ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Thursday, 25 June 2020 at 10am

Before: Ms Penny Armytage AM (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

THE CHAIR: Welcome to the Commission's panel discussion on early intervention in adolescence and youth for good mental health throughout life.

I am Penny Armytage, the Chair of the Royal Commission into Victoria's mental health system. I am joined by my fellow Commissioners, Professor Allan Fels, Dr Alex Cockram, and Professor Bernadette McSherry.

On behalf of the Commission I acknowledge the traditional owners of the lands on which we meet and I pay my respects to their Elders past, present and emerging.

Before we commence, I would like to thank our three panel members for taking the time to participate in today's panel. I want to recognise that each of you put a considerable amount of effort into developing your witness statements and into preparing for today's discussions. We are particularly mindful of the time you have afforded us in the context of the current pandemic.

These panels are an opportunity to discuss and contest issues in an interactive way. One of the most powerful aspects of our work so far has been engaging with people and evidence in an interactive way through avenues such as our community consultations, the 2019 public hearings.

In our current environment we are continuing to creatively engage with people to ensure that this is not lost, particularly with people with lived experience.

Today's discussion will focus on youth mental health, including a robust examination of current service responses, along with examples of evidence-based effective practices and the reform ideas that will achieve a stepped change to mental health outcomes for young people.

In the Commission we are very conscious that youth, along with infants and children, are our next generation, our future. If not identified quickly and treated effectively poor mental health at a young age can have such wide-ranging and deep ramifications in many aspects of a young person's life, including education, employment, independence, social participation and connection.

Positive mental health is essential to the young person and their quality of life now and into the future, but also to their family and to the important contribution they will make to our economy, our communities and our society at large.

This is why we have prioritised holding a panel on youth and why we have held a panel on infants and children earlier this week. A panel on youth is also important as we know from the submissions and witness statements that we have received so far, that there are some really challenging system design issues in youth mental health that need careful consideration.

There are also unique opportunities and we are conscious of the intersections into settings outside of the mental health system such as education, employment, alcohol and other drugs and physical and sexual health.

We are also aware adolescence and young adulthood are high risk periods for the development of mental illness with an estimated half of all lifetime mental health disorders presenting by the age of 14 and three quarters present by the age of 24.

We know that this life stage has considerable bearing on a person's opportunity to experience good mental health throughout their lives and that timely access to quality mental health treatment and care when a person is at risk of mental illness, or early in the onset of their mental illness, is vitally important.

We also know that access to care that is developmentally appropriate in settings that are suitable to young people leads to better clinical outcomes and better experiences that aid recovery and promote future help-seeking behaviour.

We are cognisant that mental health was recently ranked in a survey of young people as the most important national issue. Unfortunately, we know from the submissions we have received and from the voices of young people that our mental health system isn't always as accessible as it should be and that some people that need treatment and care miss out, get a shorter duration of treatment than they need to recover, or are provided with care that isn't as appropriate and responsive as it should be.

We recently received a statement from a young person, Kiba, who is 21 years old and bravely shared their experience with our mental health system. I think, as we hear from the panel today, it's important that we keep the experiences of Kiba and others like Kiba in our minds. I quote:

> *I felt like they were saying there was nothing wrong with me. When someone is telling me that I kind of think, okay, nothing's wrong, so it's got to be me. It made me feel like maybe I was making it up. I was beginning to believe that I had somehow made all of this up in my head and there was really nothing wrong with me, perhaps my mind is playing tricks on me, and then I kind of go into self-destruct mode and spiral out of control and attempt to self-harm or suicide again. So, I guess, the more I got dismissed, the more vicious the cycle became. I later discovered I wasn't making it up, I had borderline personality disorder. They should have helped me.*

We acknowledge that, while far too many young people are not appropriately treated and cared for in our current youth mental health system, this isn't everyone's experience and some young people receive the treatment and care they need and are supported to best utilise their strengths to recover.

We also acknowledge the innovation in the system, including in those youth mental health services you represent or have worked for, and it is important that we also acknowledge the passion and commitment our clinicians have to provide evidence-based compassionate care to everyone that needs it.

We also know, especially from the experiences around the world over the last three months, that there are great opportunities to use digital health services in youth mental health and this is changing the way young people are seeking and experiencing mental health care.

I and my fellow Commissioners have read with keen interest your respective witness statements and it is evident that you bring a wealth of expertise and experience to this topic, along with thoughtful and progressive reform ideas. Your commitment to provide a compassionate age appropriate service to youth and support them to manage and recover from a mental illness radiates throughout the words you have chosen to use in your statements.

Across your statements there are areas of agreement broadly. These are the need to provide developmentally appropriate care that looks different to care that is appropriate for infants and children and care that is appropriate for adults.

The importance of providing treatment and care early in illness and out of duration for maximum clinical benefit, understanding the context in which a young person lives, the settings and communities they engage in and all the drivers of their poor mental health including alcohol and other drugs, physical health and housing is essential, and that carer inclusive practices are also essential.

But there are also considerable points of difference, including in the structural reforms you have recommended that the Commission consider in order to redesign the existing youth mental health system.

The purpose of today is to expand on the areas of reform you proposed in your witness statements, constructively contest the ideas and potentially reach a level of consensus on priorities for change.

I and my fellow Commissioners will largely play a listening role today and Senior Counsel Assisting, Georgina Coghlan, will facilitate the discussion. Before I hand over to Georgina to outline the logistics and parameters of today's discussion, I would like to once again thank you for your time in assisting the Commission with our deliberations. These opportunities to hear directly from frontline clinicians and systems leaders are invaluable to our deliberations. We look forward to a robust and constructive panel discussion.

Thank you, Georgina.

MS COGHLAN: Thank you, Chair. I too extend thanks to Paul, Amelia and Sandra; they have all contributed so much time and energy and dedication to this process for which we're very grateful.

As the Chair has mentioned, each panel member has provided a written statement which we published on the website. Those statements cover a range of issues, not all of which will be touched on today. All panel members responded to a number of questions, some of which will be explored further in the course of today's discussion.

As the Chair mentioned, the purpose of this panel discussion is to share ideas on topics, identify points of agreement and disagreement as the case may be.

At this point I propose to introduce some of the areas that will be addressed in today's discussion.

Firstly, the core components of community-based care for young people; secondly, the accessibility of youth mental health services, particularly looking at threshold for access; thirdly, whether there should be a youth system that's separate from infants and children; fourthly, family inclusive care; and then finally, looking at governance and commissioning arrangements for youth mental health services.

The panel will broadly discuss these issues in the context of young people, and for the purposes of today's discussion that refers to those aged 12 to 25.

Can I now briefly introduce our panel members. Dr Paul Denborough is a child and youth psychiatrist with extensive experience working in the public health system. He is the clinical director of Alfred Health, sorry, Alfred Child and Youth Mental Health Service, CYMHS, and Headspace at Alfred Health. Essentially he's responsible for the CYMHS, Headspace primary and Headspace Youth Early Psychosis. He sees his job is to implement recovery-oriented practice. The CYMHS at Alfred Health provides a coordinated mental health service for young people and their families and an integrated service in the sense that people are treated so that they avoid bouncing around in the mental health service.

Associate Professor Sandra Radovini is a child and adolescent psychiatrist. She is currently the Director of Mindful, Centre For Training and Research in Developmental Health in the Department of Psychiatry at the University of

Melbourne. Her role is to provide leadership across all of Mindful's teaching, training, research, engagement and administrative activities. Sandra is also a consultant psychiatrist at Orygen Youth Health. She also has previous experience as a senior advisor for youth mental health in the Mental Health Branch in the Department of Health and Human Services, as the Clinical Director of Headspace and, prior to that, as the inaugural Chief Child Psychiatrist.

Ms Amelia Callahan is the Director of Clinical Service Innovation at Orygen. She's been involved in youth services since 1998 and health sector since 1999 and was first registered as a psychologist in 2004. Over the last 20 years she's been responsible for establishing and implementing a range of integrated service centres such as Headspace centres, Headspace Youth Early Psychosis Services, Adult Integrated Services in Queensland and New South Wales, and a Child and Family Based Early Intervention Integrated Service Centre pilot called the Poppy Centre. She is a passionate advocate for Early Intervention Services aimed at reducing the long-term impact of mental illness on children, young people and families.

The panel discussion today will be conducted in a question and answer style. The broad themes will be flagged by me and questions will follow. I will direct each question to a panel member to respond to first and then ask the others to respond subsequently.

So, enough from me, time to start asking the panel members questions. I propose to start with the first topic which is components of community-based care for young people. I propose to ask generally about the core components, then ask specific questions about possible components.

Can I direct this first question to you please, Paul: what should be the core components of community-based care for young people in Victoria's future mental health system?

DR DENBOROUGH: Right, so, I mean, that's a broad question. I mean, I notice on the - the first thing obviously we need to do is have a skilled and motivated and, I suppose, compassionate workforce, so that's the key issue. So, it's about setting up the culture where that is provided, and I guess it's also about how we work, so very much trying to implement recovery-orientated practice within mental health and that's easier said than done. We've used a few models to try and make sure that happens, like open dialogue and single session family work and Discovery College and various different innovations to try and implement that practice.

We also use an outcome measurement tool called the ORS SRS which is around making sure what we're doing is being effective with our interventions.

So, I know you're probably wanting more of the type of staff we employ, but the key is having the right culture of what the staff are operating under.

Then I guess we employ at CYMHS a broad range of disciplines, and we're very focused on trying to make sure that, where they're sort of equally represented, so we have an equal number of nurses, psychologists, OTs, social workers and doctors, because it's about, if the mandate for CYMHS is for people who need a multidisciplinary response, so we need to have a multidisciplinary team to do that.

Now, I guess one of the things you've said when we met last week was, are there other elements that we should also add in? So in our Early Psychosis Program we also employ employment vocational workers. We have a very strong and powerful sort of peer workforce, so we've got five, I think, parent peer workers, and we've got over 40 young people involved; many of those are volunteers and contractors, but we also have fully employed peer workers there. We have exercise physiologists and we have had an agreement where we employ a drug and alcohol worker within our, particularly our outreach team which has a high number of comorbid clients, and also we have employed - well, we've contracted through Launch Housing a housing worker, so actually having these workers working within our team does provide a really broad and, I suppose, responsive service.

MS COGHLAN: Can I just clarify there, Paul, just on the level of integration of that role?

DR DENBOROUGH: So, I think the level of integration is helped by employing the people. So, rather than contracting in a person from an employment agency, because we employ them and they're embedded within our service - I know Amelia's talked about this, the same thing done at Orygen was having a vocational worker employed - it has a massive difference in terms of ownership of the worker and the integration within the teams.

With the peer workers, obviously that's been a work-in-progress, but on my opinion they're fully integrated within the teams and they attend the team meetings.

And I guess the key to making a peer workforce utilised is for the clinical staff to understand that they're as effective as a therapist. I mean, I know it's a different type of thing, but it has been quite a difficult thing to actually implement. Often peer workers are seen as something on the side, that someone who might do a bit of hand holding or support, but in fact our experience has been that, you know, sometimes the peer workers are more helpful than clinicians in terms of actually clinically - I don't like to use the word clinically - but therapeutically because of their lived experience and their ability to share things that they've done, particularly with the family peer workers.

So yeah, I guess it's being part of the actual team and seen as equal members or as important, not an add-on, I think that's the key to integration. If they're seen as someone who visits or as something on the side, I think it's actually - that's the key issue for me.

MS COGHLAN: I'm going to move on to ask you in a moment Amelia, but before we move on from you, Paul, one of the things we discussed in the conclave last week was really more of a system design construction, and you commented and all panel members agreed that the three-tier framework, that being primary, secondary and tertiary, still works well, but the key issue is better integration between those tiers. Do you want to briefly comment on that?

DR DENBOROUGH: Yes. I mean, we're lucky because we run all the tiers, so we've got a Headspace Primary, we've got a Youth Early Psychosis Program and the tertiary CYMHS. So what that means is that, rather than arguing about - when someone rings up for help our job is to determine which tier they're seen in, not whether they do or don't get a service, and that is a complicated task, so it does mean that our intake teams - we have the same intake for

Headspace, early psychosis and primary, but the CYMHS intake is a separate intake but they have to speak almost on a daily basis. And it's about empowering our intake teams to make decisions and then people don't argue with it. They have to decide who's the best person or who's the best placed system to help that person, so we can't argue with each other - well, we can argue with each other but that should happen behind the client, it's not something that the client should be exposed to.

And the key reason why we do this is, when we've co-designed our services, one of the things that families hate the most is telling their story more than once, and so, you know, obviously a lot of these stories are very emotional and traumatic, and to have to tell it to somebody who then says, well, we're not going to help you or we're going to send you to someone else, I think is really terrible.

Our intake is by the phone where we take only enough information really to work out who's best placed to help them. We don't go into a whole problem-saturated discussion and for them to open up a can of worms about all the issues to someone they're not going to see again.

