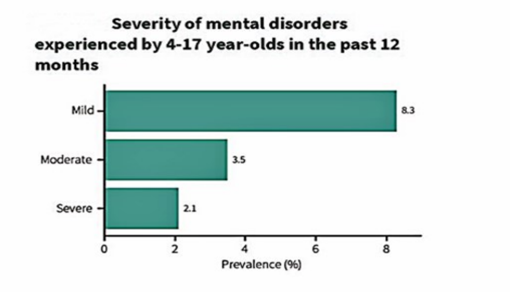
The difficulties with resourcing are primarily due to specialist services being directed towards the most seriously mentally ill (2%) and being relatively unavailable to the great majority of lesser degrees of disturbance (15%-20%). Hospital-based services are somewhat under-resourced but community-based services are particularly under-resourced.

The difficulties with efficient use of the available resources are primarily due to the segmentation of service provision across multiple budgetary centres which attend to their own areas of responsibility to the detriment of coordinated collaboration. Holistic care dissipates when, without collaboration, tasks are designated as the responsibility of other providers.

The difficulties with equitable access to appropriate care are primarily due to the uneven distribution of multiple uncoordinated services that do not readily facilitate transition to the most effective forms of care.

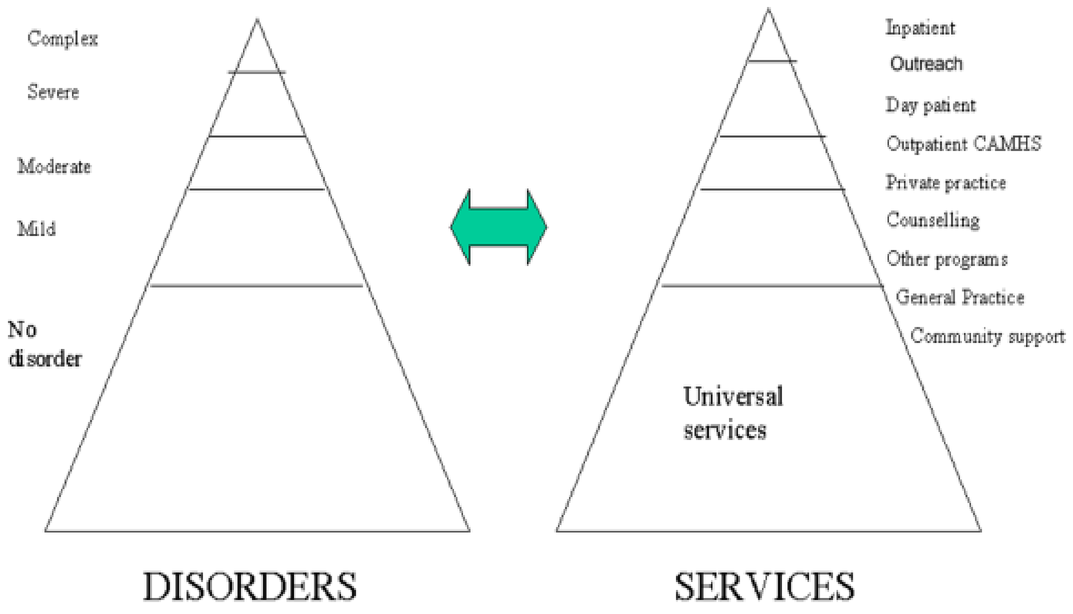
At any time about 15-20% of the population has some degree of mental disturbance, but most are of mild degree and some get better without formal treatment. However, some get worse and will need extensive treatment who would have been better treated early rather than later. The ideal system allows early assessment and management, with triage of those which require more specialised treatment. At present, only about 5% of cases receive formal treatment.





It is important not to dismiss mild cases as “worried well” because the annual number of suicides is similar in each group. Although the rate per hundred thousand is highest in the severe group and lowest in the mild group, the larger size of the mild group results in a similar number of suicides. We must take all cases seriously.

The twin pyramids diagram represents the distribution of mental disorders in the community and the range of services that respond to them. There is a rough correspondence between the strata of each pyramid, with severe and complex cases being seen by hospital services while milder cases are seen by community-based agencies. This is generally appropriate, but also highlights the aforementioned systemic difficulties with major barriers to collaboration between service delivery agencies in each stratum. Improved collaboration, even within existing resource allocation, would result in improved services but would especially respond to additional funding.



The reason why there is poor collaboration and major barriers between service delivery components is self-evident from the fragmented structure. Components of the system are funded from different sources, have different accountabilities, have different Key Performance Indicators, and they wish to operate with a manageable caseload of clients that they can treat successfully. There is a powerful disincentive to taking on too many clients or clients who do not fit their profile of “treatable” by the service, who are then deemed to be “more appropriate” for some other agency in the system but without responsibility for ensuring that the client does, in fact, receive appropriate service. The client then often gets the “run-around”.

Given that there will continue to be a multiplicity of services with their separate funding sources and admission criteria, and that clients with various degrees of mental disturbance will make contact with various service providers, the essential missing element is an agency that is capable of undertaking case assessments and case management of referrals from any of the other components in the system who deem it beyond their capabilities. That is, a place that can say, “the buck stops here”.

This would be the equivalent of the general hospital Emergency Department in its capacity to deal with referrals. It would also need outpatient follow-up capability and collaboration with referring agencies and GPs, as appropriate.

MHYFVic proposes that this coordinating service should be located within Community Health Centres, supported by shared specialist staff from area mental health services as described in the next section of this submission (see final recommendations, Section 6).

1.4 Medicare funded services and Victoria's mental health services

It is hard to know which of the forty-two changes listed in Section 1.2, above, is the most important, but the introduction of the Better Access scheme within Medicare in late 2007 has changed the landscape of mental health services. Medicare rebates brought people into the service system who were not eligible or not inclined to receive service from the public mental health services or private psychiatry and psychology. Some of these people were mildly affected in their mental health, but many were severe and chronic and reliant upon their General Practitioner. Some of the people were in the drug and alcohol services or in intellectual disability services, but not connected with mental health practitioners.

Medicare rebates have brought mental health treatment to a range of people excluded by expense and access barriers. It is time to build a system that integrates and coordinates service delivery across private and public boundaries. There are mentions of specific examples of the need to connect Medicare service provision with other service provision. We advocate the provision of Item numbers for case conferencing and travel to and from such meetings. We advocate enabling the inclusion of GPs in case planning by all means possible, as they do have a central role in many cases that lie outside public agencies. We advocate the provision of Item numbers for couple counselling and family therapy. We advocate enlargement of the number of sessions available to consumers. We advocate the provision of Item numbers to enable family members and carers to participate in professional consultation that will enable recovery in a consumer.

Medicare service provision was originally funded for twelve session per year and that a further six sessions could be allowed if approved by the GP. We would advocate a return to this level of funding. We note that eating disorder treatments have up to forty sessions per year allocated from later this year. We recognize that such expanded service is needed for such specialist treatments, but regard this as discriminatory with respect to other seriously dangerous conditions, such as borderline personality disorder, for instance.

The actual number of sessions required for an effective treatment is not easily determined ahead of time. We believe one reason for cutting back from eighteen to ten sessions was that the average number of sessions needed was, in fact, ten. This was decision-making based on a poor understanding of mathematics. An average takes into account the number of sessions that are few and the number that are many. Practitioners know that many cases require fewer than five sessions to be effective. Practitioners also know that some cases require weekly treatment for many years. Level of need should determine amount of service, not a one-size fits all "average". The severely disturbed consumer is discriminated against by the Medicare funding formula. The Royal Commission should take up these issues with the Federal government.

SECTION 2: Three tiers of mental health intervention

Service planning generally refers to 'Tiers' of service delivery. Tier One, going from bottom to top, refers to generalist health, maternal and child health, education (pre-school, primary, secondary, tertiary), and welfare services delivered through government and non-government agencies, including municipal councils. Tier Two refers to general medical practitioners (private and public sector), psychologists and similar health care professionals, and community health centres. Tier Three refers to public and private psychiatric units, specialist psychiatrists, and staff of mental health services.

Tier Three services at present are mainly devoted to management of seriously mentally-ill patients in designated mental health facilities. They undertake some outreach service but generally have significant barriers to intake of new cases. It would be better for the community if the expertise of this tier was made available to Tier Two for the management of its less severe cases.

Tier One services provide educative and preventative programs of benefit to the whole community. When alerted to symptoms potentially indicative of mental disorder it is important for Tier One services to have ready access to Tier Two services for assessment and management.

Tier Two services should be the default service provider for the whole community. No person should be refused access to assessment, and all persons should be case-managed in Tier Two, notwithstanding that components of service may also be provided by Tier Three as necessary. This does not happen adequately at present, mainly because of different centres of accountability and funding, which are not required to collaborate, but could do so if required.

General Medical Practitioners and their associated mental health professionals (clinical psychologists, generalist psychologists, social workers, occupational therapists) funded through Medicare could deal with a high proportion of cases. The psychological treatment programs of Community Health agencies (including *headspace* and *Relationships Australia*) could deal with self-referred clients or those referred by GPs because of chronicity or difficulty too great for primary care. Specialist mental health (Tier Three) workers should provide sessional input for the Community Health workers to ensure that the treatment programs can cater for the needs of the clientele or facilitate transition to Tier Three services if necessary. It is imperative that GPs be connected to other services and other professionals as they often have a pivotal role in the life of mental health consumers and their families, yet can be ignored by Tier two and Tier three service providers. Medicare may need to be modified to enable attendance of GPs and private practitioners at treatment team coordination meetings (provision of a specific Item number for attendance and another Item number for travel to and from).

While the provision of services by psychologists under a mental health care plan has significantly increased access to mental health care for a large proportion of the community, these services are still largely limited to ten sessions in a calendar year (with the recent proviso of up to forty sessions for diagnoses such as eating disorders). There are many situations where ten sessions are sufficient, but there are also many situations where at the end of the ten sessions more work is required but unobtainable till the next calendar year and clinicians report being unable to refer clients for ongoing work. This compromises the treatment given and also places clinicians in the position of having to assess and take on those clients who are likely to benefit within ten sessions, leaving other clients who need more intensive and/or long-term work with limited access to mental health care services.

This service was more effective when eighteen rather than ten sessions were offered in a calendar year. The service would also be improved by an item number which allows family members of the unwell patient to receive mental health care. At the moment the family members need to obtain a separate mental health care plan in their own name for these services. This applies particularly to referrals for children, elderly, people with a chronic or life-threatening illness, post-natal depression, where family members are significantly involved in care and where interpersonal strategies are documented to be effective treatment modalities.

There should be no direct referral to Tier Three units; all referrals for specialist mental health services should come through the intake service at Community Health Centres, staffed by Outreach Workers from the Tier Three services; in this way the specialist services can maintain control of their admissions whilst simultaneously ensuring that cases not admitted to the specialist units are provided with supported programs within the Community Health Centres. Entry to Tier Three services would be mediated by outreach staff acting as intake workers at Community Health agencies, or Emergency Departments at General Hospitals, or by outreach by CATT teams to the community (such as involuntary recommendations from GPs).

<u>Tier Three specialist mental health services should provide:</u>

- In-patient and Day-patient programs for severe mental disorders,
- Specialist assessment and management of programs in age-specific strata
    - Geriatric
    - General adult
    - Adolescent
    - Children and families
- Outreach programs which provide:
    - Community Assessment & Treatment (CATT) Teams. CAT Teams provide the most flexible way of responding to crises and to enabling services to clients who are unable to attend centre-based appointments. Although seemingly more expensive than centre-based services, there are likely to be compensatory savings through more rapid and more effective engagement.
    - Intake/Brief intervention clinicians at Community Health Centres and Public Hospital EDs. Intake interviewing of referred clients is best undertaken by highly skilled clinicians. This is because the initial session lays the groundwork for the therapeutic contract, generally offering the greatest opportunity for establishing trust and rapport, and an indication of whether the problems can be ameliorated by brief intervention or will require an extended treatment program. This advantage is lost when the intake worker is insufficiently skilled, particularly if the case needs to be transferred to another worker for treatment. Intake is best undertaken by face-to-face interview arranged as soon as possible after the request. With careful organization of staff time-allocation it is possible to offer a zero-waiting list time. This intake interview should be followed by an immediate offer of brief intervention (up to six sessions) or elective therapeutic programs.

- Consultancy services to relevant Tier Two and Tier One agencies Consultancy services are an important way of extending specialist knowledge and understanding to other helpers already involved with clients in the community. This potentially enables improved outcomes for the client through enhancement of consultee skills and obviating client transfer to other clinicians; improved consultee skills are an important benefit potentially carried forward to subsequent casework, which in turn is of ongoing benefit to the consultancy agency.

Consultancy services may be delivered in different ways to achieve different goals. They are broadly categorised as primary, secondary or tertiary.

Primary, or case-assessment consultation, involves the consultant seeing the client for assessment in order to advise the consultee about case management. The advantage of this is that the specialist has directly observed the case rather than relying upon reported observations. The disadvantage is that the case management status of the consultee is subordinated to that of the consultant, which has psychological and medico-legal ramifications. It is desirable for the consultant to see the client collaboratively with the consultee to enhance rather than diminish the role of the consultee.

Secondary, or consultee-centred consultation, involves the consultee describing the case to the consultant who attempts to enhance the consultee's understanding of assessment and management issues emerging from the description. The advantage of this is that the focus is on the consultee's needs without diminishing the direct responsibility for management. The disadvantage is that the process relies heavily on the psychological-mindedness of the consultee. Subsequent discussions may be required. Subject to confidentiality constraints, the process may be undertaken in group discussions, thereby benefitting multiple consultees.

Tertiary, or program-oriented consultation, attempts to enhance the mental health-promoting components of an agency's service delivery.

Tier Two Community Health services should provide:

- Face-to-face intake and brief intervention programs
- Family therapy programs
- Case management support and treatment monitoring
- Group therapeutic programs
- Specific purpose programs for substance abuse, domestic violence, parenting & child behaviour management.

The tiers already exist but need to be articulated more clearly, with the processes of interaction between tiers spelt out. The tiers need to be accurately reflective of current services, both public and private, and the tiers need to be attuned to the spectrum and severity of the mental health disorders, and as they arise across the geography of the state. Further, services, as provided through the agencies at each of the tiers, need a unifying philosophy that is different to the unsystematic and unarticulated set of service philosophies that currently exist. Service coordination and integration requires a client-focused shared vision.

In order to develop and maintain this client-focused shared vision the Regional Health Service responsible for public sector funding should have a management Board that includes consumer and care representation as well as officials of the agencies involved. Most importantly, a proportion of funding allocated to shared programs should be quarantined so that it can only be spent on programs that are delivered in accordance with this shared vision. This is to counteract the “silo” mentality of the different funding pathways.

SECTION 3: A new vision for the provision of mental health services in Victoria

3.1 Family/developmental approach

We propose that the government adopt a family/developmental model of mental health services, with integrated programs for prevention, early intervention, and coordinated multi-modal intervention for children and families of all ages. Connection to important others is the most effective safety net for unwell people and at-risk families. Connection means connection to community, as well.

While root and branch analysis is vital, we believe there has been a consistent failure at the policy level to see the forest rather than the tree. Each part of a forest is connected and provides opportunities for the growth of other plant and animal species that live and love within it. The history of Victorian government mental health policy has been to focus on the at-risk individual (a brief summary of the history of such legislation can be found in Appendix 1). This has narrowed attention to lone persons and emergency room response or to palliation and monitoring of dangerousness, rather than a focus upon recovery in adult mental health services.

By contrast, many private adult mental health service providers focus on recovery and nearly all child and adolescent mental health practitioners, public or private, seek to have their consumers recover. This model has been successful over many years, despite the “maintain and monitor” emphasis of adult services. We suggest that adopting the well-tried model of recovery in the family mental health field will have great positive effects on adult consumers.

A family approach is inclusive of the carers for consumers and for others who may provide resources to enable recovery from within family networks. Further, a family approach assumes that consumers can be contributors to the mental health of themselves and their families, and net contributors to society.

A developmental approach is one that recognizes that families and consumers and have different needs at different stages of their lives and of their illness. Such models of change already exist in child and adolescent mental health services. Such models also exist in work with elderly and disabled people.

Another aspect of the developmental model is the window of opportunity for early intervention. Maternal and child health clinics can be means for early detection, but it is at the pre-school level that moist can be done. Nobel Prize winning economist, James Heckman, showed the positive effects of early childhood education upon social and economic outcomes in adulthood and across nations. Schools can also be places where early intervention might occur, and this has been recognized by the recent initiative to have mental health workers employed in schools. We believe that such innovations need the underpinning of a mental health philosophy that makes sense of such initiatives as this can lead to better inter-sectoral collaboration.

A family/developmental approach is in keeping with the 2017 UN report on mental health and human rights. Much of this report is about avoiding physical restraints and the overuse of medication and speaks to the dignity of the person. It is clear that connection with family and community is essential to both human rights and to mental health.

Emphasizing connections is already part of existing state government policy with respect to aboriginal families, domestic violence, child protection, restorative justice, forced adoption, and some parts of policing practice. Again, this is not really new. We are recommending that the steady shift toward social policy that emphasizes connection be extended to mental health policy. We believe that such a shift in philosophy will help to underpin a whole of government strategy for family connections.

A 'Way Forward' program, community-led with government backing, is needed to re-invigorate, re-integrate and re-work the notion of the meaning of Community and how we as members provide for one another beyond the nuclear and single person family. Forums of communities could include the active presence of government representatives, high-profile representatives of existing organisations, and specialist representatives, along with members of the public to discuss and disseminate current information and understandings about mental illness, giving weight to means of prevention and ameliorating the likelihood of chronicity of mental illness.

The gamut of existing networks of mental health providers and accessing them needs to be better understood including: the role of allied health practices, early childhood services, education, and accommodation services. Many major hospitals disseminate their research findings about programs and services and already lead the way in publicising mental health and social issues.

Public education programmes could include a universal 'cradle to grave' model of the developing person in various life contexts and community. Topics such as values for life, of living responsibly for the sake of living well for personal wellbeing and health and for family, friends and broader community, respect and care for others, and of individual differences could be included. 'Difference' is the norm and needs to be normalised and valued for its contribution to society for adaptation and survival. The purpose of such programmes would be to reduce fear and misinformation.

