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

There are a number of factors that underlie the stigma of mental illness. One of the contributing factors is the disturbing perception that mental health seen as different and less real than physical illnesses (such as asthma, diabetes, epilepsy), and in part are related to people who are weak minded. This requires a number of innovations and rethinking about mental health. One of the more recent innovations is the co-location of treatments for physical illness and mental illness, i.e. mental health inpatient wards being built and delivered within a major teaching hospital (such has been done at the Royal Children's Hospital and Monash Medical Centre. This sends an important message to patients and their carers and increases and to increase the access of mental health patients with acute health services. The outpatient services could also follow this model, for example where treatments for psychiatric conditions like Anorexia Nervosa could be provided by paediatricians, dieticians, psychologists and psychiatrists all working in the same clinic and providing comprehensive and co-ordinated care.

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?

Early intervention is a cornerstone of prevention of mental illness. The provision and enhancement of perinatal services is essential to addressing future problems.

A major challenge is engaging adolescent boys with mental health services. The impact of early childhood neglect and trauma has different impacts on boys compared to girls and has poorer outcomes and engagement for males during these adolescent years. In the 0-12 year age group, more boys present (with predominantly externalising symptoms) though by adolescence more girls present (with predominantly deliberate self-harm, depression and anxiety). It is our contention that girls are better at activating supports and accessing mental health services during adolescence, whilst boys are less likely to present or engage in treatment, despite suffering with mental health symptoms at the same or higher level. We know that males involved in the forensic system have significant (often untreated) mental health problems. We also know that suicide is more common in adolescent boys than girls. We believe that early intervention with boys at risk of developing conduct disorder may have broad based down-stream benefits. Conduct Disorder in childhood and adolescence is highly predictive subsequent severe mental health disorders, substance abuse and forensic involvement. One of the areas that this is currently being addressed is the CAMHS And Schools Early Action (CASEA) Program. CASEA is an emotional awareness and social skills group specifically designed for children aged 5 - 9 years. We believe that the CASEA program is a significant early intervention program that will bear fruit in coming years. We are recommending more investment in CASEA and similar programs so that more schools can be targeted.

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

Boys with externalizing disorders who are disengaged from services, school and family are at high-risk for completed suicide. This group often have developmental trauma and learning difficulties that require a flexible model of engagement. This may include an outreach model and the incorporation of less 'talking-based', more activity-based interventions. Such programs could be closely linked with the CASEA programme.

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

The psychosocial factors related to mental illness needs a well-coordinated approach. A major factor in the presentation of young people to tier 3 Mental Health Services is the presence of domestic violence. Mental health problems for children are precipitated and perpetuated by familial violence and abuse. This may be verbal, physical and sexual in nature and may overlap with emotional neglect. The latter is highly toxic to the child's emotional wellbeing but can be overlook or minimised. Domestic violence and emotional neglect occur on a continuum from mild to severe. It is our experience that, like exposure to asbestos, even small amounts in vulnerable children can have significant adverse outcomes.

The relationship between child protection and child psychiatry has many strengths but there are a number of weaknesses. In relation to the areas where there are challenges, the response to notifications is variable. Generally, child protection notifications made by Tier 3 clinicians represent children at significant and genuine risk. However, there is currently a lack of consistent mechanisms to escalate these notifications where appropriate. The development of such pathways would ensure timely supports for vulnerable children and young people.

Another challenge is the limited number of appropriate placements for children requiring out-of-home care. These challenges extend to children in foster placements continuing to experience abuse, either by carers or on access with their family of origin. Challenges with out-of-home care are exacerbated by some child-protection staff having a limited understanding of the support role provided by mental health services. At times decisions are made without consultation with mental health professionals that are not in the child's best interests (e.g. moving a child from a stable placement where there are problems which could be worked through). Developing practices for enhancing consultation and communication between Child Protection Services and mental health professionals would significantly improve outcomes for vulnerable children.