I think that's a really key principle. I don't know whether that young person you talked about right at the start, that might have been their experience, is that they've rung up and gone through their whole situation and be told, no, we're not the right place for you; I think that is a really awful part of our system currently, so we really try not to do that.

I mean, I'm not saying it absolutely happens every single time and it's a complicated decision. So, sometimes our Headspace Primary will have a lot of capacity and sometimes it won't; sometimes our Early Psychosis will have capacity and sometimes our CYMHS will, but because we know what each other is doing and where we're at and what's going on we're able to work out who's the best placed. And, you know, occasionally we'll get it wrong, occasionally they'll be too risky or complicated for Headspace Primary, but we'll take them back to CYMHS if that's the case.

So I guess it's about, I'm sure it can happen without running the whole thing but I think what I've noticed is it's quite difficult to do that. I think a lot of Headspace centres become very frustrated with the state system because they feel like they can't get their clients in there, and I think that the state system gets very frustrated with the Headspace system in other areas because they feel like they're just sending all their clients to them.

So, unless you've got that good will and relationships between the various tiers it's very open to conflict, and the people that miss out obviously are the clients and their families obviously. They're the ones - that's the missing middle, is the other name for it, they get caught feeling like they have to justify the reason that they need help, which is terrible.

I mean, as the people have said, it doesn't happen in other parts of health, I don't think.

MS COGHLAN: Thank you, Paul. I'll just direct this question now to Amelia, just on the core (indistinct).

MS CALLAGHAN: Sure, thanks, Georgina. I think there are two parts of this when we talk about core components; one is the underpinning principles and the second is the service components. So, I think to pick up on what Paul was saying, a lot of what that is, is underlying principles, so regardless of whether we're providing outreach or centre-based principles, those underpinning principles about recovery focus, the culture that we want to create, the family inclusive practice, starting with, yes, you're in, yes, we will provide you with a service, and then work out where or how to provide the best service, whereas at the moment we don't have that underpinning philosophy about, yes, we will help you; we actually screen out rather than starting with hope and, yes, let's see how we can help.

The cross-continuum is another underpinning principle, to be able to work with young people across mild, moderate to severe. I think there is a part before that, so whether that's an underpinning principle or a service component that looks at prevention and how do we maintain young people's wellness rather than focusing on just, you know, the illness, because I think that sends a message too about, we're only here to help you once you're ill and you have to be very ill to get into the service, so how do we actually look at that early intervention type, prevention community engagement kind of work.

The other thing that we have talked about in terms of an underpinning principle is, we talked about this biological, psychological, social and cultural underpinning philosophy, but at the moment the system is largely focused around the biological and the psychological, so those things that Paul talked about, like housing, the other aspects of care, vocational services being provided to the young people, build on those social components as well.

And the other area that I don't think we do particularly well is the cultural aspect of providing services and how that looks and how that should look different within a system.

The other thing we've been hearing from young people is that fundamentally it's about choice and flexibility so that the family and young people feel like they have some sense of agency and control within this. So, often that's not the case, they actually feel like they have the least power, the least control, and they're the ones I think as Paul's saying that's often doing the work, you know, for the system rather than the system doing the work behind the scenes for them.

So they're kind of the underpinning principles I think that are the core service components, but then there's the core service model components which for us would be things like a front end that actually works across mild-moderate to severe, so at the moment we have what we call a front end or how a young person enters a system that is for mild and then a different system for how they enter the system when they're more severe or acute, and then working between those systems is more like siloed.

So, I think a core service component around a front-end that works across the system which is more that every door is the right door and how do we actually facilitate those bridges across that, which speaks to the access and not retelling the story that we talked about further; having those integrated service centres available for young people that offer a range of services.

We've been talking about a menu of services for young people, but also the importance of integration across those. So you might need, for example, some physical help from a GP that sits in what we would traditionally call a primary care sphere but you actually need to access say the case management from what sits in perhaps the tertiary service, but often you have to only sit in one tier, you can't actually access services across the tiers which speaks to the integration component that we talked about before. And that's even things like being able to access information and medical records and data that work across the system, and at the moment we don't have that.

So I think Paul's point about common governance also makes those things easier, because they consent for information sharing, often the medical records system's the same. But, if you don't have a common governance across those, just the ability to be able to have those systems work together.

In terms of the other core components, I won't talk about all of them because there's a lot of them, I think the one that probably more so should be emphasised is drawing on the lived experience. I think co-design and implementation. So, I think this is done fairly well in this youth space but it can also be done a lot better in terms of how do we engage young people around the co-design of our services. But not just the co-design and how do we continue to engage them beyond that.

So we are seeing peer workers, for example, and family peer workers emerge, but I'm interested in looking at other ways we can involve young people and family members in the co-implementation of these services moving forward.

MS COGHLAN: Thank you, Amelia. Sandra, would you like to address this issue about the core components.

ASSOCIATE PROFESSOR RADOVINI: Thank you, Georgina. Firstly, I do agree with the things that Amelia and Paul have already outlined. I think I'll pick up on a couple of things.

The idea of a continuum of service delivery relies on having adequate resources to do this, and also integration relies on there being those areas there to integrate, and in some parts of Victoria that's not the case. For some regional and rural services, there's no Headspace, there's very little tier 2 available, so the question of adequate resources needs to be part of this. And an idea that one size does not fit all, so how can it be done in a regional or a rural setting will not be the same as what Paul has outlined for The Alfred, it just can't happen.

But then I think one of the principles, if indeed you're bringing together or you're trying to bring together services responsible, if you like, for tier 1, tier 2, tier 3 in a region ought to be a collective accountability, but currently people can just go, well, it's not me; or a tertiary service, as Paul has outlined, can say, well, no, we don't accept that young person, and they stay with the referrer, whether the referrer is a paediatrician or the referrer is a Headspace centre and that's really not good enough. But I think this idea - and I think Paul, what Paul is also talking about is the accountability for all parts and, therefore, minimising the risk of gaps.

My other comment would be around, that collective accountability also really leads to culture. Amelia's idea of, well, you say "yes"; it's not "you're not suitable for our service".

I think both have been touched on already I think, but I'll underline it, is how do we better involve families and carers and the significant others in a young person's life, whoever those significant others - and I use "family" in a broad way, not just biologically related people, and we need to think of that as essential, not an add-on, not an afterthought, not a tiny bit of the puzzle, but actually a key component to assisting a young person: who/where are their supports and how do we engage with those.

In talking about components of a service, it is helpful I think - or helpful to me anyway, I don't know about others - to think about that vertical integration of mild, moderate and severe and horizontal integration across the other sectors that are important and key components.

Paul mentioned - or maybe Amelia, I'm not sure who - you know, things like drug and alcohol or education. So, the reason they're integral is, mental health problems don't arise in a vacuum, and so they, we need to think about the young person in their context both from the point of view of supports but sometimes from the point of view of focus of interventions, of things from a broader base that can help a young person in their recovery, not more recovery, again, in a broader sense, not just symptom relief. Thank you.

MS COGHLAN: Sandra, before we move on from you, just in relation to that last point, and I did ask Paul the same question: what does that integration look like, or to what extent are those services integrated?

ASSOCIATE PROFESSOR RADOVINI: There is great variability to what extent services are integrated. You know, Paul's service at The Alfred is an example of trying to integrate lots of things; other places have almost no integration.

And, what does integration look like? It means the capacity to bring the components together. So, if you need, if a young person needs assistance with academic issues, that it is possible to bring educational support.

If a young person, we discover that drug and alcohol use is also problematic, that can be brought in; rather than sending the young person, which may be currently what happens, to here, to there and to there, and that doesn't work, and it shouldn't be - it should be a young person or a family traipsing from one service to the next. If it is seen that those things are essential to their recovery, those things have to be brought to the table.

Now, I know that one size does not fit all so, you know, there are structures that are more helpful, but those structures will not work everywhere, so it's more the principle of being able to do this and the collective accountability that you must, rather than you can actually say "no, not me, I don't have the time" or "somebody else do it".

MS COGHLAN: Thank you, Sandra. Amelia, can I direct that question to you in terms of this question of integration?

MS CALLAGHAN: Yes, thank you, I'm glad you did (indistinct) I want to speak.

Yes, I think it's really a quite practical sense, so what does that actually mean in the service, and Orygen's looking at this at the moment for example around our front-end. So, one of the things we're looking at is having a shared initial contact tool across our Headspace centres and also our tertiary system, so we're not in place with this yet, but that's around a young person presents to Headspace, they do a Headspace assessment, and then when they get referred to tertiary they have to do the tertiary assessment, which is a different form, different questions.

Now, primarily they're trying to get the same thing, which is what does this young person actually need, but the assessment as such gets repeated over and over again. Whereas what we're trying to look at is, could we have one tool that is accepted across the system? You know, that's a really sort of practical example of integration where we would agree that, if the young person is referred from this system to the next system, that that initial contact and the information is accepted across the whole of the system, rather than needing to replicate that and do that again.

So, you know, and there's things like sharing of information - I think we talked about it last week, you know, the amount of Coroner's reports I've had where had we had information from one system that was accessible to the other system, you know, could something have been prevented here. So, integration in terms of access to information, sharing information, agreeing to work together, common case reviews perhaps or complex case reviews, reviews of where things are working but where things are not working.

So, I think we need to take some of the examples of integration and really make that - turn it into more practical steps about what does that actually mean for the service system and the clinician and the young person.

MS COGHLAN: And I think one of the things that you mentioned the last time we met was the idea that they don't necessarily have to be co-located, but they have to be connected in a (indistinct) as well.

MS CALLAGHAN: Yeah. So, we were talking about, for example, a young person presenting at one of our centres and if we do this right and understand their needs, it may be that we can't offer that particular service, but it is available at, you know, one of our other services in a different location. So, how do we coordinate that not just in our one location but across our whole system?

And I do think, and again I'm a bit passionate about this, you know, we're able to get online and make appointments to see our doctors at the moment online, but our young people can't do that with our mental health system. We can order a pizza, we can do a whole range of things. We've got the technology, the ability to do a lot of these things, but we don't do that, so we don't have our systems that share information or, yeah, as I said, that a young person can jump online and do an initial information sharing form online and we then think about how do we actually get that young person to the right service in the shortest amount of time possible.

So I think there's a whole lot of technology that we could use actually to integrate, as Sandra said, not just vertically but horizontally and ideally not just across - we're saying one system facilitates greater collective accountability, but wouldn't it be great if that was also across, you know, multiple systems, whether they're state or NGO, whether they're housing - I mean, I'm getting very idealistic here now, but you know it's good to have the vision and the end goal in mind.

MS COGHLAN: Paul, can I direct this next question to you, please. Given the extent of agreement amongst the panel members in relation to principles of core components and what you've described at The Alfred, for example, what's held the system back from achieving that more broadly?

DR DENBOROUGH: Good question. I don't know if that - yeah, I think it is the different funding streams. I guess what - this is probably a broader question, but obviously half of our funding is coming from Federal Government, half from State, and generally that structure doesn't normally happen, I think, so that's one issue, an obvious issue.

I think, as Sandra said before, I mean, obviously to be effective as a mental health service you do need to have some time. But I think, you know, often a lot of time is spent working out why people can't come in rather than actually just seeing someone. I know we're going to get onto it later and you've pre-empted this, but actually brief interventions can be incredibly effective even for very serious problems, and sometimes if you just say, "Yes, let's meet up" things can be facilitated.

So, I don't know if the integration is a problem, I know I'm probably going to go off on a tangent here, but I think what Sandra said too before about the family involvement. So, what I mean by that is that, you know, in our Headspace Primary we do have young people coming by themselves without their families, not in secret from their family but they prefer just to have individual time, but they've got sort of more milder problems.

We found in our early psychosis through our CYMHS service that we always start with as many people as possible in the first meeting. What I mean by that, so that's the open dialogue approach or a single session approach where you try and get everyone's perspective about what's needed at the first meeting rather than making the mistake of starting with the young person and then trying to involve the family later.

Like, if it turns out that the family aren't needed, which I think is quite rare to be honest, to help the young person - I'm not sure I've seen that too often - then fine, great. But if you start involving families later, firstly, the young person doesn't like it because they feel like they're going to breach confidentiality; the family feels a bit annoyed that they haven't been aware or haven't been included right from the start with the young person.

So, I now it sounds like a no-brainer, but actually it takes a lot of effort to get everyone there in the first meeting, and that's not just - and it might be housing workers, it might be child protection worker, it might be youth justice worker, or whoever it is, starting - getting a good start, I cannot emphasise enough how important getting a good start is, in terms of having everyone involved at the beginning and, if you don't need certain people, fine, they can go away.

That's generally I think the biggest problem with integration, is having a sort of medicalised individual problem-saturated approach at the beginning.

MS COGHLAN: Thank you, Paul. Sandra, would you like to respond to that?