Similarly, we believe we are not creating new models for intervention or protocols for practice. Rather, we are attempting to bring these into clearer view and make them available to a wider professional and consumer audience. The innovation is the bringing to the foreground practices and policies many people have followed for many years; many for over a century.

MHYF Vic takes evidence-based practice very seriously. One of our important initiatives is to construct what we call an *Atlas of interventions* (accessible on our website www.mhyfvic.org) that have been shown to be effective with children and families. However, we are unsure if some of the approaches to collecting evidence have sufficient application to the mental health consumer population. We note that interventions found to have merit from Randomized Controlled Trials are often called "gold standard" studies. However beneficial these interventions may be with mildly affected, well attending, single diagnosis clients of university clinics, we have not found much evidence that these interventions will work with the more usual population of consumers with multiple diagnoses and multiple adverse living conditions.

We urge the Royal Commissioners not to be attracted to such research as the basis for treatment recommendations. We have found relationship-based work that firstly secures interpersonal safety to be the most relevant approach with most people with mental health needs. This is especially true of many of the consumers who we would want to be given priority for service (Aboriginal people, out-of-home care children, self-harming consumers, infants and mothers, illicit drug users, the elderly and their carers, and anti-social youth and adults; see Strategic priorities, Section 4, below).

The recommended change in philosophy for mental health services from individual maintenance to a family/developmental recovery approach, has a sound basis in research and practice and is in line with many government initiatives, but it is also responsive to the many social and procedural changes in the field since 1986.

3.2 Suicide prevention and the family/developmental approach

The first public hearings of the Royal Commission have focused a lot of attention upon reducing the rate of suicide. MHYF Vic firmly believes that this is imperative, but are not convinced that proposals thus far have secured the desired outcome. We believe that suicide is one example of the damage caused when a person disconnects from their family and friends. We believe that the focus upon connections within the family/developmental model will have a long-term preventive effect upon the suicide rate.

The focus upon the most vulnerable mental health consumers that was the centrepiece of the 1986 legislative reforms did not alter the suicide rate significantly. This was probably because there were many vulnerable people outside the actual service receivers. Many of these non-receivers of service were in the mild range of mental disorder (this point is further expanded upon in Section 1.4).

But there was another side effect of the focus upon the lone, most vulnerable, consumer: a move from therapeutic intervention toward case management. Many professionals feel very frustrated with the monitoring and maintenance philosophy of current public adult mental health services (see Section 5.2 on Workforce matters). Case management includes protocols for risk assessment at every meeting between practitioner and consumer. This can take over half the time allocated for such an appointment. Even if, the practitioner would consider psychotherapy to be a viable option, there is little time in each session for such action, and with the focus upon admission and discharge, there is not enough time allocated across the many months that would be needed to carry out the therapy. That is, the changes to assisting the most vulnerable has rendered several useful treatment options, inoperable.

This was not the purpose of the change, but it was a clear, unintended, adverse outcome of the 1986 changes. MHYF Vic is wary of changes that do not have the effects of changes closely examined beforehand and closely monitored over time. We advocate that a research unit be established that can monitor for unexpected negative outcomes and which can offer means for amelioration in a timely way (see final recommendations, Section 6).

We believe that the family developmental approach, with its general emphasis on connection to be protective for potentially suicidal consumers. Our approach is not just a matter of changed philosophy. We offer practical steps for family engagement and engagement with others who may be resources for the family. We also want the consumers to have the opportunity to demonstrate their value as a resource to their family and friends, even while they are suffering themselves.

The practical steps we outline concern timely intake (Appendix 4), dedicated staff working on networking (Appendix 3), and a transparent process for integrated and coordinated multi-disciplinary intervention (Appendix 2), that includes therapy as one important option.

Our suggestions for redesign of professional activities are embedded within a detailed understanding of how the overall mental health system is structured to meet the specific needs of consumers with distinct disorders.

3.3 Multi-disciplinary case planning and teamwork

Multi-disciplinary case work was at the core of the Child Guidance movement, which began with the work of Healy on delinquency in 1909 and led to the establishment of the Judge Baker Child Guidance clinic under Healy and Fox Bronner in 1917 in Boston. The social worker would liaise with the referrer and the family to enable assessment to begin and would interview the parents to understand the family situation and the child's needs. The psychologist would do various assessments of intellectual and mechanical skills to establish the most appropriate pathways through education to occupation. The medical officer would assess the mental health status of the child. Then the team would meet and formulate a plan that would be presented to the parents in a case conference. Case conferencing involving the skills and experience of various team members were thus established as central to child mental health practice.

In adult mental health services, there are a number of occupations represented, but the notion of working in collaboration and through case conferencing is not practice as usual (see Section 5.2 Workforce). MYHF Vic advocates multi-disciplinary work that respects all contributing professionals and their disciplines.

MHYF Vic has always been a multi-occupational venture with collaboration as central, across disciplines. Our approach to resolving problems of case planning and implementation is predicated in multi-disciplinary work through the five-component model of intervention (see Appendix 2).

MHYF Vic believes that services will improve through multi-disciplinary teamwork, especially with the incorporation of General Practitioners into the teams and into the conferences.

3.4 Notes toward a charter of rights for mental health consumers

MHYF Vic's multi-disciplinary committee includes consumers and carers. Consumer members of our committee keep us grounded in what we advocate and ensure that the professional members of the committee, in their everyday work, recognize consumer rights.

MHYF Vic notes the production in June, 2017, of the brochure concerning the Australian Charter of Healthcare Rights in Victoria. We believe that access, safety, respect, communication, participation, privacy, and comment are basic rights that consumers should enjoy. The brochure does include mental health care as part of this overall set of rights, but we are unsure if the real needs of mental health patients are covered by these general principles.

MHYF Vic accepts that patients with psychosis do gain urgent attention when they present in crisis at Emergency Departments or at GP clinics. These patients will be provided with appropriate medication, but other services are not so available. Adult mental health services have professionals trained in complex interventions, but the primary intervention is case management. Patients need multi-disciplinary service, psychotherapy, and safe residence, not just crisis medical response and monitoring.

It is a fundamental right of all citizens to have access to the best mental health care that is available and to not be bundled out into the street because bed availability is extremely limited. In fact, we assert that the rapid turnover of inpatients and the lack of provision of psychotherapy services are key indicators of the “brokenness” of the system.

Similarly, rural and remote citizens require access to quality services in a timely way. Online consultation can ameliorate many of the access problems, but only if the consumer can access a computer and is comfortable with this form of communication. The problem can be reduced if local GP clinics provide a space for such contact within the clinic (as happens with *Call to Mind* consultations when the person does not have a computer). The security is enhanced by the presence of a practice manager or practice nurse making the connection and being on hand if something goes wrong, but otherwise is not present during the consultation. The GP setting makes for interpersonal safety, as well. But timeliness is probably more important for the rural or remote consumer, as time delays increase the possibility for adverse events.

SECTION 4: Strategic priorities

Suicide risk and danger to others have long been first on the list of mental health policy priorities. This was central to the 1986 Mental Health Act reforms. We consider this to have been a further example of failed policy that focuses upon the individual. Further, we believe that focus upon suicide among the two per cent of people with the most extreme forms of mental illness will not affect the suicide rate. We endorse the need for resourcing of severe disturbance, but note that suicide happens among the less extreme and sub-clinical populations. We would assert that family connection is very good way to promote healthy living and prevent suicide.

We would like to suggest the following strategic priorities as they represent ground for successful intervention and for long-term savings. We believe that these priorities, when combined, could reduce overall ongoing costs and contribute significantly to the overall mental health of our society.

1. Family/developmental philosophy (Section 3)
2. Focus upon prevention
3. Recognition of the need for a three-tier approach to service provision (Section 2)
4. The five-component model of integrated intervention (Appendix 2)
5. New model of access to services; including family engagement practices (Appendices 3 and 4)
6. Focus upon pre-school as best site for early detection of mental health needs
7. Aboriginal family mental health; including processes of recognition and reconciliation
8. Focus upon intervention services for Out of Home Care children
9. Focus upon early intervention services for infants and mothers
10. Focus upon early intervention services for elderly people and their families
11. Focus upon early intervention services for substance users with mental health needs
12. Focus upon intervention services for anti-social youth and adults; including stimulant medication for ADHD adults
13. Focus upon early intervention services for those who self-harm

We advocate the allocation of more resources to these areas of priority because they have potentially large capacity to improve family mental health and rapidly. Further, we believe that resources provided to these areas will reduce costs in the adult mental health clinics and Emergency Departments. We believe the traditional focus upon maintenance of those diagnosed with schizophrenia and bipolar disorder traps the clinicians into a non-recovery attitude to treatment.

4.1 Prevention

1. Prevention of mental illness and prevention of suicide are two different things, and both need to be addressed.

2. Suicide is the final pathway of diverse factors leading to ending life (impulsively or planfully) because ending a life not worth living seems better than continuing.

3. The diverse factors are grouped as biological and psychosocial although there always involves an overlapping mixture.

4. The biological factors include some major mental illnesses (such as bipolar disorder, major depressive illness, schizophrenia, substance abuse-induced mental impairments, and similar psychotic and mood disturbances) as well as despair induced by chronic pain and incapacitating physical disorder.

5. The psychosocial factors leading to existential hopelessness and helplessness generally involve grief and loss, disruption of previously supportive relationships, impaired self-esteem, and no vision of how the situation can improve.

6. It is the view of healthcare professionals that there are effective interventions in the biological and psychosocial factors such that most suicidal people can be helped to find a resolution. The challenge is to engage them in helping services.

7. It is a mistake for suicide prevention strategies to focus only on the high-risk group. Although appraisal of the risk factors can categorise people into high, medium and lower risk groups, in which the observed suicide rate per 100,000 are high, medium and low, the actual numbers of suicides are similar in each group because the lower risk group is much larger. Reduction in suicides needs reduction in all risk levels, which is a logistic challenge for service providers.

8. Improved access to mental healthcare services and motivation to attend are key drivers for suicide prevention. They are also key factors in reducing mental disorders (secondary and tertiary prevention) although primary prevention of mental disorders requires a whole-of-society approach. Improved access can be achieved (as outlined in Appendix 4). Improved motivation to attend requires a major public information campaign of positive mental health promotion.

9. Prevention of mental illness is a different issue to prevention of suicide, requiring a whole-of-society approach which may incidentally also reduce suicides that are related to mental illness. Causation of diverse mental illnesses is multifactorial, but the main positive correlation is poverty and the main negative correlation is family psychological capital. Primary prevention hinges on programs dealing with these issues.

Poverty (and its associated problems of employment, housing, malnutrition, and poor general health) generally affects not only the individual but family groups including children whose development and education is impaired, leading to failure to reach potential, thereby impeding national progress and risking repetition into the next generation.

Family psychological capital, on the other hand, means nurturance, positive attachments, appropriate parenting and supports leading to resilience, good coping and self-confidence.

Effective strategies for prevention of mental illness must therefore include all societal interventions to improve employment, housing, general healthcare and income support to optimise family functioning, childrearing, and maximise reaching potential. It must also include ready access to services for dealing with health and mental health problems (see Appendix 4).

4.2 Model of access to services

Currently access to services is uncoordinated, haphazard, and subject to uncertainty of outcome. Consumers report insecurity about approaching, heightened sense of stigma, and a fear of being judged or not being heard. Potential consumers need a means of access that leads to positive outcomes in a way that can be expected. Carers of consumers need the same things. There are two parts to the new access model; one is description of the processes of greeting and intake, and the other concerns the family engagement process, which will be discussed after the general processes of access. These processes are more closely detailed in Appendix 3.

Successful mental health access is about a perceived willingness to function with compassion, efficiency, professionalism, and authority. The establishment of these criteria in the mind of the potential consumer is critical to the work of the first contact agent (GP, emergency room nurse, MH agency referral and intake worker). If efficiency is placed ahead of compassion, contact begins poorly. If professional stance is placed ahead of efficiency, the consumer will doubt that they are being heard. If expertise is placed ahead of listening, the beginning may never lead to intake. However, if the contact is not professional and authoritative, the consumer is likely to feel vulnerable. First contact work is a clinical discipline and a clinical art. The role needs to be elevated and legitimized.

However, the actual practices of professionals at the initial interface will vary according to the point of access (GP practice, emergency room, MH service) chosen. The methodologies of access need to be set down quite clearly, but first the purpose of access reform needs to be described. Then the principles for action need to be articulated. Then the actual practices can be formulated.

Access to services needs to be timely and to encourage efficient contact with the most appropriate professional. The transaction needs to be respectful, especially of reluctance and fears about stigma and judgements. Once the first contact has been made and the consumer connects with the best appropriate professional, some of these processes will necessarily be repeated, but should not occur in a tiresome way, as the consumer will be wanting to get on with finding out if the professional is the best available person and what might happen as contact proceeds. It is not enough for the professional to have confidence to help a consumer. The consumer needs to have solid evidence that the consumer will be taken seriously, respected, not judged, and, actually, helped. The role of the access coordinator or Networking agent is presented in Appendix 3. A slightly different emphasis is provided in Appendix 4, where the need for a Zero waiting time is demonstrated to be administratively possible.

The Networker would be someone involved with referral and intake duties who would have extra duties, or someone who works solely in the defined role. The role has the following functions:

- Actively seeking to link consumers with important family and friends who may have become remote to the consumer, but who would like to contribute to the consumer’s wellbeing,
- Trace lost connections,
- Facilitate initial meetings, and

- Follow-up where necessary, but leave subsequent interactions to the professionals already involved.

The role is specialist and is time-limited. The Networker is not a case manager, but aids and supports case management. Other changes can support case management efficiencies, as well.

Technological innovation since the 1986 Act has been broad and deep with the advent of the Internet and the development of portable devices. Of course, with such changes have come mental health affecting phenomena such as online pornography and violence, cyber-bullying, and sexting. But these technologies have opened up services for rural and remote users of online conferencing and through developments, in record-keeping, professional liaison, and live research programs.

Headspace, the national youth mental health initiative, has their tech-savvy clientele register through tablet devices and provide feedback for each session. Tablet technology offers a chance for great efficiencies at the front end of service delivery with well-designed data entry templates that also accommodate boutique and large-scale research projects. MHYF Vic encourages the overhaul of such systems.

4.3 Pre-school as best site for early detection of mental health needs

Families exist within small social spaces when the children are young. Some families can come into social view through maternal illness when the baby is young, or through issues of abuse and neglect, but it is not until pre-school enrolment that most children come within the purview of state facilities.

GPs can pick up some early signs of vulnerability and will act if needed, but the relative impersonal nature of pre-school enrolment, and later school enrolment, that makes near comprehensive checking of health and welfare status possible. The aim of such checking is to ensure the best possible start in life for each child and to address small problems before they become big ones.

Heckman’s analysis of the economic value of pre-school is focussed upon helping a child achieve their educational potential by encouraging early learning, but it is also about removal of impediments to learning that may involve physical and emotional obstacles to development.

The detection of mental health needs is timely at pre-school level and it is possible. The next questions are: what we would want to detect and how would we want to organize the process of detection? There are questions of parental consent and workforce.

In some ways, the issue is not so different to immunization or NAPLAN in that it is a process expected to be engaged by nearly all children and it is for the benefit of each child. Under such conditions of generality/normality, and specific benefit, parents do not seem to have much trouble in consenting at a high rate. There just needs to be the supply of sufficiently trained gatherers of the data. Pre-school staff could conduct such screening, but would need to be rewarded and allowed sufficient time to conduct the screening. There would be benefits that flow directly to the educators who assessed the children under their care.

In turn, the benefits predicted by Heckman would be made available to the society through improved education outcomes, early intervention in cases of specific needs, and longer-term understanding of needs for each cohort as they develop. For instance, the number of Down's children who will become adults and the allocation of funds going forward that would be needed.

4.4 Aboriginal family mental health

In Australia, the ongoing intergenerational effects of the trauma associated with dispossession, oppression and societal discrimination continue to confront Aboriginal communities. Victorian Aboriginal children and youth continue to be challenged by disadvantages that flow these realities. Problems can be extreme, and many suffer. This is an area of strategic priority for Victoria, as for every other part of Australia, for both ethical and social reasons.

Mental health services for Aboriginal families in Victoria are notionally provided by mainstream State Government Child and Adolescent /Youth Mental Health Services, and by family-focused Social Welfare Service Non-Government Organisations, particularly in regional areas, where they sometimes work collaboratively with local Aboriginal Cooperatives. With the exception of the Take Two program of Berry Street (NGO), however, these mainstream services are generally not staffed by Aboriginal workers. Such services are therefore generally regarded as culturally unsafe and are rarely attended by Aboriginal communities. Such services are commonly described as not understanding or meeting the needs of Aboriginal children, adolescents and their families.

Certain state-wide Aboriginal organisations have been established in the Melbourne metropolitan area with the mandate to promote the well-being of the young and their families. These Aboriginal organisations adopt the principle of self-determination as much as is possible in their functioning, employing qualified Aboriginal workers in professional positions wherever possible.

Unfortunately, while striving for standards of excellence, these Aboriginal organisations have insufficient and unstable funding and resources, which means their state-wide reach is compromised.

Aboriginal organisations in the State of Victoria that promote the best interests of children, adolescents and their families are actively involved in the prevention as well as early intervention and treatment of mental disorders in the young. They operate on the basis of self-determination, respect for individuals and culture. They have a very strong commitment to ensuring appropriate out-of-home care within the Aboriginal community and they continuously advocate to government for improvements in Aboriginal child and youth well-being services.

The Victorian Aboriginal Health Service (VAHS) delivers preventive services to the Victorian Aboriginal communities through a series of programs, sometimes in collaboration with other services such as the Australian Childhood Foundation, Austin Health, Parentzone, and the Victorian Department of Justice. Such collaboration is considered to enhance the quality of the resulting service to children, adolescents and their families.