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

Children from Indigenous and Culturally linguistic group pose a complex challenge as they are often reluctant to engage with services. These children have often experienced a range of early challenges (trauma, displacement, separation from primary care-givers, isolation) that predispose them to adult mental health difficulties. Second generation migrants have the highest risk of developing severe mental illness in young adulthood. Traditional CAMHS services have mixed success engaging CALD populations. Establishing links with communities and existing refugee services may help to support community engagement, establishing pathways from community supports and primary care to tertiary services such as area child and adolescent mental health services. The support and development of transcultural psychiatry within such tertiary services may further enhance engagement and outcomes.

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

Many children coming to tertiary Child and Youth mental health services have parents with either severe mental illness or personality disorders. The FaPMI program is a service developed by the Department of Health, Mental Health Branch, following increased recognition of the impact of mental illness on parents and other family members, particularly dependent children. The Children of Parents with a Mental Illness (COPMI) is a national initiative. The FaPMI and COPMI Teams need to coordinate care with the secondary and tertiary mental health services to address parenting issues in adults with mental illness.

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

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

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

Restrictive Eating disorders have a high rate of morbidity and mortality from both medical complications and suicide. Eating disorders are best managed through shared care between paediatricians, General Practitioners and Family Therapists, with psychiatric case management providing individual treatment for the morbidity and comorbidity arising from eating disorders.

The best treatments for people under the age of 18 years with a severe restrictive eating disorders are through integrated tertiary treatment centres. Well-funded and integrated programs such as the service developed at the Royal Children's Hospital (and only accessible by families in their North Western catchment) need to be implemented across metropolitan and regional centres to avoid geographical inequity of service provision. Poor funding, fragmented services and extended wait-times are not uncommon in Melbourne's eastern and south eastern growth corridors. We support the provision of a new, dedicated multidisciplinary child psychiatric and paediatric clinics across Victoria to jointly manage patients under the age of 18 year with eating disorders.

Children with developmental disabilities pose special challenges for their carers, support services and mental health services. There is a growing risk that these challenges are being over medicalized, and that highly restrictive inpatient mental health services are being engaged to resolve problems with residential placement.

Across the state mental health professionals report that young people with developmental disabilities (including autism and intellectual disability) are increasingly presenting in crisis with challenging and aggressive behaviours. These behaviours are related to the fundamental challenges these children experience with emotional regulation, and are best addressed from early in development through a range of behavioural, sensory and relationship interventions. These interventions cannot be effectively implemented in inpatient settings. Where these interventions have been poorly integrated, not accessed or disrupted by family trauma, young people are typically presenting once their families no longer feel able to cope. Too often there is then an expectation that a major psychiatric illness will be diagnosed to explain behaviour (where no such diagnosis exists) and that a medication-based solution for challenging behaviour provided. These unrealistic expectations are expressed by families, disability support services and educational services alike. Often there is robust advocacy for inappropriate psychiatric inpatient admissions. Too often families and carers do not accept psychiatric opinion and recommendations, sometimes refusing to take the young person home to their care. These relinquishments of care in the inpatient setting represent a significant failure of disability care, as well as a violation of the child's right to be supported in the least restrictive setting.

These patients are being admitted to psychiatric wards inappropriately. This phenomenon has become an acute problem as disability services have been phased out in anticipation of the NDIS. Subsequently the NDIS has not been able to provide appropriate supports for these people who have very high needs due to the market place for NDIS services not being mature. There is some evidence of market-failure for brokered services under the NDIS for high needs children.

We recommend tight integration of disability services and child protection with mental health consultation, to provide an urgent response to these young people who are not suitable or appropriate for psychiatric inpatient care. We recommend a co-ordinated and urgent response when these young people present to Emergency Departments to divert them from inappropriate and potentially harmful psychiatric admissions. We strongly urge the Royal Commission to recommend the development of services to provide residential facilities for the management of young people with disabilities and challenging behaviours, both as a respite options and for longer care where appropriate. These services would require in-reach from area mental health services to monitor and manage any psychiatric comorbidity where present. Highly skilled disability nurses and carers, adept at managing complex challenging behaviours, are difficult to access through local educational institutions, often needing to be recruited from overseas. This may be a gap in education and training that requires addressing at a federal level.