ASSOCIATE PROFESSOR RADOVINI: Sorry, Georgina, I was listening to Paul and I've lost the question, would you mind?

DR DENBOROUGH: I'm not sure I answered the question.

MS COGHLAN: You did, Paul. Sandra, the question was, given that there's agreement about the core components and the principles behind that, what's holding the system back (indistinct)?

ASSOCIATE PROFESSOR RADOVINI: Yes, thank you. Some of it is historical. We've had different buckets of money and they've been given out in different ways that have created silos. And, when you give buckets of money to different sets of people, it also creates different cultures that don't easily speak to each other.

And Amelia and I, when we both happened to be at Headspace, we saw that happen when there were two different organisations: one that was for the Primary Headspace, and then another that was looking at the - oh god, I've lost the word, oh dear - the setting up of the early psychosis and trying to marry those two and the very, very different cultures of potentially the primary care platform and the workers and the way that they worked, and the workers who would look after somebody with an early psychosis. So that's some of the reasons that that gets in the way.

What gets in the way also is actually inadequate funding. If all I've got's a small amount, I become very protective of it and it does create these barriers, so that you are trying to shift people because you have long waiting lists, because you are short-staffed, because you don't think; you think it's out of scope. So, some Headspace centres become, and rightly so, very concerned about young people at high risk. They say, "We don't have the expertise to look after those young people", and you know, and try and say, well tertiary mental health service, this looks more like the kind of care that you provide.

So, we do have find ways of having enough resources across Victoria. I can't - I'm going to underline that. Having worked in rural and regional and been looking at it from the Office of the Chief Psychiatrist, we really need to think about those areas when we're having this conversation or when the recommendations might come through. That's probably I think enough from me for the moment.

MS COGHLAN: Thank you, Sandra. Amelia.

MS CALLAGHAN: Yeah, I would just agree, I think the resourcing has led to a system based on resource limitations rather than the needs of the young people, and in those environments you constantly then have a system that's more about scarcity and keeping the resources that you have, so it's quite reactive type of environment, and that also I think speaks to what Sandra and Paul were both saying, there's a shift in cultures that I believe is happening at the moment or underlying paradigms: we're moving from a more medical individualised space model of practice to a more collective, family inclusive, less of a top down approach, more of a bottom-up, co-designed lived experience, and I think that shift in cultures and frameworks is shifting but has traditionally been part of what's held us back. This ability to - for example, we don't want to work with NGOs because they don't know how to work with severe mental illness, and here we have some great NGOs running our Headspace early psychosis programs nationally. So, the times are changing but I think some of the old paradigms and frameworks and views have held back some of this integration and willingness to collaborate with each other.

MS COGHLAN: Thank you, Amelia. Sandra, can I direct this next question to you, and it concerns engaging young people and keeping them engaged with services: how can that best be achieved?

ASSOCIATE PROFESSOR RADOVINI: We learnt a lot through, I think the example of Headspace, of what will assist engagement. Some of the principles in the design of services are things that are, first of all, designed with young people: ask young people what is engaging and they will tell you what that is.

Accessibility: to be able to get to somewhere easily. The accessibility also from the point of view of, well, what hours is it open? You know, after hours, potentially weekends might be the times that best suit young people. Is it a welcoming space? Is it a place that I would like to actually walk into?

Those initial impressions are really important and it goes to the attitude of the staff but also the physical environment. You know, historically some of our mental health services are not terribly welcoming spaces to walk into; they're a bit intimidating, they're a bit clinical, and it takes courage from adults to walk into those services, never mind young people.

Some of the other components are this idea of choice that Amelia mentioned earlier; to be able to talk to a young person about, there are different ways of doing this which is going to sort you and your family and your context makes for better engagement.

The capacity to both be transparent and be collaborative. So, to be able to talk to young people and families somethings about, this is how it works, this is what we're going to do, this is why we're thinking about this, or here are some of the limitations at the moment; that level of transparency that invites people to be part of the team or to be engaged in their own wellbeing. And I guess the phrase that is often used is "done with, not done to", and we have to continue to do more of that.

I think Headspace showed that, if you can build that system, young people turn up; there isn't a problem of engaging them, they are there. You know, in some ways Headspace has been, you know, a victim of its own success: they've been really good at doing that and then have run into problems of resourcing.

This is where tertiary mental health services - some, not all - can learn a lot about that. But there's also, back to that notion of culture, there is a resistance in some places to do that, to look at how you change a tertiary mental health service.

You know, having done - sometimes been involved in reviews, also interstate and walking into a place, what does it actually look like, how does it feel, and trying to imagine that the first time a young person comes to the service.

Amelia talked about digital technologies: they're a way of helping young people. They potentially can take a tour of a service before they actually walk in the door, they can find out more about it. They might be able to have a chat with someone to have an initial reaching out, and all of that leads to better engagement and ongoing engagement.

Now, that can be more tricky sometimes when people are very unwell, but I still think those principles are sound principles regardless of, you know, people's level of illness.

MS COGHLAN: (Inaudible).

ASSOCIATE PROFESSOR RADOVINI: Georgina, you're on mute.

MS COGHLAN: Thank you Sandra. Paul, can I direct that to you in terms of how do you sustain engagement of young person, anticipating that you might include reference to families here.

DR DENBOROUGH: Yeah, so I'm going to be a little bit repetitive. But I mean Sandra's very - I agree with everything she said, I think she focused more on accessibility or acceptability. I mean I think the other thing as well, obviously you have to be effective, so only people are going to show up if they're actually getting better, so there's a lot of things to be done in that way.

I think the first one that I said before and I'm repeating myself, is getting off to a good start where you involve all of the relevant people at the very first meeting. Like, we call it in open dialogue a social network meeting; at CYMHS we call it a family meeting, or if you want to call it single session meeting, and I can go into more detail of how we - I suppose the best example of that is someone presenting with anorexia. So, we've got a very comprehensive first start meeting. I think that is, in my opinion, in my experience, is that's what leads to best outcomes is getting off to a good start.

Also, I also have a bit of a belief that young people with serious problems don't usually get out of it on their own, and so that's the other thing.

But the other thing we are doing at Early Psychosis is, we use a tool which is designed by a guy called Scott Miller which helps implement outcome-directed practice and collaborative practice which is where each session the client rates how they're going and at the end they talk about how helpful the session as been.

So, I guess it's about - I think it's a combination of what Sandra said about having a welcoming, acceptable, well recognised digitally easy to get into, but then once you get in you want to be helped as quickly as possible. So, I know it's contentious but my experience has been, is if you get off to a good start, you can help even very, very serious problems quickly if you involve other people; if you just see the young person on their own, I think it's very unlikely you're going to get a quick, positive outcome.

Unless you've got a mild problem. So, with our Headspace Primary I think they do do some brief interventions with kids on their own, young people on their own which work extremely well, but once it gets more complicated with things like psychosis or anorexia or things that are very serious, I don't believe it's easy for young people to go out on their own.

MS COGHLAN: Thank you, Paul. I'll come back to what I asked you a bit more about (indistinct) session later. Amelia, can I just direct that question to you though about engagement?

MS CALLAGHAN: Sure. I'll just answer it by, I suppose, telling you about our experience recently working with 15 young people with lived experience in the Western Melbourne area. So we recruited 15 young people to work with us around our redesigning of our front-end, which is really about engagement. They did identify a number of barriers, I suppose, but the three key areas that they wanted to focus on was improving the cultural appropriateness or responsiveness of the service, so I think that's worth - you know, in addition to all the things that Sandra and Paul have talked about, looking at different models there.

So, for example, the young people looking at the Friendship Bench model but looking at how we embed, I suppose, in the community, rather than the young person and the family needing to come into the service; how do we actually better place ourselves within the community of the young people that we're trying to assist and help. And it's a different kind of approach, it's more of an outreach approach rather than families needing to come to us.

The second thing they were interested in was peer workers at the front end or within engagement. So, at the moment most systems you engage with is a clinician or an expert or a psychiatrist or a doctor, and what they're interested in is, is there a role for other young people or peer workers with lived experience in this first experience of engagement, and does that actually give the young person a different experience on their initial contact, you know, and does that actually help with help-seeking and destigmatising that initial approach if they know they're talking with another young person with a lived experience.

Then the last thing they prioritised was the development - what they're calling, "A Passport to Me" is the name of the booklet, but it's a guide about really thinking about what do they as a young person wants to get out of this experience and how do we put them in the driver's seat. So, what are their preferences around, you know, accessing the service - a bit like Sandra is saying - do they prefer to do this online, face-to-face, walk-in, in a service. You know, what's their Passport to Me, what's their preferences for how they engage with us as a service and then how do we actually use what they're telling us, you know, in a meaningful way, to actually make them, yeah, the drivers of the whole engagement experience.

MS COGHLAN: Thank you, Amelia. Can I just stay with you for the moment; the next question concerns inpatient admissions and what you see as the purpose and role of inpatient admissions for young people in a future system.

MS CALLAGHAN: In a future system I'd like to actually think that we're able to provide a lot more of the current function, you know, that we currently serve in hospitals in the community. So, we're looking at, for example, hospital in the home set up in Orygen, we're hoping to start those services in the next three to six months as an alternative to young people needing an inpatient stay.

So, in a future state I would hope that we've actually been able to provide alternatives to an inpatient stay, to be able to provide services and support to the young person and the family through alternative modes and models of service.

But in those instances where it is still required I think there is a role and function there; sometimes it is to get a bit more diagnostic clarification, or maybe not even diagnostic, but a greater sense of what is happening here for this young person and their family. Sometimes it really is because the young person is just that acutely unwell that they do need to be in an inpatient unit for their own safety and wellbeing.

And I do think at the moment there is a function where the support network in the family that supports that young person is often no longer able to maintain the level of support and containment for that young person. I would hope in a future scenario that we would actually be better at providing support to maintain the family's and the support system's ability to maintain that young person in the community, but I think there may still be some scenarios where there just - you know, those support networks that help maintain the young person in the community are so exhaustive that there may be still a role for that in terms of inpatient stays.

MS COGHLAN: Thank you. Paul, would you like to comment on this?

DR DENBOROUGH: I pretty much agree with everything Amelia's said. I guess the other thing that's difficult in Victoria is in some parts of Melbourne or in most parts of Melbourne an 18-year-old goes into an adult ward and that's very traumatic for anybody, particularly a young person, even a young woman being admitted, you know, with 50-year-old guys is currently probably unacceptable. So, I don't think that's everywhere but it certainly is in a lot of Melbourne.

So, in terms of everything Amelia said, but I still think it might be nice to have one youth ward where maybe it was 18-28 or something, or 25 or something, where it could be a bit more appropriate. Because, I mean, I think there are scenarios where admission is necessary. Obviously, I agree, it would be great if we could try and minimise that because I think it is a last resort.

I think Victoria does have the most adolescent beds in Australia, is my understanding, and I know that Tasmania has none, so they somehow manage without that. But for us, I'm running a community service, but what we found, we actually do find Monash very helpful, and essentially because they have a role of backing us up. So, we don't really ever use them for diagnostic clarification, but we do use them when a person is acutely psychotic or lacks capacity to make decisions, or as suggested acute risk where they just need a bit of time and place of safety to get the team together in a crisis.

So I personally would be highly anxious without adolescent beds at all but if we can minimise it and I think the issue of 18-year-olds, or 18-25-year-olds being in adult wards is not ideal at all.

MS COGHLAN: Thank you, Paul. Sandra?

ASSOCIATE PROFESSOR RADOVINI: We do have examples of how you can minimise inpatient beds - inpatient use, and I think that is the aim, that you do this when you're unable to help a young person in the community, and they were the IMYOS teams, the Intensive Mobile Youth Outreach Service; that demonstrated without a doubt that it could result, if you could provide that intensive care and support young people at home, you would decrease the number of admissions and you would decrease the time in hospital. So, you know, hospitals are not always necessary if you've got those supports.

But again, thinking about it in the future, there will I think be an ongoing need for some inpatient units and it's usually around what I would call complexity; when you bring together issues of safety, issues of sometimes diagnostic clarifications, lack of support, comorbidity and the need to kind of provide a safe environment and tease apart some of the things that are unclear, and time to bring the supports in place, is how I would see inpatient units being able to be used.

And they are also effective when you have a young person's agreement to come into hospital rather than it being done coercively. And you can have sometimes a young person's agreement, but it takes a lot of work to be able to work towards a young person actually agreeing to go into hospital, and it comes from a place of helping a young person understand that at a point in time they actually need greater supports to keep themselves safe.

MS COGHLAN: Just before we move on from you, Sandra, in your view does treatment in a residential step-down facility like a YPARC make the transition to crisis services less likely?

ASSOCIATE PROFESSOR RADOVINI: I've never worked in a YPARC so, you know, my comments are going to be coming from a theoretical point of view rather than having actually worked there.