The Koori Kids Mental Health Service of VAHS provides therapeutic, counselling, trauma support, educational support, youth outreach, early psychosis and youth justice programs to the Aboriginal community. The service uses a family centred, wrap-around model of mental health care to Aboriginal families and their young, always involving an Aboriginal Health Worker as part of the team. Koori Kids also provides consultation to organisations responsible for universal services to Aboriginal children and adolescents. This specialist service needs to have an adequate level of funding which is reliably stable in order to employ the staff and training to maintain a quality, culturally sensitive, mental health child and adolescent service, equivalent to CAMHS, to the Aboriginal communities of Victoria. At present, its effective operation is limited by funding shortfalls and certainly by consequent challenges in achieving outreach beyond the northern metropolitan area of Melbourne.

The area of Aboriginal child and adolescent mental health, particularly the VAHS Koori Kids Mental Health Service, requires urgent recognition and an urgent injection of significant and stable funding to continue to function as well as it does in its delivery of services in Melbourne and to begin to fulfil the regional outreach with which it is charged. Further, educational and professional training opportunities for Aboriginal people need to be expanded in order to strengthen the appropriate Aboriginal workforce delivering child and adolescent mental health services.

The principles underlying these recommendations, and acknowledged by MHYF Vic, are well expressed by the *International Association of Child and Adolescent Psychiatry and Allied Professions 2018 Declaration on the Rights of Indigenous Children, Adolescents and Families to Mental Health and Wellbeing* (Appendix 5). It should be noted that Koori Kids Mental Health Service of VAHS had important input to this Declaration, along with other appropriate representatives of indigenous groups around the world.

4.5 Intervention services for Out-of-Home Care children

Children who enter out-of-home care (OOHC) are vulnerable in many ways: they have experienced trauma leading up to removal, they suffer trauma as they transfer from home to someone else's home or residential care, they are at risk from their carers or other children at the new home or facility, their schooling is disrupted, and important connections may be lost. In Victoria, there were over 10,000 children in such care in 2017-2018 (43,000 children referred to Child protection service). Many of these children are children of parents who were removed as children.

Without effective intervention, these children will remain a huge burden on government resources. The Victorian budget for Child protection, family services, family violence & related supports is $1.41 b for 2018-2019; by comparison the mental health budget is $1.61 b. In 2016-2017 the OOHC budget was $0.5b). These children, should they become adults, will then be a burden when they have children themselves. Urgent re-thinking of this cycle of trauma is needed. Take Two is an initiative that has been going for over ten years and shows many signs of achieving good outcomes for many of the children in this intractable group. Take Two has been designated by the Murdoch Children's Research Institute as a 'Promising Program' and is being evaluated by Harvard University (in an RCT federally funded by DPM&C). However, Take Two can cater for only 1% of the total OOHC population. Public mental health service entry criteria need broadening to improve service access for OOHC children and their families.

OOHC children are discriminated against in the mental health system. Child and adolescent mental health services often refuse to offer treatment to distressed, traumatized, ASD, and ADHD children because the placements are unstable. Instability of placement does make treatment more difficult, but without treatment, the OOHC child and their placement are at-risk of failure. Carers do not need to face the troubles of untreated OOHC children and the problems of being unable to provide safe and adequate care, despite their good intentions. A change in philosophy about OOHC children and referral to an accessible mental health services is urgently needed.

As an additional concern, while there is evidence that children do better in homecare with a grandparent (particularly grandmothers), the grandparents often do worse on financial, mental, and physical health measures. Intervention for children in OOHC needs always to include intervention to support the carers emotionally and financially, intervention to help the children feel safe and to grieve their losses or trauma, and intervention with the parents who have not been able to offer appropriate care. They, too, have had terrible losses and usually have traumatic pasts.

A significant number of OOHC children have co-morbid conditions of Autism Spectrum Disorder, ADHD, and intellectual deficits. There is a significant overrepresentation of aboriginal children in OOHC. Intervention needs to be multi-modal and multi-disciplinary, and for extended periods.

A significant number of children graduate from OOHC and transfer to prison. This is an even greater cost upon the community. The strategic and long-term value of successful early intervention is demonstrable, but requires greater resources for long-term intensive work with these damaged and vulnerable children. The potential for significant effects on the budget bottom line deserves creative focus and innovation.

4.6 Early intervention services for infants, mothers, and their families

Interruption of the connection between mother and baby can have lifelong effects. Potential sources of disconnection are post-natal depression, domestic violence, and prematurity.

Post-natal depression affects mothers, but also many members of the immediate and extended family. PND places the mental health of the newborn at-risk and that of the siblings, as well. PND disturbs couple relationships and invites poverty on top of the vulnerabilities that come with PND. Grandparents may be able to ameliorate some of the troubles that follows PND, but not all families can draw on grandparental support.

Early identification of PND prevents progression of the depressive disorder and avoids the other consequences of neglected baby, neglected other siblings, and fractious relationships. PND is best picked up by the General Practitioner or by the Maternal and Child Health nurse. The MCHN is of great value to the family and demonstrates why a family/developmental model is of great utility. Prior to policy changes in 1995, the MCHN would often help post-partum mothers deal with siblings of a newborn who feel displaced. This did occupy the time of the MCHN, but had great value for all in the young family. This was ruled out by the changes that saw each mother and child offered only four sessions a year in the first year. This was a disaster for a cohort of young families and has been progressively wound back with the MCHN now able to offer help with siblings.

We have a group of young adults in our society whose sibling rivalry was never addressed and now who act out in various ways against authority. Those of us working back then were worried by this change and warned against that policy. However, the existence of the policy and the subsequent reversals demonstrate why family/developmental approaches are of priority.

Domestic violence can cause parents to be separated from babies, or leave caring parents unable to adequately care for their baby. This underlines the importance of inclusion of partners, children, and other family members, in any PND interventions.

Prematurity is not inherently impeding of strong and warm connection between mother and baby, but the shorter the period of gestation, the lengthier the period of post-birth hospital stay for the baby, and the increased likelihood of maternal absence when the baby wakes. Technology has created the conditions for survival of early premature babies, but it is unclear if this then affects the neurology of the baby as an ordinary consequence of growth external to the womb, or if neural distortions arise without the constant attention of the mother. These are important questions that have been researched for over thirty years, but without firm findings.

4.7 Intervention services for elderly persons with mental health needs and their families

At the other end of the life span, frail, aged, and intellectually declining older persons represent severe challenges for loved ones and for professionals. Helping the elderly maintain some sense of dignity and competence in the face of such changes is difficult, demanding, and constant. If the person has had a history of mental health problems, these can magnify. On the other hand, if personality changes arise, family members can be shocked and hurt by their loved one's attitudes.

Physical and cognitive changes associated with aging have significant effects on partners and family members. It is common to have presentations of teenagers acting out with drugs, refusing school, showing anxiety and depression symptoms, and only when the family is included in the process does it emerge that a grandparent has become unwell and the parent of the teenager (child of the elderly person) is struggling with the care of the elder, leading to withdrawal of the capacity to parent and leaving the teenager feeling s/he is to blame and a failure. Opening this process up is an effective treatment strategy in these situations so that the parent can share his/her distress and grief, and the teenager can clarify that his/her father's changed behaviour is not about him/her.

Another issue is the use of ECT with this age group and the reviews of how this is used, whether appropriate psychological treatment is offered (in addition to medication) before it is recommended or indeed imposed. While we accept that there is a place for ECT treatment, we hear that families' wishes are not respected and indeed ignored, and often no psychological treatments are offered. Examples include elderly person saying "I just want to die" after losing partner and being deemed at risk of suicide and recommended for ECT. Subsequent memory loss, inability to recall names of grandchildren, and anger by family who disagreed with the treatment decision can follow. Psychological treatments should be offered to elderly persons with depression and where possible their families should be invited to be involved.

The recent dying with dignity legislation in Victoria represents another aspect to the last period of life where the decision to end one's life needs to be thought through, discussed at length and in detail, and with the support of health professionals.

Within the proposed family/developmental model of mental health service provision, there needs to be funding for the establishment of specialist teams to work with families in any of the above circumstances, and sufficient funding to train the professionals involved, as this is a relatively new field that will expand as the population ages.

4.8 Intervention services for substance users with mental health needs

Substances that affect consciousness have an ancient history, but in contemporary times, mind-altering drugs have been able to be manufactured in relatively modest laboratories and sold through networks outside any legal framework and beyond Police detection. Poly-drug use is commonplace. Many of the drugs cause biochemical addiction that resists attempts by users to be rid of damaging drug habits.

Illicit drugs have many damaging effects beyond addiction. Changed behaviour affects family harmony and increases the risk of domestic violence. Drug habits affect family income, productivity at work, and employability. Drug habits lead to connections with networks of crime and to periods of jail. Illicit drugs, when poorly manufactured, can be lethal. Many users disregard such risks.

Substance use is significantly implicated in cases of removal of children from unsafe homes due to neglect or abuse. In turn, the addicted parents find the pain of loss of the children to be only assuaged by the drug abuse that caused the removal in the first place. Similarly, lost adult intimate relationships fuel the urge to use.

The interaction between mental health and drug use is complex. Drug use may precipitate mental ill health. Mentally unhealthy people may seek relief in illicit drugs. The cycle of use and distress is reinforcing. Personality disorders can occupy a space between drug use and psychological distress. Both are individualizing experiences.

The best antidote is to bring the person back into connection with others; who may be family, friends, health professionals, or other users. The process is likely to take a long time and is likely to include periods of relapse. Group programs are important as the longevity of Alcoholics' Anonymous has demonstrated.

4.9 Intervention services for anti-social youth and adults; including stimulant medication for ADHD adults

Recent violence at the Juvenile Justice Centres in Parkville and in Malmsbury have brought this problem to the fore, but it has never really gone away. The development of the Child Guidance movement, the prelude to Child and Adolescent Psychiatry, was instigated by research into juvenile delinquency by Healy (begun 1909, reported 1915).

Anti-social behaviour has its source in poverty and discrimination against non-mainstream groups (often with ethnic or migrant identity). But there are significant numbers of people in prison who are untreated adults with ADHD.

The ADHD person is not intrinsically anti-social; it is just one of the current pathways to adulthood with ADHD. There are many people with the condition who are law abiding and respectful citizens, but have trouble focusing, holding down jobs, or pursuing study. Nearly all ADHD sufferers have problems with self-esteem as they can identify a weakness in focusing ability relative to others.

ADHD is a disturbance of attention that may include overactive behaviour, but more commonly is expressed through a failure to focus. This can be hard for the child trying to learn and for the teachers trying to help the learning, but the behaviours are often considered a form of naughtiness that deserves punishment that might include very harsh or abusive means of control. In children, the syndrome can be treated effectively with small doses of stimulant medication.

A problem arises when the child turns eighteen years of age and controls are very tight on the subsequent prescription of the drug. The young adult can become uninhibited and impulsive and a danger to self and others. If the young person was never treated, they are also likely to have self-esteem problems and anger to go with their impulsive risk-taking. These young people often end up in prison and often have multiple relationships with children being raised by a sole parent. It has been estimated that one in ten people in jail have undiagnosed ADHD. If treatment could be provided to at-risk young adults, much trouble might be prevented through reduced road incidents, traffic fines, unwanted pregnancies, and the dangers of self-administered street drugs. It is advocated that prisoners be screened for ADHD.

Treating ADHD in dangerous adults is an investment in community harmony and family health. Treatment needs to involve the five-component model of integrated intervention and relies heavily on establishing a safe treatment contract that accommodates well controlled use of stimulant medication along with psycho-education, context changes, and trauma therapy. At the context level, family therapy and couple therapy may be needed so that all know what the problem is, and all learn how to manage it best.

Similarly, there are many people in the wider population who could benefit from such treatment. People with risky behaviour and poor achievement, who experience themselves as "fuzzy-headed" or as having difficulty in focussing, should be encouraged to be assessed. Chronic users of cannabis can often give up their drug of choice when treated with stimulant medication.

Increased access to stimulant medication, through adult psychiatry, could lead to major savings for the society through reduced rates of imprisonment. Increased work productivity, and reduced family disruption and violence. Separating the ADHD sufferers from the broader anti-social population would have benefits, as well. Further, purposeful anti-social behaviour could then be attended to more directly.

There is at least one further problem that can be foreseen. The number of psychiatrists in Victoria who prescribe stimulant medication for adult ADHD is already exceeded by the current demand for assessment, and diagnosis. The professional group, Victorian Adult ADHD Interest Group, meets monthly and constantly reports exceeded demand for each patient. There is a training shortfall, but there is also a shortfall in the understanding of the disorder and the need for access to services. This is an urgent gap in services that needs to be addressed.

Treatment for anti-social behaviour does not have a strong record of success because those who have the condition are usually unperturbed by being anti-social, indeed, they may well enjoy such perception. Detention is the commonest effective intervention because the person is removed from situations of anti-social action. Sometimes family can be involved in influencing more socially acceptable behaviour, but often family have grown tired of the behaviour and have turned away from their anti-social family member. Once again, the stimulation of connection may produce a pathway to rehabilitation, and needs to be tried. The cost of not attending to anti-social behaviour is probably greater than failed attempts at rehabilitation.

Another option is further development of restorative justice programs were offenders meet with those damaged by anti-social behaviour and take responsibility for their poor decisions and provide concrete action to enable those offended against to feel safe once more.

4.10 Intervention services for those who self-harm

Perhaps the greatest change in presentations since 1986 has been the rise of non-suicidal self-harm. Such self-harm is often associated with diagnoses of personality disorder in youth and adults, along with depression among those older than ten years. While those who died by suicide are likely to have had incidents of non-lethal self-harm, most self-harm is directed at alleviating feelings of anxiety and psychological pain by the substitution of physical pain and pleasure at the sight of one's own blood. This is hard to imagine for those who do not self-harm, but seems perfectly natural to the self-harmer.

Of course, this is dangerous behaviour. The dangers of the behaviour are evident to the self-harmer, and shame and guilt can flow from the scars incurred, but the need for relief exceeds the estimates of risk and later signs of damage. Research is needed into the phenomenon to help develop preventative strategies: provision of health information is simply not enough.

Suicide rates have been greatly reduced in the most seriously mentally ill since 1986. This is probably due to the increased rates of contact and the constant use of risk assessment tools and safety plans that were developed to prevent suicide.

This group of consumers were once placed in psychiatric hospitals and received care in an environment where self-harm was less possible than when living in the community. There were many good reasons to close such facilities with their archaic practices and histories of unkind behaviour toward the residents. However, some people would benefit from good quality care in such a facility. No such facility exists, and Emergency Departments can only provide crisis care and crisis management. Specialist facilities for self-harming and suicidal consumers may need to be built.

SECTION 5: Getting things done

MHYF Vic has attempted to present a comprehensive architecture for a new mental health system for Victoria. We have tried to provide both models of philosophy and models for action, however, there is a level of detail upon which we would defer to experts in the relevant fields, so long as consumers and carers have input to the design and implementation of particular protocols for action.

Further, these action protocols require trained staff of experience and expertise to deliver the various programs. MHYF Vic is a consumer advocacy group, but it is also a practitioner advocacy group which is largely compromised of very experienced practitioners. We believe the next generation of professionals have particular needs that must be addressed through government policy and through specific training programs. Again, these would probably need to be designed by those closest to the particular domain of professional action.

Thirdly, such programs and training need to be suitably funded and made appropriately accountable. The resource implications of the various proposals tendered by MHYF Vic cannot be easily determined outside the financial branch of the government. However, we can discuss some aspects of resource implications.

Fourthly, the changes need to be monitored through a specialist unit to measure the impact of the new policies. There were a number of unintended consequences of the focus upon the most vulnerable adopted in the 1986 Act. Unintended negative consequences need to be identified early and ameliorated as soon as possible.

5.1 Intervention protocols

Philosophy, model of intervention, and strategic priorities are the underpinning to a renewed mental health service for Victorians. But these notions require formalization as action protocols which are endorsed by professionals and acted upon when relevant.

Intervention protocols for self-harming, substance use, post-natal depression, out-of-home care mental health response, adult ADHD treatment, and aboriginal mental health need to be described, but are beyond the scope of this submission and belong to specific expert organizations and people to define. But it is important that these protocols be defined and integrated within the framework offered in this submission.

We present in Appendices 3 and 4 protocols for intervention in overall case planning (the five-component model of integrated and coordinated mental health intervention) and a protocol for referral and intake (the access consultant as Networking Agent). These are examples of the many operational protocols that need to be developed. We offer these as examples of the detail that might be need for the Royal Commission to provide in order to facilitate the radical change in mental health service delivery that we believe is required.

It is unclear how best to assist pre-school service providers with knowledge and action protocols that would enable early detection of mental health difficulties. We simply assert that this is the age at which detection can happen and can offer appropriate engagement with early intervention services. We do not wish to burden the sector with an extra responsibility, but we do see the resource advantages of having early intervention referral a usual activity of early childhood educators.

MHYF Vic has concerns that the intervention protocols that might be the most attractive are those related to so-called evidence-based treatments. MHYF Vic has sought to report examples of effective intervention with various disorders and within various domains in building our atlas of best practice. However, we are concerned that much of the research on evidence-based treatments that claim to be "gold standard" are studies done within university clinics with people who have mild conditions and unitary diagnoses. There are very few studies with such tight controls on people with multiple diagnoses and who suffer from multiple disadvantage. Most people who have mental health problems would not qualify for "gold standard" studies. Incidentally, these sorts of studies are very difficult to do with models of therapy that were not developed in university clinics (for instance, CBT, IPT). This is not to say that such methods are not effective, it is to say that more complex and creative approaches to treatment are not as easily researched at the "gold standard" level.

Workforce issues are very much part of MHYF Vic's concerns. We are concerned about processes of recruitment, training, upgrading of skills, workplace health and safety, and workforce participation in decision-making. We believe resources will need to be allocated for retraining staff on any outcomes recommended by the Royal Commission.

5.2 Workforce

Victoria's public mental health system and community health system, in accord with international standards of patient care, generally propose a multi-disciplinary approach to delivery of services to patients. This is enacted in most settings by the employment of a workforce that includes clinicians with specialist training and professional recognition in the range of basic disciplines deemed relevant to the particular setting, notably Psychiatry, Child and Adolescent Psychiatry, Paediatrics, General Medical Practice, Clinical Psychology, Forensic Psychiatry, Clinical Neuropsychology, Social Work, Occupational Therapy, Speech Pathology, Child Psychotherapy, Family Therapy and/or Psychiatric Nursing. In the multi-disciplinary approach, the assessment, treatment planning and treatment of patients are contributed to by a team of medical, psychological and social work specialists, as well as of other specialists as relevant to the presenting problem. Each team member consults with the patient as many times as is needed, and a case conferencing process governs ongoing management of the case, ideally then implemented by an allocated case manager.