The following peer group of public-sector psychiatrists have contributed to this submission. This submission does not claim represent the views of any specific mental health program or hospital service.

Dr James Meyer-Grieve Child and Adolescent Psychiatrist
Associate Professor Michael Gordon Child and Adolescent Psychiatrist
Associate Professor Soumya Basu Child and Adolescent Psychiatrist
Dr Michelle Knuckey Child and Adolescent Psychiatrist
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Dr Ben Samuel Child and Adolescent Psychiatrist
Dr Charlotte Burgell Child and Adolescent Psychiatrist
Dr Lucinda Smith Mother and Infant Psychiatrist
Dr Natalie Fraser Mother and Infant Psychiatrist
Dr Dorothy Kesarios Child and Adolescent Psychiatrist
Dr Ayla Khan Youth Psychiatrist

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

Group Submission, copy below from online submission

Name
Dr James Meyer-Grieve

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
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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?
"Early intervention is a cornerstone of prevention of mental illness. The provision and enhancement of perinatal services is essential to addressing future problems.   A major challenge is engaging adolescent boys with mental health services. The impact of early childhood neglect and trauma has different impacts on boys compared to girls and has poorer outcomes and engagement for males during these adolescent years. In the 0-12 year age group, more boys present (with predominantly externalising symptoms) though by adolescence more girls present (with predominantly deliberate self-harm, depression and anxiety). It is our contention that girls are better at activating supports and accessing mental health services during adolescence, whilst boys are less likely to present or engage in treatment, despite suffering with mental health symptoms at the same or higher level. We know that males involved in the forensic system have significant (often untreated) mental health problems. We also know that suicide is more common in adolescent boys than girls. We believe that early intervention with boys at risk of developing conduct disorder may have broad based down-stream benefits. Conduct Disorder in childhood and adolescence is highly predictive subsequent severe mental health disorders, substance abuse and forensic involvement. One of the areas that this is currently being addressed is the CAMHS And Schools Early Action (CASEA) Program. CASEA is an emotional awareness and social skills group specifically designed for children aged 5 - 9 years. We believe that the CASEA program is a significant early intervention program that will bear fruit in coming years. We are recommending more investment in CASEA and similar programs so that more schools can be targeted. "

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high-risk for completed suicide. This group often have developmental trauma and learning difficulties that require a flexible model of engagement. This may include an outreach model and the incorporation of less talking-based', more activity-based interventions. Such programs could be closely linked with the CASEA programme."

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.
"The psychosocial factors related to mental illness needs a well-coordinated approach. A major factor in the presentation of young people to tier 3 Mental Health Services is the presence of domestic violence. Mental health problems for children are precipitated and perpetuated by familial violence and abuse. This may be verbal, physical and sexual in nature and may overlap with emotional neglect. The latter is highly toxic to the child's emotional wellbeing but can be overlook or minimised. Domestic violence and emotional neglect occur on a continuum from mild to severe. It is our experience that, like exposure to asbestos, even small amounts in vulnerable children can have significant adverse outcomes. The relationship between child protection and child psychiatry has many strengths but there are a number of weaknesses. In relation to the areas where there are challenges, the response to notifications is variable. Generally, child protection notifications made by Tier 3 clinicians represent children at significant and genuine risk. However, there is currently a lack of consistent mechanisms to escalate these notifications where appropriate. The development of such pathways would ensure timely supports for vulnerable children and young people. Another challenge is the limited number of appropriate placements for children requiring out-of-home care. These challenges extend to children in foster placements continuing to experience abuse, either by carers or on access with their family of origin. Challenges with out-of-home care are exacerbated by some child-protection staff having a limited understanding of the support role provided by mental health services. At times decisions are made without consultation with mental health professionals that are not in the child's best interests (e.g. moving a child from a stable placement where there are problems which could be worked through). Developing practices for enhancing consultation and communication between Child Protection Services and mental health professionals would significantly improve outcomes for vulnerable children. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
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What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

N/A

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

N/A