Where I can see a YPARC as being helpful is when a young person doesn't actually have the supports within the community and they need more time in terms of their recovery, and this is where young people who don't have family support, young people who have unstable housing, that you need somewhere that provides that as you work on your recovery.

I think YPARCs can also help young people think more broadly than the relief of symptoms but think about building skills potentially, again, so that they can be more fully in the community, whether it be with family or independently.

I don't think it's about the less use of crisis, because I think you can do that with intensive outreach, and otherwise what will happen is, you will have waiting lists for YPARCs, which we probably have now but I don't have information about that. I think the key is intensive outreach to help a young person, and what is it that a YPARC can achieve that cannot be done for this young person in the community, is really the question.

MS COGHLAN: Thank you, Sandra. Briefly, Amelia, do you want to comment on this issue about whether or not residential stay, like in a YPARC, could lessen the progression to crisis services.

MS CALLAGHAN: Yeah, probably just to support what Sandra is saying - and it's interesting, Sandra, I was reflecting on your comment about the complexity and the role with the inpatient and I think it's similar for the YPARCs, in that it is a group of young people who are going to present with greater complexity; the others will be within their family homes or their support systems or, you know, returning back to their work or their employment or education, whereas for some young people it really is more about complexity and needing some time to reduce their symptoms and increase their resilience and their skills and to transition them into longer term care within the community.

The only other thing that we talked about last week that I'm not sure we touched on here is the vulnerability of young people at different transition points. So, I think the other thing that YPARCs - sorry, I keep going to say YRRUs which is what we call them in Queensland - Youth Recovery and Rehabilitation Units - is to support young people to have somewhere to transition to that, will actually facilitate that transition, whereas often young people are transitioning to less than ideal, you know, situations that are not as stable, or they're not as connected, and I think the YPARC actually helps to support facilitated transitions around major things like accommodation and your mental health care, which I think in turn has the potential - as I said, I'm only talking, as Sandra said, I think I'm only talking hypothetically too - but I think it then has the potential to reduce the need for crisis because those transition points are better managed and the service that people are transitioning to is more comprehensive to fit their actual needs.

MS COGHLAN: Thank you, Amelia. Paul, would you like to comment?

DR DENBOROUGH: I have to chip in because, as you know, YPARCs aren't everywhere and we don't have a YPARC in the Alfred area, which would be pretty cool if we did. Because I think they are good. You know, from what I've heard they are pretty popular, and because our early psychosis team covers the whole southern region, we do access the Dandenong YPARC and the Frankston YPARC.

My understanding is that the Dandenong YPARC only takes step-down because they're so popular. It's not because - I think they would like to take step-up, which I think is the general preferred option, obviously it's to avoid hospitalisation, but my understanding is Dandenong has a waiting time and only takes step-down.

I've had some personal experience of a young person stepping up into the Frankston YPARC and it was really incredibly helpful. So, a bit like Sandra, we don't run one, we don't have one in our area so I'm not an expert in it, but my understanding is that they're really very helpful.

MS COGHLAN: Thank you, Paul, can I stay with you for the next topic which is accessibility of youth mental health services with a particular focus on threshold.

DR DENBOROUGH: Yes, so I mean I'm sort of going to repeat myself to some degree but I think, because of the stigma of mental health, I mean anybody asking for help, I think you'd have to be a pretty brave person to say they didn't require it, because I think most people don't even ask for help even when they've got serious problems.

I'm repeating myself, but if we've got a family - and usually it's the family asking for help or somebody else - I mean, I'm not saying, there are some young people coming forward but usually someone's coaxing them or advocating on their behalf usually - that really you have to be a pretty brave person to say someone shouldn't help them because, yeah, that's just the evidence that most people don't even come for help.

I think, you know, that's my job, is to try and make sure we've got somewhere for these people to go. I mean, I know - I don't know if you want to go into it, but how do we maintain no waiting list is --

MS COGHLAN: I was going to ask you that question directly, Paul.

DR DENBOROUGH: It's about a two hour answer, so I know everyone will be too bored about - well, not bored, but it's probably too long to say. But having a no waiting list is absolutely critical because, again I'm repeating myself, but getting off to a good start is so important. So, if you ask people to say, well you know, we think you've got a serious problem but you can come in two months, that's sort of not really - that just sounds crazy.

So, if you can see people straight away and then get off to a good start, I know you can actually help people quickly which leads to more efficiencies, so then they can be discharged and then you can see more. So, maintaining a no waiting list is essential.

Obviously, we've got the busiest Headspace in Australia, and the only reason we have that is because we have 25 or 30 practitioners. So, it's not rocket science if you can - and we're lucky because we're in a nice place to live and all those sorts of things, so we have lots of psychologists who want to come and work for us and you create a good environment, but the most important thing of having a no waiting list is being able to attract and retain excellent staff.

And also, I suppose it's the philosophy and culture of family practice that helps you have no waiting list, because the more effective you are, the more you're going to have no waiting lists. People think about no waiting lists as being saying yes to everyone. Well, you can only say yes to everyone if you help a lot of people and they can leave, so it's a massive combination of things, and I could go on for longer.

I guess we've always managed to have no waiting lists for our Headspace Primary as well, and I think that's mainly because we've got a lot of practitioners actually. I don't think there's anything more smart than that. I think we're going to be doing what Amelia was saying, [redacted], but we're going to have that whole volunteer peer workforce idea as part of having another offering for people.

I think Discovery College is another great thing because it's an educational approach to mental illness, and that can have any number of courses. The Nottingham Recovery College has 400 courses at once, so that shouldn't be just seen as something on the side, that can be actual treatment, attending Discovery College courses.

So if you've got a lot of groups, the more effective you are and the more things you can offer, the more peer workers you have, all of these things all contribute to having no waiting lists.

MS COGHLAN: Thanks, Paul. Can I just ask two questions arising from what you've said. The first is just in relation to the severity of the cohort that the Alfred Health is available to service, without putting a percentage on it --

DR DENBOROUGH: In terms of our system of care, obviously we take the most severe.

Actually probably what I should say: the other thing we've done with our Headspace - and we're a bit lucky because we have Early Psychosis as well - I'm sure our Headspace clinicians there see more severe cases than some other ones because we have doctors in there and we have a situation where if they say they want to refer to CYMHS we just say yes. So, they're more prepared to take more risky - plus we've had a history of having managers at our Headspace - the previous one worked on a CATT Team and the current one has worked a lot at Orygen, so they're comfortable with acute and mental health and are happy to ask for help so will go and do - will support our Headspace from the tertiary service to try and keep as many people as possible still in the Headspace.

So, I know this from my own personal experience, when we first opened Headspace, I sort of joke about it, but we used to see kids that were having trouble with their homework going to Wesley sort of thing. Now, if you went to our Headspace waiting room, I think you'd be hard pressed to notice a difference to the CYMHS. I mean, there are some very complicated young people that go to our Headspace Primary. So, the more the tertiary system can help the primary system manage complexity, the better it is for everyone; for the young people as well, they don't have to change between workers and - yeah.

And then I guess the other, I mean, there are plenty of other examples I can give but even with the new Medicare items for anorexia for example, we got flooded with referrals for anorexia in our area, but with the new Medicare items, if we provide a good start using some CYMHS staff, we have a Headspace clinician who can take on the case then, and because they get sort of unlimited sessions now, we're able to push some of the anorexia cases through Headspace, but the only way we can do that is if we provide that beginning and provide back up to it from the CYMHS.

So, that's one example, I can give you lots of other examples. But in terms of what do we see: essentially we see the ones that no one else will see at CYMHS.

MS COGHLAN: You've already mentioned the various therapeutic interventions that are undertaken including open dialogue single session. What is your response to the criticism of the use of single session in the context of treating more severe needs?

DR DENBOROUGH: Okay. So, again, I know I don't have two hours, but this is my sweet spot and something I'm very passionate about, because there's a number of elements - single session is probably a bad name because what it is, is immediately offering a referral to a problem, often suicidal teenager, or whatever, a school refusal or whatever it is, and you have a set of questionnaires that we send to the family about, firstly, what's their greatest problem, what's their second greatest problem, why are you coming now, what questions do you have, what do you want answered. So, it's sort of like a customer-focused meeting where you - there is a theory behind it which I won't go into - but it's essentially trying to sort out the problem that they have in one go.

And I'll refer you to Jeff Young because he knows more about it than me, but this is an approach that's offered all over the world and always shows at least 50 per cent effectiveness, but often is more like 70 per cent.

What we do, it's not a triage. These people have already reached the threshold for us. So, what I'm talking about, when we offer a single session, it's already gone through the stage of they couldn't go to Headspace Primary or private person or whatever, they're in the system, so all it is is how we start. So, our results show that about 70 per cent of those people are satisfied with that intervention.

Now, what is it, it's a complex situation of whether they're the more severe or mild. I don't think it's got anything to do with acuity. You know, again, just from experience, I've probably run thousands of these meetings, and I would honestly say - I challenge anyone to be able to predict whether someone's going to be helped by that session or not even at the end of it. I've had sessions where it feels like the most beautiful meeting, where everyone's cried and they've got a new result and everything's (indistinct) and then they say, look, we loved the session but no difference.

I've had other sessions where people have stormed out of the room, there's been massive conflicts, it's felt like a total disaster, and we ring them up a few weeks later and they say, well look, you didn't help us much, but we went back and had a barbecue afterwards and sorted it all out and everything's great now.

I think what it teaches you in fact is really humility and about the sort of pointlessness of sort of the medical model in a way about being able to predict what's the right way for any particular family to sort out their problem. I think it's about providing an environment where they feel collaborated with, respected, and you get different perspectives in the room, and everyone's heard and you work out some solution together with them.

And so, not only is it really important for a no waiting list, it's really critical about engendering recovery-oriented practice within a service. Because the old-fashioned way in CAMHS was that you would have four sessions of asking really personal questions over and over again and doing an assessment which might take you months before you come up with a formulation and a diagnosis, and by that stage you're lucky if they're still coming - and I'm being a bit facetious, a bit flippant - but it's not recovery-oriented practice, it's expert dominated practice.

And I guess this approach is one way, and open dialogue is another way, of bringing a sort of - as Amelia called it - a more lived experience, collaborative, more a different way of doing mental health treatment into your service - not the only way, but it is a way, so it's more effective. So, the reason why it's important than the no waiting list, is not as important as having good staff or any of those things, but it is important because, firstly it's important for that family if they don't have to come back again after that meeting because that's really efficient; but secondly, it sort of transmits a culture of this sort of practice throughout the whole system. I don't know if that - that's my trying to put two hours of talk into five minutes.

MS COGHLAN: Thank you Paul, I'm grateful for your efforts to make it concise. Amelia, can I direct this question to you about thresholds, and if you could please consider what the threshold should be, if it can be nominated or determined.

MS CALLAGHAN: Yeah, I think the threshold question is actually a resource question. You have tertiary services who are looking for a top threshold, so they take the most severe, and my experience of working in that system was that we would actually try to refer out everyone that we possibly could, even if they were acute or severe: do you have private health cover, do you have the money to pay privately, you know, out they go. Is it a behavioural problem; oh that's not a mental health problem. Is it a trauma history; oh that's a trauma problem not a mental health problem. We would screen out everything we can because the threshold there is, you take only the very top because that's what you can manage with the resourcing that you have.

The flipside of that, of being in the other system around Headspace going, we're a mild service, we're a mild-to-moderate, so then there's a threshold that is at the other end which is you're starting to be too complex, too acute, too severe, you know there's a threshold applied in the other way. This is where we end up with the missing middle in my view. We have a threshold within our primary services that take mild-to-moderate, you have a threshold in our tertiary services that take the very, very top that they can, and then we have this group in the middle where - you know, so where is the threshold?

I actually don't think, again in a service system I think we need to be not talking about thresholds, but how do we actually best provide the service - the need, you know, meet the need of that client and in what system is that, and so how do we do that? And I suspect that it's actually not just one system, it's we need to meet that need using a variety of systems, whether that's the education system, the mental health system, the GP and the primary care system, you know, how do we actually work across those systems as such to actually provide the right service of need.

I think the threshold issue is a bit like the catchment issue, it's problemsome and we end up then getting quite rigid implementation of those thresholds.

And again to Paul's point, for example in our Headspace centres, we could actually move that threshold up to take a higher level of severity or complexity or acuity when we had some support from the tertiary system.

But, you know, we are sitting in a system at the moment, I've got 600 plus young people waiting for our Headspace centres, we have done for the last year. No, our tertiary system doesn't have a wait list, but we turned away, you know, three-quarters of the calls that we had to our system. And then we have, you know, increasing calls to our Headspace centres and then we have 600 to 800 young people on waiting lists to get into our five centres.

So this idea of threshold is actually really about a resource limited system and then we get into, how do I best use the resources that I have to meet those needs for the people that I can.

MS COGHLAN: Thank you, Amelia. Sandra?