In practice in most settings in Victoria, however, this multi-disciplinary model of mental health services is subsumed under a medical model, whereby medical practitioners are the chief consultants, appropriately manage all questions of medication, and have a good deal of influence over how patients may be referred around the system, both public and private. In addition, and more alarmingly, the multi-disciplinary model is often compromised by the heavy caseloads of clinicians, such that involvement of the various disciplines relevant to the individual patient is prevented by the existence of excessive wait-lists, or even actual unavailability of a worker of a particular discipline.

Another challenge to the multi-disciplinary approach is the employment of non-medical clinicians (called "allied health workers" in the medical model) to positions that are considered "Generic", with the role of performing "Case Management". This is commonly the case in Tier 3 settings. Where this happens, and where (as usually happens) the case manager has an overload of allocated patients, generic counselling may be the best service that is offered, without the patient receiving the benefit of the specialised assessment and treatment skills the multi-disciplinary team could deliver. This is especially the case in relation to Psychological team members.

The current challenges in enabling the multi-disciplinary team model to benefit patients clearly stem from inadequate funding of the various services involved, which results in too few clinicians being available to meet the assessment and therapeutic needs of patients, and cutting of corners to achieve throughput of patients in order to create space for the new referrals that constantly present. This means that greater resources are needed to expand the workforce in all settings, and policies relating to appropriate multi-disciplinary service delivery and case conferencing need to be actively developed, implemented and monitored.

Similarly, the overall family/developmental approach recommended by this Submission has several specific implications for workforce, in addition, that will need to be resourced. Fundamentally, policy change will require engagement of community agencies and consumers with mental health professionals in the design and implementation of the model, its procedures, and its instruments. Particular experts will be needed to write procedures and design instruments. There may need to be training, recruitment, and employment of new categories of professionals beyond case managers, such as Networking Agents or pre-school screening experts. Upgrading of professional knowledge bases would be needed to enable clinicians to conduct family/developmental mental health work within case management plans developed through the five-component model of integrated intervention; different professions and different levels of seniority may require different levels of intensity in such training, for example it may be that MCHN and Aged Care assistants will need more intensive training than other professions. Finally, an expanded professional workforce would be needed to provide oversight, ongoing case consultation, and evaluation procedures to support the new model of intervention.

5.3 A review of the practical problems in implementing the NDIS and what can be learnt about other innovations in the mental health service system in Victoria

The National Disability Insurance Scheme (NDIS) has the potential to lead significant national reform in the provision of community-based support for people with psychosocial disability. Central to the NDIS are personalized responses to enable people with permanent needs due to disability, the opportunity to exercise choice and control in the pursuit of their goals, and the planning and delivery of their supports.

Hayes (Research Specialist, Parenting Research Centre, Melbourne in *Australasian Psychiatry, 26*(6), 2018) in the best known study to date aimed at identifying the most effective interventions for early intervention in psychosocial disability in the), found strong evidence base for what the NDIS terms ‘capacity-building support’ for people with psychosocial disability, especially early in their experience of disability or early in the implementation of their plan.

Three interventions that were studied (supported employment, supported housing and social skills training) meet evidence base, personal choice and recovery criteria, and are likely to reduce future support needs. Additionally, they meet commonly expressed goals and preferences for participants. Outcomes evidence for another four interventions (cognitive remediation, cognitive behavioural therapy (CBT) for psychosis, physical health management, and illness self-management) indicates they can assist with mitigation of impairment. Further interventions that more clearly meet participant needs such as the challenge of loneliness and isolation should also be considered.

The supports identified have the potential to offer significant gains in people's capacity to participate when applied early in their experience of psychosocial disability, or early in their NDIS plans, so should be routinely considered during NDIS planning.

Research findings so far suggest that early intervention in the NDIS may enable people to reduce their reliance on the scheme in the future, hence reducing costs for the scheme or reducing pressure on other health and welfare services. Many people with psychosocial disability especially could benefit from an early intervention approach.

However, it is evident that "few early intervention plans have been developed to support participants over the age of 18 years who are living with psychosocial disabilities. . . . Despite estimates that 64,000 could be eligible, there are already indications that people with psychosocial disability may have more difficulty establishing their disability and may be at risk of poorer outcomes in the scheme compared to participants with other disabilities." (Please refer: Mental Health Australia. Response to the Productivity Commission National Disability Insurance Scheme (NDIS) costs position paper. Deakin, ACT; Mental Health Australia, 2017).

While the NDIS offers benefits there also appear to be an added layer of complexity in seeking support which may have unhelpful consequences.

The following notes outline one chronically mentally ill person's application for a Support Plan and experience of delayed and inadequate implementation. This particular experience endorses one of the possible outcomes of seeking an NDIS-funded Support Plan: that some psychosocially disabled people, now called consumers, may have great difficulty establishing their disability and may be unwilling to advocate on their own behalf and thereby add to the risk of poor outcomes. The goal of describing some negative experiences is to suggest that ways of circumventing difficulties to improve outcomes may be helped by the practices of "Open Dialogue" and compassionate listening.

Negotiating a Support Plan, on behalf of the mentally ill person, that is, the consumer, the family, may be stymied by the service system that is supposed to provide support. Vested interests of providers may lead to inadequate or inappropriate funds allocation. Unfamiliarity with NDIS terminology and concepts and their application, and poor knowledge base and experience can result in significant misunderstandings between family advocates and workers. These kinds of experiences can add unnecessary layers of distress due to feelings of not being heard or understood nor supported through the process and could hinder positive outcomes for consumers. Poor partnering of service providers with family and carers may exacerbate misunderstandings.

Misunderstandings about Support Plan goals can result in inadequate networking for appropriate services. In some instances, the application of the term "capacity building" may result in benign neglect because it has been interpreted as 'don't allow dependency'. The very real disabilities of a consumer may not be understood at all because they are subtle or so basic that they are hidden and cannot be addressed.

While a Support Plan with considerable funding may be obtained, funds may not be accessed and used in a timely way for beneficial support. Lengthy delays in implementing a Support Plan may also not facilitate desired outcomes. If a new provider is sought additional delay may result in almost no service delivery prior to annual review. Poor or no monitoring of service provision may result in undesirable outcomes that can be harmful for the consumer.

Applying a monetary value of Support Plans may lead to envy and rivalry between consumers due to varying practices that require confidentiality. This may be more likely where a consumer's accommodation includes disabled people who have not accessed Support Plans.

Some consumers are vulnerable to exploitation via the portal system of access funds when the consumer cannot access the portal independently such as, in the situation for example, of delivering transport funds directly to the consumer and may unwittingly lead to misuse of funds.

5.4 Resource implications

When trying to estimate the overall costs and benefits of radical change, it is very difficult to assign dollar values. Radical change usually has high initial costs during the transition, and it is hoped that lowered overall costs emerge in time. MHYF Vic is not in a position to make such estimates, however, we believe that the proposed changes will be resource positive as we would hope to draw upon the resources of previously unaccessed supporters on consumers and carers.

MHYF Vic believes that a lot can be done that will not cost much at all. We believe that savings gained through prevention and early intervention can be transferred for innovation. We infer that the Victorian government's assertion that the system is broken means that the government is seeking to provide funds to fix the system. We encourage spending to facilitate the important changes.

We envisage costs of transition in training staff and in the provision of printed and other materials. We envisage costs in the appointer of Network Agents in MH services. We envisage costs through an increase in demand because services will have lowered their criteria for entry and will allow greater numbers of sessions for consumers and their families. We envisage costs developing and implementing effective mental health programs for aboriginal people and their families. We envisage costs in the development of interventions for OOHC children. We envisage increased costs with the treatment of adult ADHD in public MH agencies. We envisage costs in the expanded services within pre-schools and in maternal and child health centres.

However, we expect the effect of the improved services and the availability of early intervention will lower costs across the board and relatively quickly. Treating PND with a multiple intervention at an earlier stage will save much heartache later. Getting adults onto ADHD treatment will reduce costs in traffic fines, job instability, crime, drug abuse, and educational achievement almost immediately. Helping OOHC children earlier and more effectively will lower costs endured by schools and carers. Helping aboriginal families earlier will save the next generation from the ongoing cycle of trauma and poverty. We expect these savings to flow quite quickly. We would recommend that the Royal Commission consider establishment of an agency that measures changes in outcomes and costs in order to monitor the effectiveness of the new vision.

SECTION 6: Coda: recommendations and conclusions

MHYF Vic recommends:

1. The adoption of a new philosophy of mental health service delivery based on a family/developmental understanding
2. Integrated and well-articulated tiers for mental health service administration
3. Regional Health Service responsible for public sector funding should have a management Board that includes consumer and carer representation, as well as officials of the agencies.
4. Mental health intervention to include five components, as described by the five-component model of integrated intervention
5. Priority be given to the following domains of mental health service activity:
    a. Prevention services
    b. Improved access with family engagement
    c. Services for aboriginal mental health
    d. Services for OOHC children
    e. Early intervention services for infants and mothers
    f. Services for elderly people and their families
    g. Services for substance users with mental health needs
    h. Services for anti-social youth and adults (including adult ADHD)
    i. Services for those who self-harm
6. Protocols be designed and implemented that enable access and family engagement
7. Strengthen the role of General Practitioners in mental health care planning and provision
8. Ensure the existence of multi-disciplinary teams in complex cases, delivering the full range of professional interventions, including psychotherapy
9. Pre-school and maternal and child health clinics be supported as early detection agencies
10. Implementation of workforce development programs associated with the new policies
11. Establishment of a coordinating service within Community Health Centres, supported by shared specialist staff from area mental health services, capable of undertaking case assessments and case management of referrals from any of the other components in the system who have deemed the case to be beyond their capabilities
12. Establishment of a resource monitoring unit to measure changes that result from the new policies

TABLE OF APPENDICES

APPENDIX 1: Review of past mental health legislation in Victoria

Initially, the legislation of the Port Phillip district was concerned with mental health institutions, then was directed to the patients (lunatics), then was enlivened with new metaphors (mental hygiene and then mental health). Throughout there has been emphasis on the workforce and the overview of their behaviour; more recently this has been about registration, which is now national.

Along the way, other aspects related to mental health such as the children's court, child welfare, and mental deficiency were subject to ongoing review.

The actual legislation changed across the history of the legal entity which was the Port Phillip District (1836 - 1851), then the Colony of Victoria (1851 - 1901), and then the State Government of Victoria (from 1901). The legislation did not occur in a vacuum as until then, the statutes of the United Kingdom applied and shaped any subsequent legislation. Gaps in the local legislation were filled by the UK statutes.

The first relevant local legislation was the Hospitals and Charitable Institutions Act (1864) and the Lunacy Statute (1867). Charitable institutions like orphanages were required to be governed by trustees and committees or boards of directors elected by contributors. Institutions that complied with the legislation could receive grants from the Victorian government, subject to the condition that they submit statements of accounts and returns of contributions to the Treasurer. These were the subject of a Royal Commission into Charitable Institutions (1870)

By 1880, the Victorian government had appointed an Inspector of Public Charities, probably as a response to recommendations made by the 1870 Royal Commission into Charitable Institutions. The Inspector undertook the investigation of the management, and audit of the accounts, of institutions receiving assistance from the Government. This Act was repealed by the Hospitals and Charities Act (1890).

Hospitals and Charities Act 1890

Hospitals and Charities Act 1915

Hospitals and Charities Act 1922

Hospitals and Charities Act 1928

Hospitals and Charities Act 1948

Hospitals and Charities Act 1958

Children's Court Act 1906 (1906 - 1915)

Children's Court Act 1915 (1915 - 1928)

Children's Court Act 1917 (1917 - 1928)

Children's Court Act 1928 (1929 - 1957)

Children's Court Act 1956 (1957 - 1959)

Children's Court Act 1958 (1959 - 1974)

Children's Court Act 1973 (1974 - 1992)

Children's Welfare Act 1924 (1924 - 1929)

Children's Welfare Act 1926 (1926 - 1929)

Children's Welfare Act 1928 (1929 - 1955)

Children's Welfare Act 1933 (1933 - 1955)

Children's Welfare Act 1954 (1955 - 1959)

Children's Welfare Act 1958 (1959 - 1971)

Community Welfare Services Act 1978 (1979 - 1983)

Community Services Act 1987

Children's Services Act 1996

Child Wellbeing and Safety Act 2005

Children, Youth and Families Act 2014

Children and Young People (Safety) Act 2017

Lunacy Act 1928 (1929 - 1959)

Lunacy Statute 1867 (1867 - 1890)

Mental Deficiency Act 1939 (1939 - 1959)

Mental Deficiency Act 1958 (1959 - 1962)

Mental Hygiene (Mode of Citation) Act 1943 (1943 - 1959)

Mental Hygiene Act 1933 (1934 - 1959)

Mental Hygiene Act 1958 (1959 - 1962)

Mental Health Act 1959 (1962 - 1987)

Mental Health Act 1986 (1987 - 2014)

Mental Health Act 2014

Lunacy Statute (1867)

12. Every medical practitioner signing any certificate under or for specify facts upon the purposes of the last preceding section of this Act shall specify which opinion of insanity has been therein the facts upon which he shall have formed his opinion that the formed. person to

whom such certificate relates is a lunatic, distinguishing in such certificate facts observed by himself from facts communicated to him by others; and no person shall be received into any asylum hospital or licensed house under any such certificate which purports to be founded only upon facts have been communicated by others,

The word "lunatic" shall be construed to mean any person idiot lunatic or of unsound mind and incapable of managing himself or his affairs, and whether found lunatic by inquisition or not.

The words "lunatic patient" and "patient" shall be construed to mean any person detained at the commencement of this Act in any public or private establishment in Victoria for the reception of insane persons, and any person hereafter received into and detained in any asylum hospital or licensed house under the provisions of this Act.

Lunacy Act (1928)

“Lunatic" means any person idiot lunatic or of unsound mind "Lunatic and incapable of managing himself or his affairs, and whether found lunatic by inquisition or not”.

"Lunatic patient" and “patient" mean any person detained “Lunatic at the commencement of this Act under any Act hereby patient - repealed or at any time received into detained or ordered to be received into or detained in any hospital for the insane hospital for the criminal insane”.

27. Every medical practitioner signing any certificate in connexion with the reception of any insane person into any hospital for the insane receiving house receiving ward or licensed house shall specify therein the facts upon which he has formed his opinion that the person to whom such certificate relates is insane or apparently insane distinguishing in such certificate facts observed by himself from facts communicated to him by others; and no person shall be received into any hospital for the insane receiving house receiving ward or licensed house under any such certificate which purports to be founded only upon facts communicated by others.

Mental Hygiene Act (1933)

This Act was largely cosmetic, directed at changing the words used to define actors such as Inspector-General becoming Director, and certain facilities being given new names. Yet, some words remained, such as “lunatic”. It was not until the next Act that the term “mentally ill” was introduced in place of “lunatic”. Lunacy had been re-worded by the Mental Hygiene Movement of Clifford Beers, founded in 1907 in Connecticut, USA. The international movement for mental hygiene was replaced by the Mental Health movement in 1949.

Mental Hygiene Act (1958)

"Lunatic" means any person idiot lunatic or of unsound mind and incapable of managing himself or his affairs, and whether found lunatic by inquisition or not.

"Lunatic patient" and "patient" mean any person detained at the commencement of this Act under any Act hereby repealed or at any time received into detained or ordered to be received into or detained in any mental hospital, hospital for the criminal insane, receiving house, receiving ward, or private mental home.

Mental Health Act (1959, operative from 1962)

“Mentally ill" means to be suffering from a psychiatric or other illness which substantially impairs mental health.

“Patient" includes a repatriation patient and any person who is in any manner under any control or supervision as mentally ill or intellectually defective, and until discharged under this Act any person who was under detention control or supervision, or who is absent on trial leave or parole under this Act or any corresponding previous enactment, or who is boarded out or in a private mental home or private training centre but, does not include a voluntary patient.

Important in this new definition is the distinguishing of type of patient: Voluntary, Recommended and approved, Security, and Repatriation. There is also a change to the number of practitioners who can “Recommend”.

43. (1) Any person who in the opinion of two medical mental hospital practitioners is mentally ill may be admitted into and detained in a mental hospital or private mental home on the recommendations of the medical practitioners made in the form prescribed if it appears that each of the medical practitioners has separately from the other personally examined such person not more than seven clear days previously to the admission of that person and upon production of a request in the prescribed form signed either before or after the recommendations under the hand of some person accompanied by the prescribed statement of particulars.

In the enactment, the legislation repealed: Mental Deficiency Act (1958), Mental Hygiene Act (1958), and Public Trustee Act (1958).

Mental Health Act (1986)

Several major changes were made to the Act, some of which were terminological and many of which were about raising the rights of patients and oversight by autonomous bodies. The extent of the changes in this Act are not to be underestimated, but most of the improvements required further adjustment in the 2014 Act.

A person was seen as mentally ill if he or she ‘has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’. Added to this were grounds for exclusion: a person could not be thought to be mentally ill because of certain conditions, beliefs, views or behaviours. These included intellectual disability, immoral conduct and sexual promiscuity among 13 other conditions.

Involuntary assessment and treatment were divided into three parts: request and recommendation, Involuntary Treatment Order and Community Treatment Order. Interim treatment could be given by the registered medical practitioner prior to the person seeing the Authorised Psychiatrist if it was not in the person’s interest to wait and if the person was unable to consent.

The person could be placed on an Involuntary Treatment Order to prevent a deterioration in their physical or mental condition or for the protection of the public. The person could be placed on an Involuntary Treatment Order if they refused or were unable to consent to treatment.

A patient had a right to a second psychiatric opinion. The obligation of the Mental Health Review Board or the authorised psychiatrist to consider the second opinion was not prescribed.

Information must be provided to the patient about their rights, yet, there was no provision for a patient to nominate a person to receive information about their treatment and care, and there was no mechanism to support patients to exercise their rights.

The authorised psychiatrist was able to provide substitute consent to ECT for involuntary patients if they did not have the capacity to consent. Informed consent (for patients with capacity) was not required if the authorised psychiatrist was of the view that the ECT was urgently needed. The 1986 Act was silent on children and ECT.