ASSOCIATE PROFESSOR RADOVINI: I agree. I think thresholds are about scarcity and they're about silos, so that's what creates - what, historically, what has created those thresholds.

If we come back to a very earlier point: if we have an integrated system, we don't need it, there is no threshold. The threshold is, yes, you need help, where is the help for you? Not a, not here or not there idea. And, you know, Paul is describing an integrated system that has found a way of working efficiently and effectively.

Now, we have dilemmas because there are tertiary services that are not connected to a Headspace even if a Headspace is there, and there are, again the flipside, of Headspace centres that are not connected to their tertiary mental health service, where there is this yawning gap and it results in a pile of people in the middle who struggle to try and get some kind of help.

And what does that mean in practice? It means Headspace centres stretch themselves sometimes beyond their scope of practice, if I can call it that, for the skills of the clinicians that are there and are looking after young people that they feel ill-equipped to look after, or you have the other part of young people's problems have to "reach a threshold" to get into a tertiary mental health service. That is really not acceptable to have that occur.

So it does come back to, we can join things up better, the bits that are not joined up, so that you can remove a threshold; we can train people to work collaboratively, to work better, to think about new ways of working, the things that both Paul and Amelia have talked about.

And, one of the things that I think Paul talked about but if I can put it in a slightly different way: the way that Paul described is recognising that there is strength and resilience in the young person, their family, their network; that they can come up with some of their solutions if indeed they have a facilitated place to do that, and that, some of the solutions have actually nothing to do with us as clinicians, and that's the bit that we need to better harness and better assist families and young people.

MS COGHLAN: Thank you, Sandra. Could I direct this next specific question to you, Paul. The Commission has heard of an opinion that case management takes up so much time at CYMHS and CAMHS that it significantly reduces the capacity to deliver therapeutic interventions.

DR DENBOROUGH: Yes, so that one puzzles me a bit because obviously, in my mind a case manager is really just the person who's accountable for the case - that's what it would be at our CYMHS, and hopefully 99 per cent of the time they're doing therapeutic activity.

So, I think where that might be coming from - I know with our intellectual disability team there's certainly a lot of time - my understanding, whether you call this case management or not - working with the NDIS. I know that, that I've heard that, is really stressing out our staff about how much time, and that probably is probably what you could call case management type, because preparing reports in a certain way that's going to allow that person to get the right supports, and apparently that's incredibly time-consuming.

But aside from the NDIS, obviously working with other services like child protection and youth justice takes time, but I would have thought that is therapeutic. So it's not I don't I think our - yeah, I struggle a bit with that one because, sure, that is their job though, their job is to be accountable. So, the rule is, because there's whole EBAs across all the places, there's around a caseload of 20 active clients is what most CYMHS operate under, and essentially that's who they're case managing which means they're accountable for those people, and generally sometimes the amount of liaison they do with outside agencies is a lot and sometimes it's minimal.

But I guess as we've become more and more a service of last resort, if you like, there's a lot more working with other agencies, like child protection or youth justice, that's possibly what that's referring to. But I think that's par for the course if you're going to be dealing with the most difficult - and you know, getting back to the earlier question, how we see it is what the threshold is; if they really can just be seen on their own they're going to be seen at Headspace Primary whatever the diagnosis, whether it's psychosis or anorexia or whatever - I mean, often that's not the case for those problems.

So the threshold which is in the CAMHS and communities document which I was talking to Phil about yesterday, whatever it was, the threshold - the idea of coming to CYMHS is if you need a multidisciplinary team, and so that's what we have here, and so there is a bit of, maybe what that question's referring to is coordinating the various members of the team to be involved with that person.

But that's the beauty of coming to CYMHS, is that, if you're just going to see one person for therapy, you probably don't need to come here, you can go somewhere else. I don't know, it's a tricky one, that would be what people would see their core job was, was making sure that the families coming here are getting the input from all the right people.

But NDIS is a problem from what I've heard, and maybe that's just a teething problem, maybe that will change, but I know that's causing a lot of time.

MS COGHLAN: Thank you, Paul. Amelia, would you like to comment on this?

MS CALLAGHAN: Yes. Just that I probably agree with the statement: I think it is difficult because clinicians are trying to manage what I think they see as case management which is assisting the young person to meet their practical goals often, so whether that's - or functional goals - so whether that's education, employment, linking to Centrelink, family meetings, and I think sometimes there's two sets of goals which are sort of your practical functional recovery type goals and then your therapeutic type goals.

I know at different points what I've seen in different areas, for example, where the State Government system will do the case management and then they'll actually refer the young person to Headspace to do the ten sessions of therapy or therapeutic intent. Now, I don't think that's necessarily the best model, but I think that that's people trying to go, how do I actually meet the full needs that the young person is presenting with within the time and the scope that I have to do that?

And where I've seen that, I will add that that's where caseloads are a lot higher than 20, so that's been in systems where clinicians are carrying significantly higher caseloads, more like 50 young people within those systems and going, how do I actually manage all of that.

So, yeah, I think it speaks to clinicians trying to fulfil a number of functions. I do wonder as we increase the peer work workforce, whether there is some capacity for the peer work, or for peer workers to be able to assist in some of those functional goals which I think at the moment is falling back to the clinicians to do as part of what they see as case management as such, rather than the coordination of, you know, care as Paul's talking about.

MS COGHLAN: Thank you, Amelia. Sandra, we're about to have a break, but would you like to comment on that before we do?

ASSOCIATE PROFESSOR RADOVINI: Sure. I think this question comes back to thinking about complexity. So, when you have a young person with multiple and complex needs, a young person from perhaps a history of cumulative disadvantage and mental illness, then you do need the multidisciplinary team and you need the other sectors around the table.

And, rather than thinking about case managers versus therapeutic, it is therapeutic; you know, your interventions are - you know, are they interventions directly with the young person, are they interventions with the family or the carer, or are they in fact interventions with the system, of bringing the system together to facilitate the liaison, the collaboration, to address those broader needs?

And it is essential when you have young people sometimes from out-of-home care, or young people in the justice system, or young people with disabilities, that you have the capacity to do that, and I don't distinguish between something called case management and something called therapy; it is therapeutic and it's how you look at it. And it requires - it needs to be resourced properly. You know, collaboration is a lovely word, but it doesn't happen unless you're resourced to do it properly.

MS COGHLAN: Thank you.

DR DENBOROUGH: I'll just jump in there sorry because Sandra put it better than me, that's probably what I was trying to say. I think the job of a CYMHS clinician is often to be a systematic worker and doing less individual work with one person. So, I think Sandra put it better, but that's what I was trying to say.

MS COGHLAN: Thank you, Paul.

MS CALLAGHAN: Can I add one more thing, sorry, and I will be quick, but we haven't actually talked about today the importance of language. And I think the other thing is this sort of idea of case management, and I'm not saying I think the function should change, but again we hear young people say, "I'm not a case to be managed."

So again, changing the language and I think that this is the future of the system; I don't think we should be talking about assessment, I think we should be talking about meet and greet and understanding what's happening, and we're trying to move away from triage, for example.

But I just flag, because "case management" has made me think, actually because I cringe every time I hear that term, and I think, it's not what people are doing within that, but it is something about that language that, in a future system, I think would be great to challenge.

MS COGHLAN: Thank you very much, Amelia. If now is a convenient time, we'll have a 10 minute break, so coming back at a quarter to 12. See you shortly, thank you.

SHORT ADJOURNMENT

MS COGHLAN: It looks like we've got everybody back, so let's recommence.

We've got three further topics to cover. The next topic is a youth system that's separate from infants and children. Sandra, I'm going to direct this first question to you.

In the discussion we had last week it was apparent that you all agreed that there should be a separate system, and furthermore, a system for 0-25 is an appropriate age bracket to have. Could you just articulate the reasons why that's the case and why there shouldn't be a separate system for, say, a 0-11 age group.

ASSOCIATE PROFESSOR RADOVINI: Okay, thank you, Georgina. It was quite revolutionary when Victoria adopted the 0-25 age bracket for children and young people, and what it resulted in was better continuity of care and better care.

The 18 to 25 bracket was missing out altogether in our earlier system of stopping at 18, and then that transition to the adult system was extremely difficult and many young person transitioned to nowhere, and in fact there was a big gap. So, to have done that has meant greater access to services for that age bracket.

Similarly, the 0-5. CAMHS did not do the 0-5 very well and left that to - I don't know who, paediatricians maybe. And when we adopted the zero, people needed to look at that end and to think about how they - if that was a gap in their service, how did they address that gap.

So this continuity of care is important. Some problems arise in childhood and they continue into adolescence. There's not a different set of problems in childhood and then a different set of problems in adolescence and, you know, there's this divide.

Some young person, their chronological age is not actually an indicator of their functioning. So, first of all there is a broad range of normal: you know, if you picked a 12-year-old, there is a broad range of what a 12-year-old is like and, you know, are they more functioning like an adolescent or are they more functioning like a younger child, it's not just about chronological age. And if you add in the mix young people with disabilities, young person with severe illness, young person with backgrounds of trauma, et cetera, et cetera, then you see that chronological age is not the way to determine what service they should go to; it comes back to, what are their needs? So, the continuity is important.

The flipside would be, if you make a service for 0-12 you create another very problematic point of transition and discontinuity of care at that point which will not serve a young person or their families very well to go, and now suddenly we're going to hand you over.

And all kinds of funny things happen around transitions in practice. It means, services go, oh, you know, you're 11 and three-quarters, so maybe we won't - we won't start seeing you, we'll wait till you're 12 until you can go to the other service. So, I think that's really, really problematic.

The other thing that's problematic is this issue of critical mass and expertise. If you chop at 0-12, in some parts of Victoria that will be a complete nonsense when your critical mass of child and adolescent mental health workers is two. That's what it is in Swan Hill, you know, one person's going to do this and one person's going to do that; it just does not make sense to do that.

But even critical mass and expertise, you narrow the expertise if you're going to have one lot for children, one lot for adolescent, and the people being able to move and work across.

And speaking to Paul's point about, well, sometimes in a service, you know, you have some people who perhaps their caseloads are less, or there is capacity, and so you can shift and use your resources. But if you're going, well, I'm just, you know 0-12, well, it doesn't matter if I'm twiddling my thumbs, I'm not going to be seeing adolescents.

And it leads to that problem of training: how do you train a workforce, this bit and that bit, when in fact, you know, if you, in inverted commas, if you are working with adolescents you need to understand childhood. In fact, if you are working with adults you need to understand developmentally what has happened to this person, and so, you can't just chop people up into chronological bits, would be the way that I would think about it.

MS COGHLAN: Thank you, Sandra. Amelia?

MS CALLAGHAN: I'm going to try not to be confusing in my answer, because I actually do support a 0-25 system, but I do think that the services might be different.

So I'm drawing on my experience of running our Headspace centre and next door was our service called The

Poppy Centre. So, The Poppy Centre was for 0 to 11-year-olds more - and again, we set The Poppy Centre up at the time because we were hearing in this particular geographical area families coming in and going, well, the sibling also needs support but they're not 12 so they can't get into the Headspace Centre.

So we set The Poppy Centre up next door to the Headspace, it was run by the one organisation, the one medical record, the one system; I would call that the one system as such, but the services themselves looked very different.

And the reason I mention this is because, to walk into a Poppy Centre that was targeted around 0-11, of course, it looked a lot more like a children's kind of centre, and family oriented, and lots of toys, lots of bright things, you know, hopping and jumping down the hallway.

My concern about that is, if this is the service for a young person, they come and go, that's where the babies go, that's where kids go, that's not for me as an emerging adult. You know, often part of being a young adult is a transition into feeling more of an independence and more of an independence from your family, whereas this service system is designed around children and young people versus the older age group.

So I think there's a complexity there about, yes, I think it should be the one system, the one governance so that there isn't, you know, whose responsibility is this, this is our responsibility, but the look and feel and the delivery, and I do think there are different areas of expertise.

So, infant mental health, for example, being a very different expertise in those staff than, say (indistinct) more or less, but it's just different expertise than say to work with a more young adult population. And then, if you have a system that's 0-25, the expectation can be that everyone needs to actually work across that full age range and do we actually remove some of the specialisation and skills for different subgroups within that range.

MS COGHLAN: Thank you, Amelia. Paul?

DR DENBOROUGH: Yes, I think in terms of the CYMHS system, so the state-funded system, I mean, I think there's no advantage to creating a separate structure because, again as I talked about before, we've got a - the idea is we're a family service actually, so as Amelia said with siblings.

We get a number of referrals for anorexia, for example, kids who are 10 and 11. We've got an amazing system I think within our CYMHS for doing that. Imagine if they had to not be able not able to access that, for example, it would be a disaster.

The training aspect is massive. People always get deskilled if they're working in too a narrow a team. Even in our infant team which we do have, a lot of those workers are I think potentially a bit deskilled about working with other people. So, you can manage a bit better in a big system, but there are so many problems.

I think 18 is a bad age to transition, I'd say the only worse age I can think of is 12 or 14, so to create that now would be really - I don't think anywhere else in the world does it either, so that would be interesting to see but I think that would be a really bizarre thing to do.

In terms of the tier 2 though, I think, I hadn't heard of a Poppy Centre before until Amelia mentioned it last week but that sounds amazing. And I guess, I've been thinking and I've talked to Jason Trethowan at Headspace about this because I always thought why can't Headspace be 0-25 because, you know, the 0-12s do miss out on a Headspace equivalent, there is nothing, and usually they have to see people, one off people working in isolation, psychologists who often do very individualised approaches with these small children which is probably not good.

So, I think it would be ideal to be under the same governance, like, if we had a Poppy Centre or - Jason actually did say, be prepared to trial a 0-25 Headspace by the way in Victoria, so but notwithstanding the issues that Amelia is talking about, that's usually the biggest anxiety is that the waiting areas would be unsuitable for teenagers, but either you have a separate waiting room or you have a separate centre next door like The Poppy Centre sounds amazing actually.

So, I think there's no possible advantage of changing the CYMHS system, that would be all negatives, but to having the tier 2 system being accessible for 0-12s as well as teenagers I think would be amazing.

MS COGHLAN: Thank you, Paul. Can we move on then to the next topic. You've all mentioned the importance of family inclusive care, and Paul, I'll stay with you to direct my first question.

What are the barriers to its implementation? Why isn't it being taken up more broadly?

DR DENBOROUGH: Look I think to be honest with you I think this is the biggest thing almost that needs to change because, and there are lots of barriers, and it's taken us a very long time to feel like we're more of a family service than an individual service, and there's many, many barriers.

All of our staff that start here have usually had no experience of working with families; they come out of undergraduate training with - in my opinion it's a very practical skill. The only way you can really learn about working with families is by doing it and being supported by people that also value that.

I think you have to have that value system like I talked before, of getting a good start with the first meeting which needs to involve everyone. That's not normal practice, and often - I'm talking about myself as a psychiatrist, in my training, admittedly it's a long time ago now, what was seen to be a good psychiatrist was someone who could make a good diagnosis of an individual. There was no examination of whether I could work with a family, it was never assessed, it wasn't seen as important.

So, if you're trained to do a good job by getting really in detail about people's problems as an individual and making diagnoses and stuff like that, it's then hard to shift - you almost have to unlearn that to become a sort of collaborative family practitioner, and it is possible to do but it can only really happen in workplaces, I think.

So you have to have your models embedded in the workplace which promote that. And open dialogue is one model which does that, single session is another, there's probably other models, but you have to make a really concerted effort.

The other thing, when we first introduced a family peer worker for example, and this is a long time ago now, the first one was over 10 years ago, there was a lot of resistance from our staff saying, well why should she write in the file, should she be allowed to read the file? You know, what's the point, there's just going to be finding, you know, extra funds from Centrelink or something. But rather than seeing actually the value of lived experience as being something that is therapeutic - I know I've talked about this before - so, you have to tackle it from every angle.

But the biggest thing I think is a barrier is staff anxiety about doing it and not actually understanding - even the evidence says with psychosis that good family intervention is more powerful than medication. So, even though despite all the evidence is the fact that this is the way to work with young people, I think the barrier is fear and lack of confidence by clinicians to do it.

MS COGHLAN: Paul, how can that be alleviated?

DR DENBOROUGH: I feel quite proud of the fact that we've done that but, as I say, the philosophical thing I think is the key one which is that young people - and I actually probably would say it's, I won't go out on my lone and talk about adults but I suspect adults is the same if I'm going to be brutally honest - but I think it's a bit rich to expect young people to get out of serious problems by themselves: that's the first thing.

So if you come with understanding from the first meeting that for this person the quickest way and the most effective way for them to get better is that they get supported and helped by their family, if that's your first thing that's going to be the priority: you have to engage the family right from the first moment otherwise you're going to be behind the 8-ball. If you wait, if you do some sort of problem saturated assessment over a few months and then call the family in you've lost it, you've missed the point, because both the young person and the family will be annoyed.

So you have to start with the idea that that's your first job: your first job is to engage the family, to understand their perspective, to understand how they can help their young person who's suffering from whatever it is.

The classic one is with anorexia, I mean, you can't possibly expect to help someone with anorexia without working with their parents and their siblings because, that's probably the one that we've most developed, but that model we have with that where we have a first meeting where we see the whole family, it's very much focused on - you know, it takes 5 seconds to work out what the diagnosis is, I mean they're not eating enough food, but the trick is about how to help them eat. We have a family peer worker, we have a nurse, we have a dietician and we have a family worker, with the case manager if you want to call it that - I know it's a bad name - but that then can then take the case forward, but they've engaged these people.

For example, our peer worker runs fortnightly groups which is about nourishing parents, so which is about getting groups of parents who have got acute problems with their daughter all in the same room together - we're doing it all on Zoom at the moment because of Corona virus - and there's a whole lot of supports in place for families that go alongside the intervention with the family.

So that is a family intervention. Now, there's very few cases come to CYMHS, I hope, that don't require a family intervention. I mean, if they don't require a family intervention, as I said before, they can possibly go to Headspace Primary. And that's fine, there will be some young person who, that's better and appropriate, like a 22-year-old who's broken up with his girlfriend or is sad or depressed might not want to involve his family - fine, that's totally appropriate, but they don't need to come to CYMHS, they can be see someone who's very good at that at Headspace Primary, so that's I guess, I think it's almost like the most important thing.

MS COGHLAN: Thank you Paul. Amelia, can I ask for your comment on this.

MS CALLAGHAN: Yes I agree with everything Paul's said. There's three more things I would add. I think in Headspace we get so passionate about engaging the young person and the rights of the young person we forget how important the family is, and sometimes I think there's a misunderstanding about privacy and consent in that space too from the clinicians, that I can't actually engage the family about without respecting the privacy of the young person, when in fact we can, but I just think we need to work with our workforce around understanding the privacy and consent legislation in regards to families.

The second thing is, there are systems where you can't see the family members if the young person doesn't engage. So, if the young person doesn't think they have a problem, doesn't want help, doesn't - you know, with a drug and alcohol problem, whatever, but the family member's saying "I don't know what to do", often the systems are arranged so that we can't actually see the family unless the young person engages.

I think the capacity to be able to open that up and see the family members, even just by educating, supporting, upskilling the family, actually leads to the likelihood that the young person will engage and be able to again be sustained and move towards, you know, some level of being able to want to seek help.

The third thing I think is again systematic, but we don't have a family - a Medicare item number for families to be able to access counselling and support, so we need to use the young person's mental health care plan if we're going to see the family members. Again, there's sub-conditions around that; you have to see the young person for a certain percentage of time before you can actually see the family member to charge the item. So, some of these things are built in, they don't make it easy for you to say actually I'm going to do a session now with the family to support the young person because I can't technically bill Medicare to do that.

MS COGHLAN: Thank you, Amelia. Sandra?

ASSOCIATE PROFESSOR RADOVINI: CAMHS historically, I think, started off as family centres, that in fact sometimes they were too rigid, that they would not see a young person unless a family would come along. But also, back in the bad old days, they were potentially blaming of families rather than supporting families or seeing families as part of the solution; that was also problematic.

I think - and again, if I think about back then, people did have skills about how to work with families, and what has happened over time is, our workforce has been deskilled; that the pressures, the waiting times that services have has meant that the focus has become just seeing the young person.

Or, if you're a new clinician, there was often a way in the workforce of developing the skill of working with families by being a co-therapist, or having a more experienced person with you so you could see how did that theoretical knowledge, how did that translate into the skills I need to help families, and that doesn't exist in many, many services.

So, I think it is about the knowledge, the skills, the capacity of workplaces to actually create the space to help people skill up, and indeed back to the culture of, it is absolutely developmentally appropriate to have families as part of helping a young person. And the key is developmentally appropriate, like, what you're going to do with a 5-year-old and their family is not the same as the 17-year-old and their family.

And it speaks to Amelia's point of, people do muddle consent, capacity, confidentiality, and then go, oh, I can't see - you know, I can't do this, never mind some of the structural barriers that get in the way.

MS COGHLAN: Thank you, Sandra. We're going to move onto the final topic which is governance and commissioning arrangements for the youth mental health system. I'd like to direct this question to you, Amelia, first.

The question is this: what are the relative advantages and disadvantages of CYMHS or CAMHS being governed or commissioned through a centralised statewide model on the one hand or by continuing with a more regional and local approach on the other?

MS CALLAGHAN: I love this question, because I think it's really complex and I reflect on my experience of working at Headspace National in the establishment phase, and of course that's a system originally where you had centralised, you know, roll out of the service model.

I think there are some advantages particularly in establishment phases to centralised models, so you do have some greater consistency around model - because often it's a model that's developed but it hasn't necessarily been tested at scale, so there is some benefits in being able to work through the actual detail of the model, the model components, things like outcome measures, you know, how are you going to show that it's effective, an evaluation framework; what is, you know, your minimum KPIs, what does that service look like on the ground, and being able to provide support as an advantage that is drawing from the knowledge of the network. So you have a group of services and you can draw on the experiences across that and actually facilitate a supportive network across that service stream.

I think the disadvantages though are that often it becomes too rigid, so the ability then to localise and adapt and apply that model in different ways locally can be taken away. So, I think there is - the reason I love this question is, I think there's actually a sweet spot in the middle of this, which is about having some core components to function, but the form of that being able to be adapted locally, so what does that look like within a local environment.

I think the benefits of doing some of this at a centralised kind of model is also about accountability, so who holds - for example, when you have a decentralised model, it's great if things are working really well and you have a really strong system, but if things are struggling, or if that model, that area, is not, you know, performing, it's not actually achieving what it's meant to, how does that system support itself, I suppose, within where it already - like, how do you escalate that up, how do you actually, well, one, even compare across the system.

So again, not here, but you know in other areas I was running seven Headspace Centres across three different PHNs, with three different contracts and three different requirements. So, you know, again, the ability there to sort of lose some of the strengths of that model is a risk and a concern, but the ability then to be able to look at, I think, the support functions are better done locally, but the accountability and governance functions are better done centrally.

But, yeah, I think there's advantages and disadvantages of all of it if you apply some of these criteria too stringently; it has to be about a sweet spot in the middle about, you know, some degree of components that are uniform, but some flexibility around form and how they're applied.

MS COGHLAN: Thank you, Amelia. Paul, can I direct this question to you.

DR DENBOROUGH: Sure. I mean, I suppose Victoria's got a sort of extreme devolved governance situation, which I obviously personally quite like, because you've got a lot of freedom to innovate and it's great. It didn't used to be quite as extreme, we used to have meetings in the Department every three months where we'd sort of at least information share about what we do; we haven't had those for a very long time.

So, I think as the Headspace National model, but I think New South Wales - and I think that's because there's virtually no staff in the mental health branch, is the reason for that, is my understanding.

But the mental health branch, the equivalent in New South Wales, is much more heavily staffed, they've got a lot of staff in there and they have a much more statewide model and there's quite a lot of - I don't think you would say their CAMHS is functioning any better than ours and I think actually worse because, one example is all of the CAMHS in New South Wales have to do what's called the CAPA model which has some good things to it; it's a type of intake or access model, but in that model almost always the person has to tell their story at least twice, the family. So, that would be something I don't think I would - families or I would like, and so, that can be imposed on you.

The problem with having a centralised model is things get imposed on you, and things that get out of date like risk assessment forms, for example - nobody I don't think believes that we should still use risk assessment forms, but in Sydney, in New South Wales, they all have the same form because it's centralised, so that's even weirder.

So, the problem with centralised things is they're often slow to change and adapt with the times. Whereas, if you're in a devolved governance situation, you can adapt with - because like everything, like anything like running or swimming, mental health services are improving. You've probably heard a lot of terrible stories and you might not agree with that, but I think mental health services are improving, and if you have a centralised system it's harder to change. It's like the NHS in England, it's a massive service and it's very hard to change, centralised systems are hard to change and adapt.

Personally, probably - obviously you can tell I favour the devolved governance, but as Amelia said there might be a sweet spot where we can learn from each other more. So, the disadvantage of devolved governance obviously, it depends on where you live and what sort of service you get and that's definitely true, so I'm not going to disagree with that. But sort of like a free market approach here, where you do what you can.

But one thing that we used to have in Victoria was the Chief Psychiatrist audits which I personally found fantastic, because you are able to, first, be audited by your peers, so in terms of a quality control thing and, secondly, you'd be part of auditing other people.

What that meant was, you got some good feedback about what you were doing, but also you could learn when you're actually doing the audit what some good things other people were doing. At the moment there's no real mechanism where CAMHS teams learn from each other, you know, we're quite siloed and we do operate quite differently, so that would be frustrating if you're in the Department, I suspect, but anyway it's a long story.