Restrictive interventions were defined as seclusion and mechanical restraint only. Mechanical restraint could be used for the purpose of medical treatment, to prevent the person causing injury to self or another and to prevent a person persistently destroying property. Seclusion could be used to protect the person or another person from immediate or imminent risk of harm or to prevent the person from absconding. A person subject to restraint and seclusion was required to be seen every 15 minutes by a registered nurse and examined every four hours by the authorised psychiatrist.

The chief psychiatrist was required to be given a report on episodes of seclusion and restraint every month.

The Mental Health Review Board had the function of reviewing Orders and treatment plans and hearing appeals on behalf of involuntary patients and security patients.

The Mental Health Review Board was instituted with the function of reviewing Orders and treatment plans and hearing appeals on behalf of involuntary patients and security patients. The MHRB had to act with equity and good conscience without regard to technicalities or legal forms and was bound by the rules of natural justice.

The authorised psychiatrist required to prepare, review and revise a treatment plan for each patient on a regular basis. The treatment plan had to contain an outline of the treatment the patient was to receive and had to take into account the wishes of the patient, any guardian, family member or carer (if the patient agreed) and any beneficial alternative treatments available.

There new guidelines for monitoring, mostly by the chief psychiatrist, but with little definition of the functions of the chief psychiatrist. The chief psychiatrist received and investigated complaints or concerns from mental health consumers, but a complaints function was not assigned to any particular body.

Community Visitors were to visit mental health services in the region for which they were appointed and were able to inspect any part of the premises, make enquiries about and see any person receiving treatment unless that person asks not to be seen. They were able to inspect any document or medical record if the person receiving treatment had given consent in writing and any other records required to be kept under the Act.

Mental Health Act (2014)

The major changes in this Act relate to upgrading patient welfare and rights, including recognition of the rights of consumers and carers and facilitation of processes of monitoring of governance. Also, of significance was the ongoing monitoring of the professions through registration processes. The Act was devised to effectively protect the rights articulated in the Victorian *Charter of Human Rights and Responsibilities 2006* (the charter) and the United Nations' *on the Rights of Persons with Disabilities* (the disabilities convention). The changes do not alter the working definition of a patient, but five further exclusions were added related to antisocial behaviour and economic or social status and gender identity.

Briefly, the changes include a more rigorous compulsory orders regime, the presumption of a capacity to consent to treatment, the enacted right to a second opinion for patients, inclusion of a signed statement by patient about treatment which the psychiatrist must take into account, even if the decision is to override the advance statement, the capacity of a patient to nominate someone to act on their behalf, employment of consumer advocates, consent for ECT by patient that, if declined, cannot be overridden, ECT for children when least restrictive method available, and tightened procedural guidelines for the Mental Health Tribunal.

There were substantial changes to restrictive interventions. restrictive interventions are defined as seclusion, mechanical restraint and physical restraint (mechanical restraint and physical restraint are together categorised as ‘bodily’ restraint). Restrictive interventions can only be used to prevent *imminent* and *serious* harm to the person or another person. Bodily restraint may be used if necessary, to administer treatment or medical treatment. There is no provision for bodily restraint to be used to prevent the destruction of property. There is no provision for seclusion to be used to prevent absconding.

The concept of the treatment plan has been dropped in favour of a Treatment Order that has to be ratified by the Tribunal. The Treatment Order must state whether the Order is a Community Treatment Order or an Inpatient Treatment Order and the Tribunal must have regard to the person’s views and preferences, the view the person expresses in their advance statement, the views of the nominated person, guardian, carer and parent if the person is under 16 years of age including any recovery outcomes they would like to achieve.

A person who is subject to a Temporary Treatment Order or Treatment Order (or their guardian, parent of a person under 16 years of age) may apply at any time while the Order is in force to the Tribunal to have the Order revoked.

The powers of the chief psychiatrist have been defined: the role is broader and includes clinical leadership, continuous improvement, promotion of rights and advice to the Secretary. a total of 11 functions are made explicit and include:

- monitoring compliance with standards and guidelines
- monitoring quality and safety
- undertaking clinical and practice audits
- the analysis and publication of data.
- to assist mental health service providers to comply with the Act

The Mental Health Complaints Commission was established, being appointed to Governor in Council on recommendation by the Minister. The Commissioner has functions including:

- to manage and investigate complaints relating to mental health service providers
- to resolve complaints in a timely manner using formal and informal dispute resolution and conciliation
- to issue compliance notices
- to provide advice, information and education to mental health service providers about their responsibilities for managing complaints
- to assist consumers and other persons to resolve complaints directly with mental health service providers
- to identify, analyse and review quality, safety and other issues arising out of complaints and make recommendations to providers, the chief psychiatrist, the Secretary and the Minister

Community Visitors are appointed by the Governor in Council on the recommendation of the Public Advocate. There is a requirement for the Public Advocate to appoint an equal number of male and female Community Visitors as well as people from diverse backgrounds. There is no reference to Community Visitors being appointed for each region. The term of office is defined as three years and some exclusions are identified (that the Community Visitor is not to be an employee of the Department of Health). Minimum monthly visits are no longer specified.

***Nurses Act* (*1993)* and *Medical Practice Act* (*1994)*.**

These mark the beginning of tighter registration of all professions. Eight new Acts of Parliament were subsequently passed, and common core provisions were introduced to regulate the registered health professions. However, not all of the health practitioner registration Acts were updated to incorporate the modern provisions. Subsequently further legislation was introduced: *Health Legislation (Miscellaneous Amendments) Act (2005)* and *Health Professions Registration Act (2005).*

Health Practitioner Regulation National Law (Victoria) Act (2009)

This allowed for National registration and the formation of the Australian Health Professionals Registration Authority.

Child Protection Acts

As far as can be seen, there have been nineteen Acts of parliament since the Children's Court Act of 1906. Most recently, in 2017, Children and Young People (Safety) Act was introduced which was designed to hasten the process of permanent placement of children who had been removed from their parents. Children had been languishing in care under the previous Act which allowed parents to continue to have rights regarding their child, if the child was visited twice a year or more. This meant the status of a child could be on hold for indefinite periods and produced instability in the child and in the placement; that is, in the minds of the carers.

MHYF Vic is part of a coalition of community and professional agencies who regard this legislation as authorizing the estrangement of children from parents in a manner similar to that involved the forced removal of aboriginal children. The fundamental objection to this legislation is that it attacks connections and sets the children up for mental health problems.

Children who come to out of home care are a particular concern for MHYF Vic as they can be destined to multi-generational problems that might be better addressed by family-based intervention at an early stage of development. As with the legislation concerning adults with mental health problems, individualizing the subject of distress is not the solution; it is a recipe for maintenance of disorder and of preventing recovery.

Conclusion

Not long after a massive set of legislation changes, we enter the process of a Royal Commission. It is worth reflecting upon the trajectory of all those changes.

There has been a move since the last Royal Commission (1870) from buildings to administrators, from patients to consumers with rights. Along the way, there have been more processes of review which have been associated with legal actions and tribunals, although natural justice has been more to the fore in recent times. There has been less support for restrictive interventions and violence against patients. More recently, there has been recognition of the needs and rights of children, but mostly the regulated activities have been about the most disturbed people with the most disturbing conditions. These people are in the public mental health system. However, most mental health services are consumed by moderately well people in private practice locations and living within families of variable functionality (prior to the 1986 legislation there was much use of the pejorative term “worried well”).

The history of the changes within the system since the days of the Port Phillip District has been of programs and procedures for the most ill. History can map patterns of failure. The pattern has been clear; there is a need to move away from programmatic responses to classes of at-risk adults, to a more integrated and recovery-oriented system.

APPENDIX 2: A five-component model for coordinated and integrated intervention

One of the major criticisms of the existing mental health system concerns the lack of coordination and integration of services and interventions, the lack of a multi-disciplinary team approach, and a lack of conceptual coherence. It is proposed that the model presented below will be understood immediately by many in the child and adolescent mental health field and by many who practice with adults, as this equates to ordinary practice.

The significance of the model is that it has finally been articulated in a way that can help unify and integrate intervention through multi-disciplinary work. The model provides a simple test of adequacy of response (have we covered all components? and, do the interventions fit together?) that can be communicated between professionals and agencies and provide a readiness of accountability. It is hoped that consumers and carers could use the model to check if adequate and integrated services are being provided.

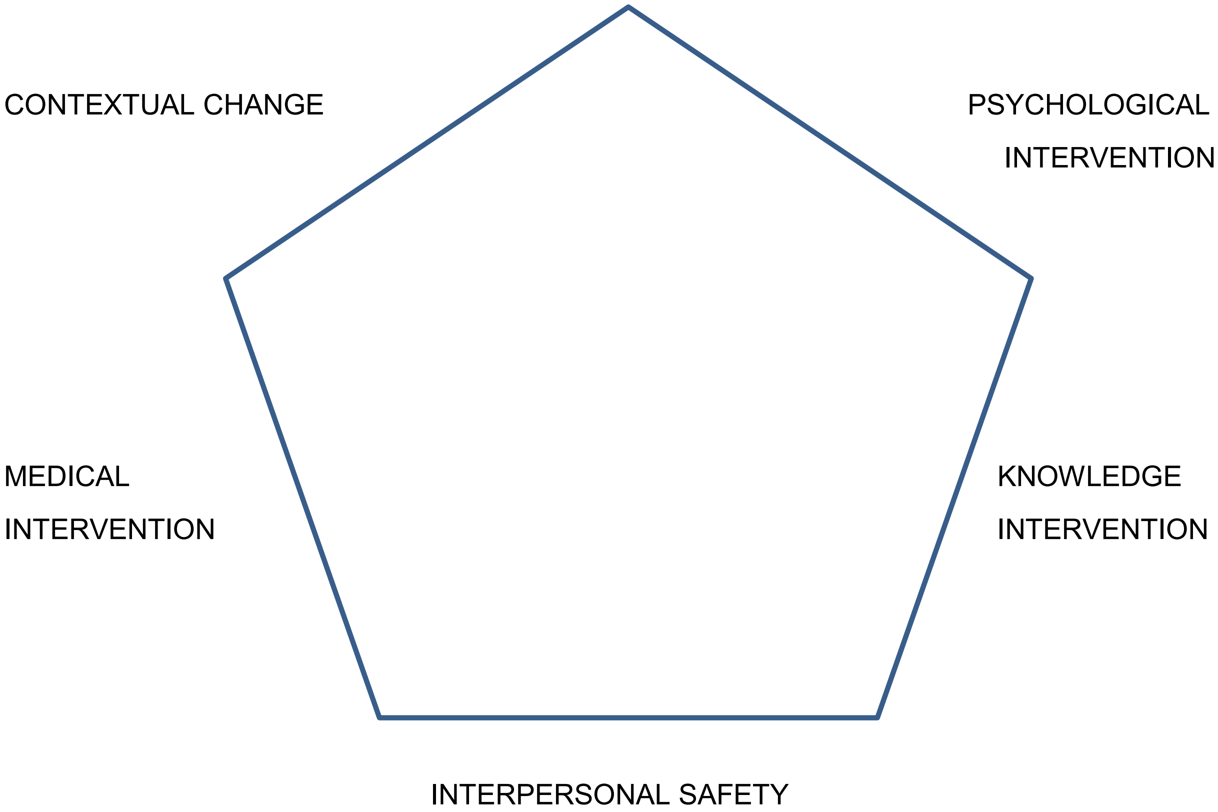
This model arose through practice with adults with Attention Deficit Hyperactivity Disorder (ADHD) and presented at the recent 7th World Congress of ADHD in Lisbon, Portugal (25-28 April, 2019). The more general applicability of the model was recognized during the presentation. It is presented diagrammatically, below. In fact, the model has been in practice for many years, but has not been formalized.

The five components are: Interpersonal safety, Medical intervention, Knowledge intervention (psycho-education), Psychological intervention (trauma focus), and Contextual change. It is proposed that effective intervention has always required action on all these fronts, but the links between each intervention have usually been generated on an ad hoc basis, and the overall structure of interventions had been hidden, even though the participating multi-disciplinary professionals (psychiatry, psychology, social work, occupational therapy) provide interventions that cover each of these components. This is not a new model; it is an articulation of current practice that formulates integrated practice.

It has been pointed out that the five components could be arranged diagrammatically as points on a star, which has some appeal. However, the pentagon is preferred as a pentagon contains within its boundary all the professional and consumer activity with respect to mental health difficulties, and describes the necessary lines of communication. Secondly, a pentagon has a firm base which corresponds well with the notion of interpersonal safety. Thirdly, a pentagon comes to a peak that indicates a shared direction of purpose. A star could imply heading off in five different directions. This is a metaphor for the work, of course, but the image of containing and collaborating is helpful to understanding the shared task of all involved.

All five components are needed, but there is a natural sequence of interventions. Interpersonal safety concerns precede all intervention; a consumer needs to feel safe before being able to commit to a program of intervention. Early on, medical examination is needed to rule out physical causes and to assess the constraints that any physical conditions may have upon a program of recovery. Almost at the same time, and to enhance feelings of safety and professional trust, the consumer needs sensitive and accurate education about presentation, about potential treatments, and about timelines for action. All of which requires appropriate communication that addresses any concerns of consumers and of important others. Important others need to be included to enhance safety and to support intervention.

Psycho-education need not be provided by the medical team member; social workers, psychologists, and occupational therapists can be involved, especially if they are to help with the other forms of intervention. At some stage, psychological work will need to be done, if only to address the trauma of the period of distress; but often long-term work on sources of trauma will be required. Similarly, the network of persons associated with the unwell consumer need to be consulted and sources of exacerbation of symptoms and sources of support investigated. In cases of adult ADHD, for instance, after medication and psycho-education and the beginnings of trauma therapy, partners, family, workplaces and work colleagues, and friendship groups need to be considered, perhaps just through the consumer, in order to find ways to enhance the social situation and to remove sources of negative influence (for example, drug dealers, bullies, marital conflict). Family therapy or couple therapy might be useful. It is suggested that this last option, often overlooked, can further enhance safety and speed up the effects of other interventions.



Interpersonal safety is difficult to define and is often overlooked. Existing practice holds that the consumer should give esteem to a diagnosing psychiatrist by virtue of training and position. It should be assumed that a professional will act with integrity and respect. This assumption obscures the simple observation that unwell people fear external control and do not easily welcome the intervention of powerful figures. The perception of undue force is not far from many people's consciousness when they encounter the mental health system in an unwell state, particularly if they have had unhappy outcomes in the past.

All professionals need to attend to the interpersonal safety needs of the consumers within their care throughout all periods of contact, and especially in the initial stages. In turn, such attention increases the safety of all present and subsequent practitioners who do not have to encounter fearful or dangerous consumers distressed by their presentation and the initial greeting. Included here would be sensitivity to physical needs, cultural practices, and other differences of ethnicity, religion, sexuality, or disorder (for instance, personality disordered people at presentation experience high levels of antagonism directed against them, independent of the actual behaviours of the professionals). Interpersonal safety is best determined contextually by being engaged with levels of arousal and distress within the consumer.

A2.1 Case examples used to test the five-component model against both current presentation and future practice as usual

Seven case examples are presented that have been checked for plausibility among the committee of MHYF Vic. The case studies were written from general mental health experience and with the philosophy of the family/developmental approach to mental health. Each study was written as if the five-component model had become an ordinary part of professional practice that facilitated both case planning and communication between interveners in a coordinated and transparent way. The matters are somewhat reduced in their complexity and the process is described as if the case plan emerged relatively easily. Of course, this will not happen so easily in real practice, but the case studies provide templates for how the processes might be managed.

The five components of the five-component model are: Interpersonal safety, Medical intervention, Knowledge intervention (psycho-education), Psychological intervention (trauma focus), and Contextual change. Effective intervention has always been required action on all these fronts, but the links between each intervention have usually been generated on an ad hoc basis, and the overall structure of interventions had been hidden, even though the participating professionals (psychiatry, psychology, social work, occupational therapy) provided interventions that cover each of these components. This is not a new model; it is an articulation of current practice that formulates integrated practice in a transparent way.

To repeat: seven case examples have been written to indicate how the model could be applied to specific cases. Each involves multi-disciplinary teamwork and multi-disciplinary case conferencing. These cases are obscured versions of real cases and have been tested for plausibility among the committee of MHYF Vic. The name of the person provided in the heading indicates the person who was of primary concern at the point of recognition and of referral. As will be seen, the person referred is not always the person that needs most professional attention.

The purpose in writing these case studies is to demonstrate how the model can be used in the beginning stages of contact in a wide variety of presentations to enable case planning and to ensure coverage of all relevant clinical concerns. The model can then be used to ensure communication between professionals and to review cases when things change.

A2.11 Case example 1: Jimmy and his post-natally-depressed wife

Jimmy attended the first Maternal and Child Health clinic with his wife, Tran, and the newborn baby, Michael. Jimmy was very pleased. The couple had achieved their pigeon pair and their daughter, Harriet, was happy to have a baby brother. Harriet was being looked after by Tran's sister, who had twin four-year-old girls who were at pre-school this morning.

Jimmy rambled on about having the family they wanted and planned. Tran sat silently cuddling the small baby. She did seem as happy as Jimmy described. The baby was underweight, which Jimmy wrote off with the comment “we are small people; it’s our Vietnamese background!”. The baby was also very quiet; Jimmy was pleased and recalled how noisy and difficult the first baby had been. The MCHN listened and observed and asked if she could talk with Jimmy on the telephone in the afternoon. She asked if they had been back to their GP since the birth and encouraged them to visit as soon as possible. She checked who the GP was and said she would contact the GP to report on progress since birth.

When the MHCN called Jimmy, she asked if he was concerned about his wife or his new child. He admitted he had been very positive about the situation because that is what his wife had asked him to do. In fact, he was worried about how unhappy she was, and he was not getting enough sleep, as he felt he needed to be awake for her when she had her nightmares. He drove a delivery van for Asian goods, mostly food, and worked across Melbourne. He had taken to calling in whenever he was in the area of the couple’s home, and she would be pleased to see him and he would then find it difficult to leave, again.