But I still think having a centralised system has more disadvantages than advantages.

MS COGHLAN: Thank you, Paul. Sandra?

ASSOCIATE PROFESSOR RADOVINI: If I take a statewide or my experience from being the Clinical Director of Headspace and looking at things at a national level, it's not the well run services that you have to worry about. They will flourish and they will do well regardless of whether it's centralised or in fact if they're left to their own devices.

I think, how do we assist the (indistinct) struggle, and I do agree with Amelia that we have to find the balance between setting standards within it and having rigid controls like Paul is talking about, a system that rigidly controls actually stifles innovation and stifles the ability to adapt local knowledge, local needs.

There was something else I was going to say. Yeah, so you leave struggling services to struggle and there's no accountability and no support from anywhere, or you have to beg favours if you happen to work in those services, from people to help you when you're struggling, and you shouldn't have to beg favours; there should be a recognised way of alerting that you have issues, that you need help, and again, this collective accountability at the top end for how do you get that.

You know, I can attest to the ability of the Chief Psychiatrist audits, I was the chief child psychiatrist, and so in fact I was involved in doing a version of those, because there were several versions, which was about talking to services about, tell us the things that you are doing well, and also - sorry, I'm getting a bit distracted by background noise - and tell us about the things that you struggle with and how can we help you, and I think that that was - and it (indistinct) done by your peers as Paul said, by your equally significant peers from other services with a very, very high level of confidentiality.

You can't expect people to talk about their struggles unless they know, (a) it will be really confidential, and (b) it will lead to support, or else what's the point? And, if you like, there is a parallel process in what we have talked about with families; that you have to think about when services struggle, and many do, how do you assist, and that help will be available; rather than, you will be blamed for not meeting some kind of standard that you can't possibly meet potentially in some areas.

So this middle bit, I think, is necessary; I don't think it's this or that and I have seen problems actually with both.

MS COGHLAN: Thank you, Sandra. I've just got one final topic that I'd like to raise with the panel members just to give the Commissioners a sense of, there was some debate between you, it wasn't all agreement at all points in time.

Paul, one of the matters that you raised in the course of the discussion we had last week was support for the responsibility for the whole system of care resting with tertiary mental health services. Can you just elaborate on that?

DR DENBOROUGH: Yeah. So, I think I was talking about this with Phil a bit yesterday. So, there is a document called CAMHS in Communities which came out, I think in 2006, he reminded me of it, and it is about the tiered system. I think it's a great document, it's a fantastic document. The problem is, does it ever happen anywhere? Is that what that aspirational vision of how the system should work, does it happen? And, if it's going to happen, who's responsible for making it happen?

And I do think it should be the tertiary service because I think the people who are dealing with the - where the rubber hits the road is where the most complicated cases are not being seen, or they're not being managed, or they're not getting in or whatever, and as the end of the line service I like to call us, I suppose, I feel like we have to back up the tier 2, who then back up the tier 1.

So, you can't - I don't think you can expect that tier 1 services, even though they might be more on the ground and more in touch with the community, to be able to make the system work I think. And again, what Sandra was saying before, it's not about being blunt, it's about providing support. We should have the most skilled workers in our teams, in terms of mental health where there are supposed experts. So I think it's down to us to support the other tiers and make the system work.

Now, we don't have full control over their capacity or how many people they can see, but I think we have a better chance than the others tiers, and also the catchment, even though it's a problem it's an advantage, in that, we should be responsible for the mental health in that way, or particularly the seriously mentally ill people in our area, and we should support the other services in our area to help them manage as best as they can, so that's why I think it should be us who's - not in charge - accountable.

We can't make people do anything, but we help them manage the best by support, a bit like what Sandra was saying, not by telling them what to do or --

MS COGHLAN: Thank you, Paul. Amelia?

MS CALLAGHAN: I feel like I'm going to be quite controversial. I feel like the most important thing in a service is actually fundamentally the culture, and by that I don't mean culture at the risk of being unsafe, but I do think that culture is a lot harder to embed within a service system and that often within our community mental health systems I think there are often more of those fundamental underpinning principles that we're looking for in a new system.

So, I think for me it's more about, where do those underpinning principles lie, whether they're in community systems or in state-based systems, and how do we actually support those systems that support underpinning principles to provide the services based around that?

I actually think that there's examples of where that sits in a community-based NGO, for example, and again our Headspace Early Psychosis programs are a great example of this: there were some great NGOs that really went, we're not experts in early psychosis, not sure, you know, we've never employed psychiatrists, but they upskilled really quickly and embraced the opportunity and have really solid - you know, strengthened their clinical governance, set up board communities, brought on board psychiatrists for the first time and run amazing services.

And the opposite can also be true: if the state systems can adapt and embrace some of these things Paul's talking about, about Discovery Colleges and peer workers and those underpinning principles, then that's actually the more important question, I think, for me rather than whether it's state or, you know, tertiary systems or community-based NGO type systems.

I think the last thing I just want to add, I know we touched on it earlier but I'm not sure we really - is that, essentially what we were trying to look at with Headspace Centres was this idea of a collective community of youth services that actually holds collective accountability. I don't know that we should ever be talking about one system holding all of the accountability.

I think again it's, yes, we can say primarily that service is accountable, but I don't think we want to be letting everybody off the hook. I think we need to say, actually we're all collectively accountable for this need in our community, and how do we collectively meet that, and how do we draw on our different strengths and perhaps weaknesses across that system to meet the need within that.

So again, it's a more complex, I understand, but I think it's more about culture. And, you can upskill people; I'm not sure that culture is as easy to upskill in, or change or shift, like fundamental values and principles.

MS COGHLAN: Thank you, Amelia. Sandra?

ASSOCIATE PROFESSOR RADOVINI: Setting up the Early Psychosis services in Headspace was a really interesting and challenging thing to do, and it highlights bits of what both Paul and Amelia have said.

Culture was really, really important. It was revolutionary to think that you could have what "should be" tertiary mental health care, i.e. young people with psychosis be looked after on what was a primary care platform, because that's what Headspace was designed to do; so, could you marry these two and deliver a safe, effective service?

And what we found was in some places, as Amelia highlighted, whatever the primary platform service was, they did a brilliant job; they brought all of the advantages of Headspace and the skills of looking after young person with psychosis.

And then in some areas we found tertiary mental health services, that their culture was rigid; that they were risk averse, that they would not consider, really, anything other than doing what they usually did, and that's the problem. And so, to put that kind of a tertiary "mental health service" in charge of leading all the rest is to impose rigidity, to be risk averse.

And that was even in the design of the building; we had some extraordinary people say some extraordinary things about, oh no, you need big barricades at your reception desk because, you know, of the risk of a critical incident.

So again, I don't think one size fits all, but I do think accountability is really the key here, and that collective accountability. And if you have a model where, sure, your tertiary mental health service is the lead, if I can put it that way, there are advantages to that, but it's not to say that that will work across the board, I don't think it will.

MS COGHLAN: Thank you, Sandra. Paul, do you want to briefly reply? I'm about to hand over to the Chair for Commissioner questions.

DR DENBOROUGH: Yeah, I actually don't think there's any disagreement really, so I don't know if we're trying to manufacture disagreement because I don't think so. I think I sort of pretty much agree with what they're saying, it's sort of semantics really.

I mean, of course it's got to be collaborative. I mean, to make the system work everyone has to be responsible and do the right thing, and I think culture is the key actually, I agree with Amelia, I mean it's got to be a more modern recovery-oriented culture in all the services. I'm not sure if there is disagreement honestly but --

MS COGHLAN: That's encouraging, Paul, it's just to have something to ask you to debate about.

DR DENBOROUGH: Yeah, I thought you were trying to manufacture something we disagree on because I feel like we agree on most things.

MS COGHLAN: I think the perspective as discussed last week, perhaps there wasn't time to explore them so this gives the opportunity to delve into it deeper, and it's helpful for the Commissioners to hear a united point of view.

So, perhaps now's an appropriate time, Chair, for me to hand over to you for Commissioner questions.

THE CHAIR: Thank you very much, Georgina, and thank you very much for the panel, it's been a fabulous discussion, there's a few issues I want to raise.

Paul, just to finish off that conversation, given what you have all described are community-based mental health services, that's where the focus has been, what advantage is there for your service being hosted by The Alfred, by a hospital?

DR DENBOROUGH: There's a lot of - well, I'm not sure if this answers your question, but I guess what we've got is quite unique, is also hosting Federally funded services within a state funded service. And I think there's, as we discussed, massive advantages for that because we are able to actually be accountable for the whole system of care. That's because we control everything - I mean, in a way we control the funding, so that's the best way to control the system. We argue with each other, you know, with ourselves if - you know, if someone says, well, this person really should be at CYMHS, or they should be at HSHEPP, or they should be at primary or whatever, we have to sort it out and we've got systems in place to do that.

The main idea of that is around making sure that the people taking that first phone call are given the authority and the empowerment to direct it where they think and, if there's a problem later on, we'll argue about it later.

We don't spend time deciding whether someone's in or out, we decide who. And, sometimes people will be annoyed, but then that sort of works out in the end. And, if it is a mistake, say someone is referred to Headspace primary where it's too risky, we'll just take them, you know, back at CYMHS.

I'm not sure if that's - there's lots of other advantages, I guess. It's critical mass advantages, so for example, if there is a serious incident and things like that, we're able to - we've got a system across the whole system. We have young people from our primary and our CYMHS accessing our Discovery College, for example. The groups tend to be more run independently.

But things like, we do have two youth Advisory Councils, but essentially they are able to give ideas and things that come from that can be used across all of our teams. The peer workers can - gives us more critical mass for peer workers, both family peer workers and youth peer workers.

I'm trying to think, there's probably lots of other advantages, but I think having one bigger system, the critical mass advantage though is really important as well.

THE CHAIR: I think that is a very powerful example of what you've been able to do with attracting the Headspace funding and other things that you've now been able to use in that vertical integration. But am I correct when you describe the fact that, if you need an inpatient admission, you're dependent on Monash?

DR DENBOROUGH: Yeah, look, to be really honest, and I don't want to suck up to Monash too much but, I mean, they're usually very - they see themselves as responsible for our area. So, I'm not aware of any unfavourable treatment by them in any shape or form, you know, so that actually isn't a problem that I've really noticed.

THE CHAIR: Fantastic, thank you. So, one of the other issues I just want to touch on I think you've also all mentioned is, you wanted to see inpatient care as an option of last resort where it's absolutely necessary, and Sandra, you talked about the need to sometimes work hard with young people to engage them in recognising their need for inpatient treatment.

I think it's fair to say we as Commissioners have been a bit disconcerted by the data that has come to us about the increasing use of compulsory treatment for young people, and the trend that we're seeing - and I think, Paul, in your witness statement you describe this very risk averse culture that you think has grown out of adverse events and the way they're being examined.

But if we think this is an issue that is - so, we're seeing a trend going in the opposite direction really to the trend we'd like to see, which is a reduced use of compulsion, how do you think we should be tackling that as a Royal Commission?

DR DENBOROUGH: Can I answer here, answer that too, because no-one has yet asked me about Root Cause Analysis, which is my passion, and I don't know if anyone else has mentioned it in your evidence?

THE CHAIR: No. I did see it in your witness statement, so I'm giving you an entree.

DR DENBOROUGH: And I'm not trying to say this in a flippant way, but it really is one - you know, I'm talking about family-inclusive practice, that's which I think is the biggest reform that's needed, but I think the second biggest reform is doing away with Root Cause Analysis because it does have very insidious effects within the mental health system when you try and use that methodology, which has been used for plane crashes, to find a cause or blame for why someone took their own life, and it's very hard to describe unless you've really lived through these things.

I have to go to a risk meeting every month at The Alfred and it's very traumatic because people feel they have to find blame on somebody. Now, that might seem fair enough in some ways, but what it does, it leads to so many issues.

Someone has asked me about files and why - how distressing it is for clients to read their file when they get them sometimes, because it's very judgmental and very bad language in them - I mean, in terms of pejorative paternalistic language and all that sort of stuff.

Well, the problem is that people feel the file is a way of covering themselves. They don't see it as a way of - that it actually really should be the client property. It should be about how to document what people are doing together to get well. Rather than, they're always - some people just word-for-word verbatim use it like they're about to defend themselves in court when something bad happens. You always come - people have to see a doctor because, maybe if the doctor's seen them, then that'll mean we're covered if someone dies, and so, it leads to many, many bad effects in the system.

Which doesn't mean you shouldn't review deaths because there's ways - but the methodology that's used particularly in Victoria, and it's getting potentially worse, creates so many problems. And, I think it is a way that does increase the use of voluntary treatment, because people are feeling scared that they'll be blamed if someone takes their own life.

So, it's a real thing, and I actually feel like that's something I've noticed has got worse over the last 5 or 10 years actually.