On investigating, the MCHN found that the family had good support from both sides, even though both sets of grandparents were still working long hours. His parents had an Asian foods shop. Her parents worked in real estate. She had a sister who was very supportive and would come around on the mornings when the twins were in kinder. Some days Harriet would go to work with her paternal grandparents, but usually Tran would ask them to take the baby instead.

When the MCHN asked Jimmy if he needed to go to the doctor for his sleep problems. he said he did not want to sleep more soundly because of Tran’s nightmares. The MCHN suggested he take Tran to the GP to see if she could get help with her dreams. He thought that was a good idea and said he had already booked in for later in the week for the post-birth follow up appointment with the GP. The MHCN called the GP later that day and discussed the probable diagnosis of post-natal depression and the potential need for an inpatient stay in a mother-and-baby unit.

When the couple turned up with the baby, the GP was well-prepared, discussing how live had been changed by the new arrival. Tran volunteered that her daughter seemed jealous and she thought Harriet might have hit the baby once. Jimmy was surprised by this news. Jimmy said he was not sleeping well, and the attention turned to Tran’s nightmares and then to her low mood. The GP noted how quiet the baby was and wondered if the couple might be concerned about this. They both responded that this was much better than when Harriet came home.

Eventually, the GP said that he felt that Tran was post-natally depressed and needed some rest in a MAB unit. They discussed how this could happen and sick leave was arranged for Jimmy and he was provided with some sleeping tablets for when Tran and Michael while in the unit. The GP contacted the MAB unit and arranged admission for the following Monday and the opportunity to visit the unit that afternoon.

The whole family visited the unit and were welcomed by a Social Worker, admission details were confirmed, and a check was made of family supports. Tran had been reluctant from the start, but having had an explanation about why the admission would be helpful and that it was not her fault that she was having a very sad period in her life when she thought she should be overjoyed, Tran agreed. Jimmy called his boss and explained the situation and he was immediately allowed time off work on sick leave. Harriet wondered why mummy was going to hospital and seemed angry that the baby had made mummy sick. The Social Worker explained that having a new baby was hard work, but she did not remember this as a hard time because babies don't remember things all that well. Harriet did not remember being a baby.

The Social Worker explained that Tran would have the opportunity to meet with a counsellor during her stay and talk about her worries. Tran did not seem to think that was necessary, but Jimmy thought that might be a good idea as she not been talking like she used to do. The Social Worker then asked about family supports and suggested that the grandparents and the sister could have a chat with her about coordinating support for the period after she left the unit.

After they left, a letter was sent to the GP and to the MCHN explaining what the immediate plan was and suggested that a longer-term plan would need to be made after some assessment during the inpatient period. The Social Worker suggested the plan would probably need a counselling option and a psychiatrist familiar with treating PND. They had one on their staff who would assess during the stay, but it was likely that ongoing care might need to be arranged independent of the unit, but that the unit would communicate with the psychiatrist once the arrangement had been made. Further, it was suggested that Tran would need regular, if not weekly, visits to the MCHN. The Social Worker then wrote that she felt that this plan met all parts of the five-component model in the immediate term and into the future, but that she would be interested to discuss any other matters that might be included in the plan.

When the GP received the letter, he called the MAB unit to check on Tran and talk with the Social Worker. Tran had settled well, and the baby already seemed brighter. They talked through the plan and agreed that the five-component model was complete.

A2.12 Case example 2: Sexually-abused Eleni

Eleni had been down for weeks and she no longer seemed to want the rebel lifestyle that had infuriated her parents for several years. Her younger sister asked if anything was wrong as she seemed unhappy and not interested in her social life. Eleni disclosed date rape. The sister immediately suggested visiting the new female GP at the family's regular GP clinic and an appointment was made. The sister also called the nearest CASA and made an appointment for Eleni.

The GP considered the situation as presented and suggested that it might be sensible to discuss the events with her parents, but Eleni refused as she felt her "bigoted Greek" father would only yell at her and tell her "I told you so". The sister felt that this would complicate things, but did agree things were already complicated. A check was made of other supports that Eleni might use. It was left for Eleni to discuss with her CASA counsellor.

After the first consultation, and with Eleni's consent, the counsellor contacted the GP and discussed a management plan based on the five-component model. It was felt that family therapy might be useful in the future, but not for the moment.

A2.13 Case example 3: ADHD Nicholas

Nicholas turned up at the family GP on his own for the first time in several years. He said he was having trouble sleeping. The GP had always been rather concerned about the erratic behaviour of this man and was not surprised to learn that he had lost another job. She was surprised that Nicholas had not told his wife. The GP advised him to do so that day. The GP also suggested that he might see a psychologist to discuss his inability to hold onto a job.

The next day Nicholas' wife, Jenny, saw the GP and laid out a host of complaints about his behaviour, his work attitude, his relationships with the three children, his family of origin and how

awful they had been to him, his use of cannabis or alcohol to calm himself down, and her level of exhaustion in coping with everything. The GP discussed the possibility of ADHD and said she would refer him to a psychiatrist for assessment. This would not replace what the psychologist would do, but it could help the overall management of the situation. She discussed with Jenny the possibility that she might be depressed, and Jenny burst out in tears. Neither she nor Nicholas had many other supports beyond each other. However, she did not want to take anti-depressants. She accepted a referral for family therapy after talking about her children.
The psychologist quickly confirmed the need for ADHD assessment and an appointment was made with a psychiatrist. The psychologist liaised with the GP and the family therapist and checked all interventions against the five-component model; the other professionals agreed that this was a comprehensive plan.

A2.14 Case example 4: Maureen the foster carer

Maureen had had enough. She called the agency Social Worker to say that she could no longer cope with her two foster children. Lizzie, 9 years, and Eddie, 6 years, had been with the foster family for eighteen months, having been removed from their “ice” using parents. There was a baby brother who was still with the mother and had just turned two years-old. The parents had broken up before this baby was born and there were intervention orders in place to prevent contact with the father and his partner and their children. It was the school who alerted the Child Protection service to the plight of the children, just three months after Eddie had started prep.

The Social Worker had been an infrequent visitor to the foster placement and had always admired the efforts that Maureen had put in to help the children, not just care for them. Maureen’s husband, Brian, had been an enthusiastic support, initially. Now she said he was working longer and longer hours. He would always be doing things to help their adult children on weekends; he was a handyman by trade, and he would spend days fixing things at their sons’ homes.

Maureen talked about the children and their troubles. The hard part for her was hearing stories of what they did at school. Lizzie had taken to bullying Eddie’s friends. Meanwhile Eddie was always in trouble for not sitting still and interrupting the learning of other students. He had taken to lying about what happened at school. Both Maureen and Brian were appalled by lies. Sometimes Eddie would lie about pooing his pants and hide the soiled underwear in his cupboard.

But the worst thing was the regular access visits at the local centre with the mother and their brother. She would often be late or not turn up at all. The baby would occupy the mother’s attention and Lizzie would get very jealous and distract herself by teasing Eddie. The mother would ask Maureen not to be present, and she had done this once, but the children told her that the mother instructed them to behave badly so the children would have to leave Maureen and return home. This was when the children were in a sort of honeymoon phase having escaped from their erratic mother to the safety of Maureen’s home. For several months, the children would not want to visit and afterward would be out of control, fighting with each other and repeating words that their foul-mouthed mother had just directed toward them. Maureen felt she was being actively undermined and no longer felt supported as foster parent by her absent husband.

Maureen finished with the Social Worker and a visit was arranged for two days' time. Maureen went to the GP to discuss her lack of sleep and her rising feelings of not being able to cope. Wisely, the GP called the Social Worker and asked if a treatment plan could be developed that included counselling for Maureen, anti-depressant medication, couple therapy, but most importantly treatment for the children. The GP and the Social Worker discussed other ways of support. It emerged that Brian and Maureen had not wanted therapy for the children as they believed that their love would be enough and a counsellor or two would make life too hectic. The Social Worker said she would contact Child Protection service and ask for suitable referral of the children. The Social Worker was surprised by the breadth of the plan, but the GP said he was just following the five-component model.

Fortunately, the CP service was able to expedite a referral to Take Two and engaged the School Support service to help with the troubles at school. The Take Two worker convened a meeting at the GP's office and set out a plan for the case according to the five-component model. Brian acknowledged his absence and apologized to Maureen and they visited the psychologist within the GP's rooms to talk through how to support each other better. Maureen continued to see the psychologist for further sessions after two visits as a couple. The involvement with Take Two and the now activated foster care Social Worker did involve many appointments, but things improved.

It emerged that the children were angry that they did not get to see their father. Take Two met with the mother and asked her to withdraw the intervention order against the father with respect to the two children. The father was very pleased to be able to see his children and the children's behaviour improved rapidly. The school arranged for Lizzie to have a support person and she stopped trying to be with Eddie and bullying his friends. He was referred for assessment for ADHD.
Regular meetings occurred and each professional or carer would check any changes to the plan against the five-component model.

A2.15 Case example 5: Self-harming Rachel

Rachel was taken for the third time to the Emergency Department by her housemate, Sophia. Sophia was getting rather sick of having to bandage up this woman, whom she had hoped would be a friend, to stop the flow of blood from her wrists and race her to hospital. Sophia did not know of the seven other appearances that Rachel had made to the ED with her former partner, Rex. "Not you again" said the triage nurse in a jocular way that indicated familiarity, but was not judgemental, either.

Sophia did not know of the diagnosis of Borderline Personality Disorder, either, even though when told this did make sense of Rachel's "hot and cold" behaviour toward Sophia and toward others. Sophia and Rachel had shared a flat for the past six months since Rachel had left Rex. Sophia had been looking for a flatmate for some time and she felt that Rachel and she had much in common: estrangement from family, work in administrative jobs, interests in music and movies, and the preference for a tidy home. Sophia, though, had been surprised by how fastidious Rachel could be most of the time and then how she would drop her bundle for a couple of weeks. Sophia thought this happened whenever Rex appeared and so she blamed Rex for the problems.

Sophia asked if she could talk with someone about her concerns about Rachel. She did not want to go behind Rachel's back, but felt the need to have a few things clarified and to get a few things off her chest. The triage nurse gave her a contact number for a mental health professional within the hospital.

Eventually, Rachel was stitched up, assessed by a junior psychiatrist, provided with medications, including sleeping pills, provided with a follow up psychiatry appointment, and was sent home with Sophia. Sophia was not happy! She tried to talk with Rachel on the way home, but Rachel refused to engage. Rachel hated the humiliation of facing the ED, but was thankful that Sophia had helped: but she did not say thank you.

Sophia was able to see someone at the hospital three days later and poured out her concerns about Rachel's erratic behaviour and horrible family. Another appointment was scheduled, but the counsellor and Sophia came to agree that Rachel needed intensive intervention and that Sophia could not be expected to continue to support Rachel.

The counsellor met with the duty psychiatrist and discussed Rachel's repeated attendance. She spoke with triage nurse who had become familiar with Rachel. She spoke with the psychiatrist who was due to see Rachel and urged the making of an appointment sooner, if possible. It was noted that previous attempts to engage had failed and the diagnosis of Borderline Personality Disorder was only provisional as Rachel never turned up for subsequent appointments, even if she turned up at all.

At the mental health team's weekly case meeting, Rachel was discussed, and it was agreed that an integrated set of interventions was needed. The first problem, though, was how to make Rachel safe in being treated by the psychiatrist and the mental health team. If the diagnosis was accurate, and there was now strong evidence that it was, especially with Sophia's description of her fluctuating behaviour, non-attendance was one symptom that needed to be managed or attempts to help would fail. It was decided that a nurse be sent to visit Rachel to check on her bandages and to offer to get her to her psychiatry appointment. The visit was planned for a time when Sophia would be home.

Sophia was surprised by the visit, as was Rachel. Nothing like this had ever happened before and Rachel was grateful for the attention as the stitches did not seem quite right. In fact, there were no real problems with the bandages, and these were replaced after the wound was cleaned up. Rachel accepted the offer to take her to her appointment. The nurse did a check of other possible supports for Rachel.

The psychiatrist began by saying how concerned the staff were by her repeated presentation with self-harm and how she might feel humiliated by such presentation. She agreed and acknowledged she did need medical help after she cut. He asked if he could be allowed to help her with her mental wounds and if she would attend for six months on an outpatient basis and also participate in a group program. He then discussed her apparent lack of connections. This caused some distress and he said that more could be talked about later. He asked about whether talking therapy had ever been tried and if it helped. She spoke of her school counsellor who tried to help, but things were too horrible at home for her to really benefit from talking, while still living at home. When she escaped, she felt so much better she did not want to raise anything to do with her family of origin, back home, interstate and in a small country town. She agreed that she did not really trust words or people. She was asked about how to make her feel safe and to begin to trust; she did not know, but was willing to try. She warned she might not be able to maintain her commitment. Rex, her ex-boyfriend, had complained that she lacked real commitment.

The psychiatrist reported back to the team meeting and it was agreed that Rachel should enter the group program and part of the work within the group program would be to monitor her social relations and her capacity for connection at a safety level. The team's Networking Agent would try to gather information about Rachel's connections and if support could be found outside of her accommodation. The therapy would continue with the psychiatrist. Sometime, in the future, internal referral for EMDR might be useful. It was agreed that if there were subsequent cutting events that the same nurse would visit to attend to the wounds. Triage was informed of the plan in terms of each component of the five-component model : build safety through the psychiatrist and the visiting nurse, help the consumer to understand her disorder through the supportive therapy and the group program, monitor her mental health state at the same time through both sets of contacts, work on contextual issues through the group program, and refer for trauma therapy once safety was secured and the sources of the trauma were starting to be clear. Triage was asked to be another participant at the safety level. It was decided that the group program person would discuss with Rachel the overall case plan and provide a written copy, and this could also be discussed in her therapy sessions with the psychiatrist.
A letter was sent to Sophia thanking her for help and informing her of the plan. However, Rachel had already decided to move house and was now living in a share house with two young men. This was where the therapy, proper, began.

A2.16 Case example 6: Dodgy Lorenzo

Larry had a tough background and overcome problems at home and school by becoming a bully and then a dealer in marijuana. His Italian background seemed to have opened some doors, even though his parents had migrated to get away from negative influences in Sicily. He had grudges against how father who he felt favoured his two sisters and their law-abiding husbands.

Lorenzo's mother, though she loved him for all his faults, would help him out when he got into awkward situations. For instance, by paying his many traffic and parking fines and getting the family lawyer to support him in court. It was never clear whether he caused trouble or trouble just seemed to find him. Things became much more difficult when his mother died, and his father became demented.

Larry's sisters felt obliged to help, even though they shared their father's distrust of his habits, and continued to support him in getting legal assistance when needed. He had managed to get off heroin through help with methadone and the support of the pharmacist, but still liked to visit coffee shops at night and play cards with his "old crew". He had taken over the family home.

The long-term family solicitor retired, and the office was taken over by a young, ambitious woman, who seemed to regard law as a means to rehabilitation, rather than a means for punishment. The new solicitor was very active in seeking consultations with a clinical psychologist and a drug and alcohol psychiatrist. At about this time, another series of traffic offences emerged, and CCTV footage had Larry at the scene of a crime; Larry maintained his innocence and expressed a lot of fear at going back to prison for a fourth time.

The solicitor was very strategic. Armed with the five-component model, she took on the role of making things safe and liaised with Larry's GP, who was rather tired of the antics of this patient.

Despite the company he was said to have kept, the solicitor believed that there was little value for the society to have him go to jail, and much risk for him being caught back in networks that he had wanted to avoid. She was clear about what the sort of assessment that was needed, while being careful not to impede the professional independence of the assessors. The psychiatrist was uncomfortable with implied directions from the solicitor, but this was accepted by the clinical psychologist.

The psychiatrist made Larry very clear about how his conduct problems needed to be changed. A referral was made for assessment of ADHD by another specialist psychiatrist. Both reports assessed Larry as more likely to benefit from a community order with specific recommendations for treatment, rather than imprisonment. Larry began therapy with the psychologist focussed upon trauma when he as connected to a motorcycle gang.
The GP offered to help Larry understand how treatment was to be provided and how it was to be integrated, but that he needed to participate in changing his context. Larry's sisters decided that they should help Larry to develop other friendships and would regularly invite him over for dinner.

A2.17 Case example 7: Dementing Agnes

Paul had been taken by ambulance to the ED after having been found slumped in his car at a shopping centre some way from his home. The car doors were unlocked and when he was revived, all he could do was ask about where Agnes was. Eventually, it was determined that Agnes was his elderly partner and they had stopped at this place because he felt ill. She may have got out of the car to try to help, but was demented and would have become disoriented very quickly.

An urgent call from the ambulance officer established that Agnes had been found wandering earlier in the day and had been taken to her brother's home by Police. Paul was suspected of having a stroke and was taken to for immediate assessment and admission.

The brother had called Agnes' sons, his nephews, who lived interstate and told them of their mother's mysterious appearance several hours after the unattended lunch date that the couple must have never got to; the Uncle did not know where Paul was but wanted his nephews to know lest something terrible had happened.

The Police were informed of the nephews' contact numbers and asked if they could help with the care of their mother and with providing background information to the hospital about the stroke patient. This was worst nightmare for the brothers. Eight years earlier there had been a family discussion about their mother's declining state and two of the siblings were worried and two weren't. The most worried, a professional occupational therapist, travelled to Melbourne to assist at the hospital. The other brother made arrangements to visit the Uncle over the next weekend.

At the hospital, Paul refused to speak to the son, whom he did not trust and openly said so. This son then went to speak with the social worker on the unit to explain as much as he could. Paul had always distrusted the OT son, but was in good terms with the other brother. The OT son did the nasty heavy lifting and the other son the nice stuff, which worked well, but meant the latter son had to take on all sorts of legal responsibilities for estate and assets of both older adults.

The social worker took out the five-component model and discussed options with the OT son. He was surprised to learn of this model and quickly appreciated its utility in case communication and planning. There were problems of consent and confidentiality that meant hospital staff could not speak with the OT in great detail, but this line was managed well. There were problems of neurological assessment of the stepfather, but it was clear that the mother was demented, and her partner had been barely coping with the care of her, but had refused to communicate the extreme vulnerability to her children.

The five-component model for the stepfather could not be completed very well, as there was a lack of knowledge about his affairs, but it was clear that he would need aged care and they hoped the two could be placed together. The mental health status of the mother needed to be assessed, but only after she was admitted to a facility. On the weekend, the mother was admitted to the same hospital, but on a different ward. Paul would visit her, but would soon need to go back to bed to sleep.

The brothers conferred with their overseas resident siblings and it was decided that the couple needed to move to be near the homes of the Australian resident sons. In the meantime, both parents needed to be protected by the Public Advocate office. After several weeks, temporary accommodation was found, and two months later, the couple were transported to the state of the sons. The OT son used the five-component model to navigate the system and to plan interventions for the short-term in Melbourne, and for the longer0term when the move away was confirmed. Suitable, shared, aged care in a high dependency unit was arranged and the couple remain in acre together. Paul has declined over time.

A2.2 User’s guide to coordinated and integrated mental health intervention for case planning, for ongoing process, and for accountability

The five components for integrated intervention in mental health practice are not abstract ideas. They have been used for over a century. The innovation, here, is that the accumulated wisdom of the field has been articulated through packages for treatment.
In each case plan, each of the components needs to be considered, along with assigned roles for particular practitioners and communication lines established. With all participants having expectations of case planning using the five-component model, efficiencies in the process will be developed and connections made that will expedite future case planning.

A2.21 Case planning

The first contact agent (intake worker, GP, ED nurse, family member, youth worker, Maternal and Child Health Nurse, pre-school educator, employer, solicitor, Housing officer, Police officer …) needs to locate the professional most suited to the role of Interim Case Manager. This may be a lasting role, but is crucial to beginning with a comprehensive approach.

The Interim Case Manager needs to help the consumer (and connections) feel comfortable with seeking treatment and with the process of developing a case plan. If a GP is the Interim Case Manager, arrangements would be made for consumer (and connections) to be assessed medically and psychiatrically, while information is provided about treatments, other referrals, and prognosis: such knowledge will enhance the sense of interpersonal safety.
Referral for psychological assessment needs to occur with relative haste and, through liaison between those already involved, decisions would need to be made regarding management of psychosocial and contextual needs. It may be that many of such factors can be managed by the

consumer or family members. The psychiatrist and psychologist may be able to help with these matters. Within a public mental health service, a Social Worker may provide such services. The key is to check if all five components are covered and processes put in place to address particular aspects of each component, as the need arises.

A2.22 Case process monitoring

Once the treatment plan is established, agreement on roles, responsibilities, ongoing case coordination and communication patterns need to be affirmed. In some cases, this may only require exchanges between the GP and the psychologist, with infrequent psychiatric review. Within public mental health services, case management teams (of psychiatrist, mental health nurse, social worker, occupational therapist, and psychologist) might require weekly meetings. In all cases, frequent communication with the consumer (and connections, if warranted) would be needed to ensure interpersonal safety and not to overload the consumer with professional input.

A2.22 Accountability

The five components for integrated intervention can be used to ensure accountability. The consumer and carers can point to each component and ask the professionals to explain how and when certain needs will be addressed. Third parties, such as friends and neighbours, could also point to other needs or express concern over the case plan. Other professionals, like solicitors or physiotherapists, may be able to ensure that their clients, who have mental health care plans, are being appropriately and comprehensively treated in an integrated and coordinate way.

A2.23 Transparency

The five-component model allows for carers and consumers to check on the interventions being offered in terms of adequacy, coordination, and breadth. That is, the interventional package is transparent to those for whom the package is provided and open, therefore, to refinement from the consumers and carers. Mental health intervention has not had transparency as priority in the past; with this model, transparency is a given that professionals will need to recognize in their transactions with their patients.

A2.24 Integrated intervention

People live in connection and resources can be drawn from communities and families to support a person with mental health needs. Integration requires a case plan that covers the five components and is coordinated, with clear lines of communication.

It is asserted that integrated and coordinated intervention plans will make intervention more efficient in each case, although this may be time-consuming, initially. The delays in putting a plan together will recede as the understanding of the plan and its elements grows

It is expected that connections will develop between professionals across public and private lines and within particular clinics. Enhanced cohesion across the system will be built on a case by case basis. Integration of services will be built from the bottom up, and with consumer involvement.

APPENDIX 3: Referral and intake processes: the access consultant as Networking Agent

In recent years, the trend has been to consider the first contact role as akin to emergency room triage, but this is a mistake. PhD research by MHYF Vic President, Jo Grimwade, distinguished the triage function from mental health access consultancy in the following ways: for mental health access there is neither a no treatment nor death option; action has to occur, if only to suggest alternative options. Secondly, triage involves minimal conversation and much expert action; mental health access requires respectful conversation and consented action. Thirdly, mental health access involves developing trust and security with an unknown system; triage involves rapid decision-making about subsequent actions that have relatively clear and pre-determined outcomes. Triage involves minimal time; mental health access takes as long as it takes, often this can mean a half-hour telephone exchange.

The primary purpose of access consultant is to encourage contact with the best available professional. How a GP or emergency room professional enacts such a transaction needs to be informed of this primary purpose and not to act in triage mode. Similarly, the mental health agency intake worker needs to have a similar attitude; but it is probable they already intuitively act this way, or, at least, that is what was reported in the research.

The principles for action are relatively straightforward: take time to facilitate a positive attitude to a process that may hold fears, help the consumer consider alternatives, offer alternatives, prepare the next professional for the possible presentation of the consumer, and provide details to ensure the consumer knows who to contact, how to contact, and where to go. Answer questions that help frame the consumer’s expectations in a realistic way that has a view to the several steps that might be involved.

One aspect to the principles for action concern the permeability of the tertiary mental health services. MHYF Vic believes the walls are too high for access to these services. Too many people needing highly skilled response are excluded. This is especially true in cases of suicide where inpatient care is warranted in the less severe mental health presentations as suicide attempts are more characteristic of less severe mental health problems.

We are also concerned by the operational rule of C&A MHS that children in out-of-home-care rarely are accepted. The premise is that specialist help for recovery has to happen against a background of stability of the placement. We believe that treatment creates the conditions for stability otherwise not able to be obtained by child, parents, or carers. We believe carefully thought through integrated interventions can help severely disturbed children in care.

The actual practices will vary according to contact context. The protocol for referral acceptance and intake action can be defined quite closely for a MH agency and could be used by other first contact agents to establish their own protocols. It should be obvious that this is not a triage protocol.

Stage 1: Greeting the potential consumer and establishing if the agency is appropriate to discuss consumer needs

Stage 2: Initial data gathering; confirming appropriateness or starting to consider alternatives

Stage 3: Considering alternatives; making suggestions and establishing timelines for action. Establishing connectedness with others of the consumer and who would enable referral and subsequent contact (family, friends, employer …)

Stage 4: Explaining mechanics of referral and intake and answering questions about reluctance, stigma, and judgements. Discussing participation of others

Stage 5: Planning for alternate pathway or taking referral data

Stage 6: Smoothing the way for internal or external referral and intake; seeking consent to talk to others, including important supports; termination of contact making expectations of next steps clear, once more

Stage 7: Documentation and checking of data; passing on information in timely way

The purpose of initial contact with the best available professional is to establish in the mind of the consumer that the professional can be helpful, will listen, and will not judge.

The principles for action, again, should be straightforward: address concerns, describe approach, describe collaboration with others, describe short-term and immediate goals, describe how assessment leads to treatment and the period over which contact might occur, and then gain signed consent for engagement and for contact with important others (professionals, family, friends, employers …).

The actual practices will vary, again, according to contact context, but also with respect to presentation, engagement with important others, participation of other professionals, and to treatment options that the professional might use. The processes whereby important others are engaged need also to be described. Although, actual practices for particular agencies cannot be prescribed here, the details should be able to be used to generate specific protocols for action.

Family engagement should be integrated into the processes of access. The procedure described here is focussed on engaging with family members estranged by time, events, or geography. The process would not be so complicated if the consumer is willing to meet at the agency with parents, or sibling, or other, who has remained in contact with the consumer. The people most compromised by mental illness are often the ones most estranged or isolated, and the ones with important others more reluctant to be involved. A secure and conservative process needs to be implemented for such cases. But then purpose of connection as part of the solution should remain a clear purpose.

Where possible, at the first point of contact for the consumer, attempt should be made to gain a listing of family members (and other important persons) by name, birthdate, probable address, and telephone number. This may not be possible within the scope of a request for a referral, but needs to be collected early in the process to emphasize the importance of gathering resources from concerned others as a means to providing support and generating solutions that are family based.

Consent to contact important others needs to be obtained; this is better in signed form, but agreement over the telephone should be sufficient to begin the process of finding others who might be willing to contribute to recovery.

The consumer and professional can then use a letter template to personalize a message to potential supporters of the consumer. This is then sent by the agency to the potential other seeking engagement in the process of recovery. Included with this mailing would be another template letter that an important other could use or modify to send back to the agency consent to be contacted or not, with contact details provided where necessary. Once received the agency would contact the important other and discuss the next processes.

When ready, the consumer and the potential supporters would meet at the agency with the focus upon what all could contribute to wellbeing and harmony. This would enable the completion of the five-component set of interventions in cases of severe mental illness and in cases of sub-clinical presentation.

The role of the professional overseeing this process of connection in MH agencies needs to be defined. In private practice services, the functions of the role would need to be understood and acted upon by the professional concerned. For lack of another title, it is proposed to call this professional the Networking Agent or Networker.

The Networker would be someone involved with referral and intake duties who would have extra duties, or someone who works solely in the defined role. The role has the following functions:

- Actively seeking to link consumers with important family and friends who may have become remote to the consumer, but who would like to contribute to the consumer's wellbeing,
- Trace lost connections,
- Facilitate initial meetings, and
- Follow-up where necessary, but leave subsequent interactions to the professionals already involved.

The role is specialist and is time-limited. The Networker is not a case manager, but aids and supports case management. Other changes can support case management efficiencies, as well.

APPENDIX 4: Zero waiting list intake and short-term treatment

It is possible to run a zero Waiting List intake and short-term treatment program, but it requires rigorous timetable management. The time required for treatment is the same as when there is a waiting list; the difference is when the treatment is provided.

All accepted referrals are offered an intake appointment within one week of contact. This requires the Intake worker to reserve appointment spaces for the anticipated interviews. Crisis same day referrals require special flexibility, which can be dealt with by reorganising the administrative hours. All new cases are scheduled to have ten hours of casework time and ten hours of administrative time, normally spread out over a ten-week period. Every face-to-face client contact hour inevitably consumes a further administrative hour of report writing, telephone calls and liaison with other agencies, case discussion and staff work. The first couple of casework hours are in intake/assessment followed by a **maximum** of eight hours of short-term treatment. Clients are then usually discharged. Some are resolved in a shorter time, but some are transferred to a longer-term follow-up program.

All staff must schedule 40% of their time on the Intake/STT program and 60% on other work. For a full-time employee this means about eight hours of client contact per week in this program, plus about eight administrative hours, which copes with about one new client each week and about eight ongoing short-term cases. The other 60% includes the long-term cases, specialty programs or discipline-specific tasks such as psychometric testing, and agency tasks such as consultancy to other agencies.

This plan is based on research showing that about 70% of cases will be successfully treated in the short-term timeframe, which consumes about one third of available staff time. The other 30% take much more time but this method avoids the 70% having to wait long periods before they are seen. It is analogous to the Supermarket Express Checkout.

The method, however, is not a solution for under-resourced services. As one full-time staff member can maintain a throughput of about one new case per week, a referral rate of five new cases per week will need five staff members to maintain quality service. If there are not enough staff members to meet this demand, the quality of the service will be sacrificed in one way or another. Either the long-term treatment and support would have to be curtailed or case referrals refused. (The traditional waiting list did this by making people wait so long that they went elsewhere in a state of considerable dissatisfaction with the poor quality of service). One psychiatrist in private practice resolved this by making assessments of all referrals but immediately sending most of them back, untreated, to the referring agency with recommendations about further management. Clients are generally unhappy with that solution and the preferred management is for cases to be assessed and treated by the clinician of first contact.

Intake is best undertaken by experienced caseworkers. This is because the initial session lays the groundwork for the therapeutic contract, generally offering the greatest opportunity for establishing trust and rapport, and an indication of whether the problems can be dealt with by brief intervention or will require an extended treatment program. This advantage is lost when the intake worker is insufficiently skilled, particularly if the case needs to be transferred to another worker for treatment.

Intake interview needs to cover:

- A summary of the issues of concern and the client's rating of their severity
- A genogram of the client family including psychosocial histories of members
- A description of the social circumstances of the client family

If the Intake worker is experienced, the intake and assessment processes can be seamlessly merged, and a conclusion reached as to whether the treatment is likely to be achievable in short-term intervention or that longer term arrangements must be made. If it is to be short-term, the experienced worker can continue with the case already engaged. If it is not likely to resolve with short-term treatment it is **not seen** in the short-term program but seen in the longer-term program.

If there is no trained and experienced Intake worker it is still possible for a novice to gather the necessary information, but it is preferable for it to be done using structured and standardised instruments such as the Achenbach Child Behaviour Checklist, the Family Assessment Device and (in the case of adolescents) the Youth Self-Report Checklist. In this way the novice gains experience and the necessary information is available for monitoring by supervising staff. A novice should not make treatment decisions unless under supervision.

The **assessment** needs to additionally cover:

- Mental state appraisal of relevant family members
- Family function appraisal
- Commitment of the family for a therapeutic process

At the end of assessment, a case-formulation and **management plan** should specify:

- The nature and extent of the problems perceived by clients and therapist
- The supposed predisposing, precipitating and perpetuating reasons for the problems
- The changes acknowledged by clients to resolve their problems (treatment goals)
- The treatment plan agreed with clients to bring about those changes (therapeutic contract).

The treatment may be in the short-term program (if it is anticipated that the goals can be achieved in that timeframe) or in appropriate longer-term support and treatment where necessary. The latter includes referral to other agencies.

The issues of concern and the extent of achievement of treatment goals of all clients should be periodically reviewed and recorded. This self-monitoring is essential for quality improvement and for evidence of effectiveness. This is needed for advocacy and funding submissions. "Evidence-based programs need program-based evidence, and this is how you get it".

Dr Allan Mawdsley MB BS, BA, DPM, FRANZCP, OAM, KStJ.

APPENDIX 5: IACAPAP DECLARATION ON THE RIGHTS OF INDIGENOUS CHILDREN, ADOLESCENTS AND FAMILIES TO MENTAL HEALTH AND WELLBEING, July 2018

The International Association for Child and Adolescent Psychiatry and Allied Professions

IACAPAP DECLARATION ON THE RIGHTS OF INDIGENOUS CHILDREN, ADOLESCENTS AND FAMILIES TO MENTAL HEALTH AND WELLBEING, July 2018

IACAPAP declares recognition of certain fundamental mental health rights of children, adolescents and families of indigenous communities everywhere, in concert with the United Nations Convention on the Rights of the Child (1990) and the United Nations Declaration on the Rights of Indigenous Peoples (2007).

Indigenous communities are identified as those within nation states that can regard themselves and be regarded by others as indigenous on account of their descent from the people who inhabited a particular territory (land and waters) at the time of conquest or colonisation of that territory, and who, regardless of their legal status, retain some or all of their own social, economic and cultural traditions. This statement follows United Nations policy, set out by the Indigenous and Tribal Peoples Convention of the International Labour Organisation (1989) and by the website of the UN Permanent Forum on Indigenous Issues (2018).

IACAPAP's Declaration on Children's Rights (Jerusalem, 2001) asserts that all children have the same and equal human rights. Additionally, IACAPAP calls for special recognition of the rights of children affected by Maltreatment, War, Terrorism and Disaster in its Rome Declaration (2003). In this context, **indigenous children, youth, and their families face unique challenges to mental health and wellbeing, challenges stemming from colonisation and dispossession**, often involving warfare which only sometimes resulted in a treaty. The sustained brutality of associated massacres, poisonings, rapes and genocide campaigns commonly leads to transgenerational trauma in communities. Of course, for some, warfare is ongoing today, but wherever colonisation has occurred within the memory of the community, we find that children and youth can continue to experience emotionally its horrific impacts. In addition, colonial dispossession of homeland and of traditions of culture, language, spirituality, kinship structures, and child rearing practices has typically left communities with an abiding sense of loss, affecting group identity and individual self-identity and dignity. Continuing colonisation by modern, globalised culture and policies of assimilation can further erode traditional culture, often bringing a continuing questioning of basic values by the young.

With remarkable resilience, creativity and commitment to their children, indigenous communities live with an awareness of the great effort required for survival in the face of unemployment, physical and mental health problems, family discord, substance abuse, and justice and welfare issues. The lives of their young can be challenged by absence of hope, even despair, fuelled by negative discrimination, frequent racist persecution by society and governments, and, in some places, extremes of trafficking, sexual exploitation and child labour.

It is acknowledged here that one of the barriers to addressing the damage wrought by colonisation is that the beneficiaries of colonists appear to inherit, in parallel with indigenous people, disturbing effects of oppression and dispossession. **Members of mainstream society remain victims too, often experiencing deep-seated and largely unconscious anxiety and guilt related to their ongoing failure to act with humanity, if not to historical wrongs.** This awareness of their own loss of humanity in relation to indigenous people is kept at bay both by denial of their own people's history and by a dissociation of feelings accompanying continuing processes of colonisation and oppression.

Of course, we cannot speak of attempting to heal the ongoing trauma of colonisation while such processes remain at play. However, indigenous children, as infants and growing young people, may benefit from the special acknowledgement offered by this Declaration. Members of IACAPAP, which represents child and adolescent mental health organisations across the world, can **use this Declaration to join with indigenous groups to advocate, at many and varied levels, for recognition of the rights of indigenous children and youth to mental health and wellbeing. Such advocacy is an ongoing responsibility of the mental health field.**

Indigenous mental health professionals and community leaders have been consulted in the formulation of this Declaration. It is a **Living Declaration, to be discussed and amended in a continuing spirit of collaboration through regular reviews by indigenous communities and mental health professionals**, to ensure clarification of its complexities and to ensure its expanding relevance internationally.

Accordingly, IACAPAP declares special recognition of the following rights to mental health and wellbeing of children, adolescents and families of indigenous communities everywhere.

1. Indigenous children, adolescents and families have the right to experience good developmental health, mental health and wellbeing, in addition to safety and general social and emotional wellbeing in daily life, as identified by the indigenous community to which they belong.
2. Indigenous children, adolescents and families have the right to be recognised and respected as members of the indigenous culture which they identify as their heritage.
3. Indigenous children, adolescents and families have the right to good quality legal, justice, health and welfare services that are appropriately culturally sensitive and competent, as determined by the indigenous community to which they belong.
4. Indigenous children and adolescents have the right to be consulted as individuals about matters affecting their own mental health and well-being and consulted collectively in groups regarding institutions and services involving them; indigenous families have the right to collaborate in institutional decision-making regarding their young.
5. Indigenous children, adolescents and families have the right to expect indigenous community leadership and self-determination in mental health services, supported by high standard clinical and cultural training of both indigenous and non-indigenous professionals in the mental health area.

6. Indigenous children, adolescents and families have the right to expect provision of institutions and policies enabling parents, extended family systems and guardians to care appropriately for their children.
7. Where indigenous children, adolescents and families are educated within a government education system, they have the right to full engagement in preschool, primary and secondary school education which involves, in both planning and review, consultation with the extended families and community of those indigenous children and adolescents, and which provides opportunity for the education of the young in their own languages.
8. Indigenous children, adolescents and families have the right to access, when a government education is provided, inclusive learning programs embracing the culture, history, language and religion of their traditional heritage, especially regarding healthcare and healing; programs should also include relevant current affairs, especially as these feature participation and achievement by indigenous individuals and groups seeking positive and creative change in society that aligns with indigenous self-determination.
9. Indigenous children, adolescents and families have the right to recognition and consideration by society of the historical community transgenerational trauma which they and their ancestors have experienced through colonisation by the mainstream culture, and to expect such consideration to be built into health, educational and welfare services offered to them, with understanding extended to them by those services, and with affirmative action as determined to be appropriate by their communities.
10. Indigenous children, adolescents and families have the right to expect that these rights inform the relevant laws of the mainstream government concerned, and in the structure and delivery of government services at all levels.
11. Indigenous children, adolescents and families have the right to have their human rights communicated to them by governments in a consultative way, with opportunity for any related concerns to be addressed as determined by indigenous communities themselves.

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APPENDIX 6: Responses to questions of concern by the Royal Commission

A6.1 What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Implement a family/developmental philosophy to mental health intervention (Section 3)

Reduce problems of access (Section 4.2 and Appendix 3)

Implement family engagement procedures (Section 4.2 and Appendix 3)

Implement five-component model of integrated intervention (Appendix 2)

Pre-school and maternal and child health clinics be supported as early detection agencies

Identification of diagnosis of a chronic or life-threatening illness and/or approach for assessment for aged care services as triggers for offers of referral for mental health assessment and/or treatment

Implementation of workforce development programs associated with the new policies

Establishment of a resource monitoring unit to measure changes that result from the new policies

The occurrence of and frequency of mental illness across the life span needs to be acknowledged in a systematic way to highlight the fact that most families will be touched by the mental illness of a family member at some point.

Conversations about mental health, Including attitudes and beliefs about mental illness, difference, stigma and the discrimination that occurs on many levels caused by misunderstandings can result in stigma, shame, victimisation, bullying, and discrimination.

Need to re-invigorate, re-integrate and re-work the notion of the meaning of Community and how we as members provide for one another beyond the nuclear and single person family.

Broader knowledge of existing networks of mental health providers is needed (the role of allied health practices, early childhood services, education, and accommodation services; major hospitals)

Public education programmes (values for life, living responsibly for the sake of living well for personal wellbeing and health and for family, friends and broader community, respect and care for others, and of individual differences) to reduce fear and misinformation. For instance:

- "Seven Up!" Series (1964) 7 years now to 63 years
- "The Final Quarter" (Victorian Aboriginal Sporting Hero, Adam Goodes' response to prejudice and victimisation could be used in conversations about difference and mental health, and the role of the (Aboriginal) community in politicising a problem (Aboriginality) (includes the role of the Flying Boomerangs -teenagers from the football development and leadership program, and Fans #IStandWithAdam)
- Respect Victoria program is raising awareness about Domestic Violence.

A6.2 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?

Things working well

Universal Services, public education, and ongoing professional education can build community competencies in preventing and supporting individuals and families across the board to address mental health issues. Expanding the knowledge base of the broader community about mental health and illness and the significance of early intervention can come about through informal information sharing and specific information dissemination through education programmes and by specific service providers.

Universal Programmes for all ages

Universal Programmes include the Maternal and Child Health Nurse program which provides early screening for all newborns and preschool early health and development screening, and is one means of early detection and management of concerns that could be preventable forerunners of later mental health illness.

The School-based Youth Health Nurse Program Service delivered in partnership with Education Queensland is an example of schools being the forum for implementing universal programmes, given that there are vulnerable periods in development that can be monitored.

Universal programmes have the potential to reduce the community prevalence of mental disorders. Please refer 2018 Ninth Winston Rickards Memorial Oration in which the hierarchy of significance of needs-based services for vulnerable children outlined in the (World Health Organisation's literature on Prevention of Mental Disorders) was addressed by Dr Allan Mawdsley OAM www.mhyfvic.org/orations

Education of Service Providers

One encompassing model that addresses aspects of development (neuro-bio-psycho-emotional-social) over the life span for Service Providers is the Introduction to Developmental Psychiatry Course (DPC) at Mindful - centre for training and research in developmental health, Department of Psychiatry, University of Melbourne (DPC). The DPC is a training program open to all workers across the state of Victoria in Child and Youth Mental Health Services, Department of Health and Human Services, NGOs and non-government services such as Victorian Aboriginal Health Service's Koori Kids programme and other programmes. Some of the benefits arising from the DPC are the use of consistent concepts to facilitate communication and coherent service provision, especially when multiple agencies are needed.

Service Provision Networks

Alfred Child and Youth Mental Health Service (ACYMHS) for 0 to 24-year-olds could be considered as a service that addresses mental health/illness across the life span. Identified patients, children and youth are viewed in context with care givers schools and other settings. With its extensive range of services ACYMHS supports the education of families and of workers in the field of Child and Youth Mental Health. Infant Mental Health (0 to 3.5 years) for example, Neurodevelopmental assessment and management of complex disorders, Early Psychosis CATT and Outreach, and Education-related programmes. Being connected to a leading teaching hospital, the Alfred, via its structures and systems of accountability and its range of specialist services including Community Mental Health, Crisis Assessment, other Community Health Outreach and Psychosocial services, enables linking and coordination with medical and surgical and research departments that can cover the management of psychological sequelae in those fields.

Some well-publicised target programmes addressing acute mental health needs include: Beyond Blue Support Service; Lifeline, SANE, and Suicide Call Back Service that help manage acute trauma and provide triage into targeted intervention programmes. Funding to meet need and research into demand and outcomes of these programmes is vital.

Needs to be done better

GP management of cases

C&AMHS

A family/developmental approach is needed (Section 3)

Programs that address acute mental health needs of aboriginal mental health, post-natal depression, adult ADHD, substance use, anti-social persons, self-harming, OOHC children, and mental health of older adults and their carers (Section 4)

Employ five-component model of case planning (Appendix 2)

Pre-school and maternal and child health clinics be supported as early detection agencies

Implementation of workforce development programs associated with the new policies

Establishment of a resource monitoring unit to measure changes that result from the new policies

A6.3 What is already working well and what can be done better to prevent suicide?

Things working well

MHYF Vic would like to hope that some things were working well, but the overall lack of change in the rate of suicide would suggest that that those programs that are achieving rate reductions are not widely available

What can be done better

Aboriginal people experience higher rates of suicide

People identifying as LGBTQI experience a higher incidence of suicide, across the life span

Integrate GPs with other services

Recognize and articulate tiers of service provision (Section 2)

Move attention from most compromised to general population (Section 4.1)

A family/developmental approach is needed (Section 3)

Employ five-component model of case planning (Appendix 2)

A6.5 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.

Obstacles to good mental health

Mental illness, stigma, and discrimination are significant obstacles to good mental health

Poverty and disadvantage

Poor access to services

Remoteness from services

Stringent criteria for access to services

What can be done better

A family/developmental approach is needed (Section 3)

Employ five-component model of case planning (Appendix 2)

Reduce problems of access (Section 4.2 and Appendix 3)

Pre-school and maternal and child health clinics be supported as early detection agencies

Implementation of workforce development programs associated with the new policies

Establishment of a resource monitoring unit to measure changes that result from the new policies

A6.5 What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Drivers behind poor mental health outcomes

Mental illness, stigma, and discrimination are significant drivers of mental illness. However, poverty is by far the most important factor negatively correlated with mental health. Improvement in safety, housing, food and welfare is the single most important universal intervention in the relief of mental disorders.

Marginalisation, social isolation, and stigma of specific communities are other significant drivers of poor mental health outcomes, as evident among the Aboriginal community, refugees, and the LGBTI community.

What can be done better

To engender better mental health outcomes, evidence needs to be collected on models of Best Practice and the formulation of policies to address the needs.

Best Practice requires housing and income support for all families to live at better than the abovementioned standard. The level of support needs to be regularly updated.

Best Practice for Prevention of Mental Disorders requires universal programs that address a) Safety, housing, food, welfare; b) Family functioning, parenting and Pro-social functioning (Human Capital); c) Education to potential; and d) Reduction of toxic factors

A family/developmental approach is needed (Section 3)

Employ five-component model of case planning (Appendix 2)

Reduce problems of access (Section 4.2 and Appendix 3)

Pre-school and maternal and child health clinics be supported as early detection agencies

Implementation of workforce development programs associated with the new policies

Establishment of a resource monitoring unit to measure changes that result from the new policies

A6.6 What are the needs of family members and carers and what can be done better to support them?

Needs of family members and carers

Mental Illness, Chronicity and Disability: Beyond the ‘net’ of ‘universal services’, ‘early intervention services’, chronicity and ‘early psychosis’.

Lifecycle nodes of developmental vulnerability in chronically mentally ill can be reactivated throughout life and provide new opportunities for growth in mental health well-being but also increase the likelihood that there will be a repetition of trauma and maintain chronicity.

Implementation of the National Disability Insurance Scheme (NDIS) and needs of and support for family members and carers may be of particular relevance in situations where long term residential care is part of the picture and occupational and ancillary supports are required.

Consultancy services provided by Community Mental Health Services and Outreach Services may also of be of significance in research, monitoring “capacity building” and outcomes for consumers, and upskilling workers in long term care and occupational and ancillary supports service provision.

The NDIS has potential to lead significant national reform in the provision of community-based support for people with psychosocial disability

What can be done better

Integrate GPs with other services

A family/developmental approach is needed (Section 3)

Employ five-component model of case planning (Appendix 2)

Reduce problems of access (Section 4.2 and Appendix 3)

Pre-school and maternal and child health clinics be supported as early detection agencies

Implementation of workforce development programs associated with the new policies

Case assessments and case management of referrals from components in the system who have deemed a case to be beyond their capabilities.

Regional Health Service management Board that includes consumer and care representation, as well as officials of the agencies.

Establishment of a resource monitoring unit to measure changes that result from the new policies

APPENDIX 7: Summary of input by MHYF Vic on the terms of reference of the Royal Commission

A7.1 How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.

MHYF Vic propose a family/developmental approach to mental health, delivered by means of the five-component model of integrated intervention, and effective at three tiers.

Move focus to prevention and early intervention.

Early detection of cognitive, emotional, behavioural, and psychosocial difficulties is advocated through an early detection process conducted through pre-schools. Early intervention should follow if a concern is detected.

Suicide is a problem of the broader community, not the most disturbed population and needs to be handled through encouragement of connection and early access to specialist services.

Focussed programs for vulnerable groups: Aboriginal people, refugees, LGBTQI.

Establishment of a coordinating service within Community Health Centres, supported by shared specialist staff from area mental health services, capable of undertaking case assessments and case management of referrals from any of the other components in the system who have deemed the case to be beyond their capabilities.

Regional Health Service responsible for public sector funding should have a management Board that includes consumer and care representation, as well as officials of the agencies.

A7.2 How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through:

A7.2.1 best practice treatment and care models that are safe and person-centred;

The five-component model of integrated intervention is predicated upon safety.

Incorporate multi-disciplinary teamwork as standard practice.

The family/developmental philosophy is concerned with the person as they live their lives with others.

Protocols be designed and implemented that enable access and family engagement.

Pre-school and maternal and child health clinics be supported as early detection agencies.

Establishment of a coordinating service within Community Health Centres, supported by shared specialist staff from area mental health services, capable of undertaking case assessments and case management of referrals from any of the other components in the system who have deemed the case to be beyond their capabilities.

Regional Health Service responsible for public sector funding should have a management Board that includes consumer and care representation, as well as officials of the agencies.

A7.2.2 strategies to attract, train, develop and retain a highly skilled mental health workforce, including peer support workers;

Training in the philosophy, understanding of the three tiers, the five-component model, and in the procedures and instruments will be vital.

MHYF Vic suggests multi-disciplinary forums be established within health districts that have professionals from different disciplines and different agencies working together to learn these new approaches and systems.

Modules for learning the approach and the model and its procedures and instruments should be produced for the use within training courses of all participants (including carers, consumers and peer support workers, and other professionals like Police Officers and Residential Care staff). Online modules can support in class experience.

Protocols be designed and implemented that enable access and family engagement.

Retain highly trained and skilled practitioners by allowing practice of psychotherapy, not just case management.

A7.2.3 strengthened pathways and interfaces between Victoria's mental health system and other services;

The pathways would be strengthened by a shared philosophy, shared understanding of the three tiers, and a shared model with shared procedures and instruments.

Recognition of the pivotal role of GPS in private mental health services.

Further, by training together in multi-disciplinary groups and having access to agreed online content, pathways will be fashioned, and interfaces will be made more penetrable.

Protocols be designed and implemented that enable access and family engagement.

Pre-school and maternal and child health clinics be supported as early detection agencies.

Establishment of a coordinating service within Community Health Centres, supported by shared specialist staff from area mental health services, capable of undertaking case assessments and case management of referrals from any of the other components in the system who have deemed the case to be beyond their capabilities

A7.2.6 better service and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements; and

Protocols be designed and implemented that enable access and family engagement.

Recognition of the three tiers of mental health service provision and better articulation of connections between these levels and across private and public lines.

Again, shared training will open up interfaces that have been rigid and have prevented information exchange and accountability. Shared terminology will also improve communication and accountability.

Establishment of a monitoring unit to document impacts of proposed changes and to direct amelioration of adverse or unintended consequences.

Regional Health Service responsible for public sector funding should have a management Board that includes consumer and care representation, as well as officials of the agencies.

A7.2.6 improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms.

Adoption of tablet-based intake technology (as at headspace).

A common vocabulary and a common set of procedures and instruments will allow for widespread early detection and monitoring of prevalence, procedures, measures, and outcomes.

Establishment of a monitoring unit to document impacts of proposed changes and to direct amelioration of adverse or unintended consequences.

Regional Health Service responsible for public sector funding should have a management Board that includes consumer and care representation, as well as officials of the agencies.

A7.3 How to best support the needs of family members and carers of people living with mental illness.

MHYF Vic believes that a family/developmental philosophy in mental health services will reduce stigma and enable families to contribute to the care of mentally ill family members and encourage resourcefulness within the family network.

This would need to be supported in appropriate training of professionals and the use specific procedures and protocols to encourage connection.

Protocols be designed and implemented that enable access and family engagement.

Pre-school and maternal and child health clinics be supported as early detection agencies.

A7.4 How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health, including but not limited to people:

Establishment of a coordinating service within Community Health Centres, supported by shared specialist staff from area mental health services, capable of undertaking case assessments and case management of referrals from any of the other components in the system who have deemed the case to be beyond their capabilities.

Regional Health Service responsible for public sector funding should have a management Board that includes consumer and care representation, as well as officials of the agencies.

A7.4.1 from Aboriginal and Torres Strait Islander backgrounds;

The most important step is recognition and reconciliation with First Nations people of Victoria (this is a Victorian government policy). Then, within a family developmental approach and using the five-component model, intervention that is culturally designed and should be implemented.

Protocols be designed and implemented that enable access and family engagement.

Pre-school and maternal and child health clinics be supported as early detection agencies.

A7.4.2 living with a mental illness and other co-occurring illnesses, disabilities, multiple diagnoses or dual disabilities;

The family/developmental approach recognizes different needs at different time for various presentations. The model empowers carers and consumers to use the model to design integrated interventions and to hold service providers accountable.

Protocols be designed and implemented that enable access and family engagement.

Pre-school and maternal and child health clinics be supported as early detection agencies.

The implementation of the NDIS needs to be reviewed and lessons learnt for changes to the mental health services in Victoria.

A7.4.3 from rural and regional communities; and

The development and use online media can augment service provision and provide quality psychosocial intervention.

The training forums in local communities will enable better communication across interfaces and increased pathways to service package design and implementation.

Establishment of a monitoring unit to document impacts of proposed changes and to direct amelioration of adverse or unintended consequences.

Protocols be designed and implemented that enable access and family engagement.

A7.4.6 in contact, or at greater risk of contact, with the forensic mental health system and the justice system.

The forensic services would participate in integrated intervention using the five-component model.

Specific interventions would target contextual change, while also focussing on trauma therapy and medical needs within a framework where an alleged perpetrator can feel safe to pursue recovery and rehabilitation.

Expansion of treatment services to adults diagnosable with ADHD.

Protocols be designed and implemented that enable access and family engagement.

Pre-school and maternal and child health clinics be supported as early detection agencies.

A7.5 How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.

Design services that correspond with the three tiers of mental health provision and ensure appropriate connections and communication.

Substance use services would interface with agencies through interventions designed with the five-component model.

Protocols be designed and implemented that enable access and family engagement.

Harm-minimization would be organized through the contextual change interventions and the safety premise.

Pre-school and maternal and child health clinics be supported as early detection agencies.

A7.6 Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1-6.

Bring GPs more firmly within the mental health service system.

Recommend new Medicare Item numbers for case conferencing with GPs and other professionals and an Item number for transport to and from such meetings.

Recommend increased number of psychological sessions under the Mental Health Care Plan for persons in need of these additional services.