THE CHAIR: Sandra or Amelia, do you want to comment on that, because you've both referenced this? So, Sandra?

ASSOCIATE PROFESSOR RADOVINI: I might go next. I agree with Paul that cultures of blame lead to increasing restrictive practices, and cultures of blame also exist where people are - or those restrictive practices also exist where people feel unsupported, and so they go, well, not on my watch, you know, this young person must go into hospital.

And my experience, and it was really quite amazing, when I was the clinician for the Intensive Mobile Youth Outreach Service for 7 years, it was right at the beginning of doing outreach work with high-risk young people, so this was the people where the rest of the service said, these young people are really risky, so the risk was indeed of young people dying.

And I can say to the Commission, we had no deaths, other than a death that was a car accident. We had no deaths in 7 years. We decreased hospital admissions, we decreased length of stay in hospital. Why? Because we could wrap-around a young person the supports they needed, and we had a service that understood that that's what we were doing, and that, to indeed enforce inpatient admissions was often counter-therapeutic and it would lead to worse outcomes.

But you can only do that if you have all these levels of support and understanding and, back to Paul's point, and you engage families and carers and talk about options and preferences, and talk about risks and be quite transparent that indeed this is a risky situation, and here is what we're all going to try and do, and you talk to a young person themselves.

You know, my comment before was, it might take several days, if not weeks, of talking to a young person about why being in hospital might give them a break, might give them support, might decrease their distress, and we tried really, really hard to have the young person agree. We hardly ever used the Mental Health Act; often it happened after hours or when people attended casualty.

And the other thing you need is, you need to know a young person and you need to know their supports so that you figure out this question of, how risky is risky? And, if you don't - if you can't answer that question, then people will go with the, well, I have to be safe because otherwise I will be blamed, and that's when you have admissions that use the Mental Health Act and, you know, I agree.

And also to Paul's point about Root Cause Analyses: that things are reviewed, absolutely they should be, and that we consider the care that a young person has had and that we look at, was there something more that we could do or not do; but, regardless, that does not mean that the outcome would necessarily have been different, because people have agency and sometimes things happen in people's lives that, sadly for them, at that moment the solution, the only solution, is that they end their own life.

So, we need to review, but really to be careful about this question of blame, and sometimes perhaps an audit process allows a review that is a bit different from a Root Cause Analysis.

DR DENBOROUGH: Look, I don't know if - I'll just jump in, because you could call it a retrospective care analysis, because I'm not saying we shouldn't review situations.

I mean, we've got a very sophisticated way of doing it here which I haven't mentioned in any of these witness statements, but the idea is to see whether we're doing family inclusive care, whether they're welcomed in, you know, whether we provided good care for this person; not who said what or who did what on that day or who's to blame for that person ending their life.

It sounds like it might be just a subtle change, but it's actually a massive change to review cases on, like we would any care of any person here. You know, sure, if no-one's ever called the person back after they rang in, or we never saw their family, or we gave them too many drugs, you know what I mean, if the care was shoddy, fine, that's - we do need to review that. But it's not about - these Root Cause Analyses are nothing about that, they're always about, who was the last person who saw them alive and why didn't they put them in hospital - always.

THE CHAIR: Amelia, did you want to comment on that or not before we move on?

MS CALLAGHAN: Yeah, just one quick thing, because we've been talking about, really what we're saying here is that part of the involuntary treatment is driven by the clinician's needs, and so, while I think we can add other support options for young people to reduce the need for involuntary admissions, I think until we add additional supports around those clinician drivers, then we may still see the same thing happening.

So, whether that's greater supervision, greater mentoring, changing approach, as Paul was saying, from RCAs to, you know, more of a quality improvement system. It's not just about increasing the support options that are available as alternatives to hospital, it's also about the supports for the clinicians so that those underlying drivers about risk aversion and blame don't keep continuing in the face of other service options.

THE CHAIR: Fantastic, thank you. I heard the comments you all made about the need to keep the age ranges very broad and I guess the one thing - it was very heartening in our conversation today to hear the emphasis on family-centred practice, engaging and working with families as part of a resource.

Can I just ask on your reflections, with the consumers you work with, the 18-25-year-olds in particular, where some would say they have a greater level of self-agency, greater maybe desire sometimes for independence; is there anything particular in still adopting that family-centred practice that we need to be mindful of? Because it's something the adult system absolutely struggles with from all of the feedback we've had about how to reconcile these two things. How have you done that with that older cohort that you're working with?

DR DENBOROUGH: I'll be very brief, but the main issue is offering the first appointment to the whole family, because no-one expects anything different if you set it up that - and then, if it turns out that that's a bad idea, which normally it isn't - I mean, once in a million it is, but let's just say it isn't - it doesn't mean that young person can't be seen by themselves after that; that's fine, and in fact that might the primary focus, but at least the parents or the family have been involved in that first meeting, and so they feel like they're part of it, even if we all agree that they take a back seat for the next three months or whatever.

But that's the key thing, you don't have to do anything else in my opinion apart from that, because that gets around the confidentiality, the everything and, you know, it sets up the expectation that your belief system is that, for this young 18, 21 or 24-year-old, at some point they may well need their family to help them and they need to know who's helping the young person; at the bare minimum just, you know, put a face to a name and then, if things come up later, but generally with the psychosis we need to have them in every meeting often.

So, I'm not saying - I'm just saying, the worst-case scenario is you have one meeting with the family and never see them again; that's the worst-case scenario and that's very unusual, normally we'll keep seeing them. But, if you don't do that, it's very, very difficult.

THE CHAIR: Thank you.

MS CALLAGHAN: Can I?

THE CHAIR: Yes.

MS CALLAGHAN: I suppose I'm a bit - I am - I agree with Paul, but I think there are some scenarios though where that could actually be seen as a barrier to the young person accessing support; that, if I can only come if all my family can come, then I'm not going to come.

So, I think again what we've heard from our - I mentioned the 15 young people that we've been working with in the community with lived experience in this region, is that they want flexibility and choice within how that happens. So, we can say, these are the options, this is what we think works best, but there still is a sense of, that they have a sense of agency around that.

So again, my preference would be that we see the young person - if the alternative is, you know, yes, we see them with the family, great. If they're not going to come with their family, we see them and build towards the family coming in at some point. Rather than, again, you know, we see this young person, particularly in the 18-25, needs to really feel like they have the sense of agency here.

THE CHAIR: Yep --

ASSOCIATE PROFESSOR RADOVINI: (Inaudible).

THE CHAIR: Sorry Sandra, keep going.

ASSOCIATE PROFESSOR RADOVINI: Yeah, I was going say, I'm going to jump in and say, when young people don't wish their families there, we need to understand what that's about; that not all families are the same, dare I say.

So, there are sometimes good reasons why young people are saying initially, no, you know, and when you understand those reasons then you can do exactly what Amelia is talking about, you can try and address those reasons and work towards thinking with the young person about, well, can we see the advantages of families being involved and help a young person, again, get to that place, but also help the family to think about how to support - you know, it kind of goes in both directions, that sometimes families need assistance as well to think about this scenario now of a young person being unwell and what that might look like.

And I think about, I guess, my experience particularly with young people who might have neurodevelopmental difficulties, and so, even though they might be 20 or 22, they're not necessarily functioning independently, they absolutely are embedded in their families and need their families, but how and when is important.

DR DENBOROUGH: I guess just - I think what Amelia is saying is right; I mean, anything that's too black and white is not gonna work.

But I suppose the default - the expected position is, the family will come, obviously there will be exceptions to that. What normally happens I think in most places is, it's normally the young person that's seen first and then the family - or that's the other way round, and sometimes the family will comfortably be there at the first meeting.

So, it's more I think the black - it's not black and white. I suppose what I'm getting at is, the default position is that we expect everyone to be there and that's the open dialogue model; where in fact what they do is, they go to the house, and you know, I think that's even better; if some families would much prefer if we had the first meeting in their home, and we do do that a lot in our

Early Psychosis Program and that's where you see everybody in their home.

THE CHAIR: Thank you very much, that's a very helpful discussion. Alex, can we go to you next?

COMMISSIONER COCKRAM: I think I'm following up on a question that you were asking, Penny. I'm not sure if this is where that question was heading, but I'm going to ask Paul this.

I think where we were kind of starting to ask the question about is, what is the advantage of being mainstreamed with the Alfred as a service? And, I guess, you know, I'd be interested in your thoughts about the advantages and disadvantages of the concept of the mental health system being embedded in an acute healthcare provider.

DR DENBOROUGH: Yeah, umm, I suppose. Yeah, that's a good question, I'm not sure I've answered it well. So, the advantages for us - so, I'm trying to wear two hats.

The advantage for CYMHS, and feeling responsible for people who are mentally unwell, is that we have a partner that can help us by seeing - I think our Headspace saw 3,000 people last year, for example. Now, I'm not saying all of those potentially would come to CYMHS, but a lot of them might have been trying to come to CYMHS, so it takes the pressure.

Obviously, all services --

COMMISSIONER COCKRAM: Sorry Paul, I'm just going to interrupt you. But the question isn't about your relationship to Headspace, the question is about your relationship to Alfred Health.

DR DENBOROUGH: Oh, Alfred Health, I see.

COMMISSIONER COCKRAM: Yes. Why are you connected - what is the advantage and disadvantage to you being mainstreamed with Alfred Health?

DR DENBOROUGH: Yeah, there's probably - I mean, I'm quite fortunate, the people above me leave me alone a lot, so I'm not sure - obviously, it is a bit easier to employ doctors in a hospital, so that's one advantage.

Umm, yeah, it's a good question. Obviously, they do back us up after hours for our older 18-25-year-olds. It's interesting being linked with Alfred Health because it's not a - the casualty or the ED doesn't see young people, so that seems to work okay, but we have to have quite a bit to do with Monash Hospital both for admitting paediatrics and with anorexia sometimes, or as least as possible, and their ED.

What's the advantages? I'm not sure what the alternative would be; maybe I'm not imaginative enough but.

THE CHAIR: A stand-alone governance arrangement for community-based mental health services?

DR DENBOROUGH: Yeah look, I don't think that would be terrible, to be honest. Obviously, what's been a problem for the Early Psychosis services in other states, where they're not, is that, for registrars all of the other services have really struggled. Because we have a good relationship with the broader Alfred system we can - we're fully staffed with registrars, and I know that's been a big problem, and I see it's probably more the doctor side of things that is an advantage.

I'm not saying they still wouldn't do that, but I know the NGOs who run services - and there's lots of reasons behind that, I think New South Wales in particular are particularly annoyed that Headspace got the money in the first place, so there's problematic relationships from the start. But yeah, I don't know if that - I haven't really thought about that, to be perfectly honest with you, and I wouldn't be totally saying it's a bad idea.

COMMISSIONER COCKRAM: Okay, maybe it's a conversation you might want to come back to at another time but interesting to ask.

One very small question for you, Paul. The conversation at one point was talking - and Amelia was talking about it - is the problem of not being able to get support for families where the identified consumer is not necessarily wanting to engage.

Does the Discovery College provide a broad level of support to people even if their children aren't willing to come into the service? Can they still go?

DR DENBOROUGH: The first thing I'd say is, we don't do that, we do see people without the young person. So, the difficulty is, Headspace Primary can't really do that very easily because of the fact that it's Medicare, but I'm not saying - it's not impossible either.

But in our HSHEPP and CYMHS we - I wouldn't say - we'd obviously try and avoid that, but we often see parents without the young person, and that's quite a common problem problem actually because - that's another thing about single session, is that, particularly - and I'm going to be a bit provocative here - but sometimes dads, but definitely teenage boys don't want to come. But if the mum who's the one who's desperate to get help says, "Well, will you come once?", it is actually one of the commonest things that we use single session for, is for people who don't wanna come. Because they'll agree to come - they'll go, "Oh, I'll come once", because people have this idea that, if they go there, they're going to be coming for ages, that's the sort of perception.

But actually Discovery College philosophy, just getting back to your question, is supposed to be - it's a really strong held belief that it's for everybody. So, you can come. In fact, I've had my friends come to our mindfulness course and it's - yeah, so that's a really - because it's very - the Discovery College is very strong about their philosophical position, which is about equality, democracy and people, anyone's welcome, and so, yeah, anybody can come to that.

COMMISSIONER COCKRAM: Okay, thank you.

THE CHAIR: Commissioner McSherry.

COMMISSIONER McSHERRY: Yes, most of my questions have been answered, but just one for Amelia. I was interested, when you mentioned you were working with the 15 young people, and you mentioned they raised the concept, I suppose, of cultural responsiveness. And, we've certainly heard from members of various community groups that, you know, there is no notion of mental health, or they might talk about, you know, for African Australians, Ubuntu or a collective sense of health.

So, I'm interested to hear from you how you would respond to individuals from different cultural groups, and do you use translators, or how can we take that into account in mainstream services?

MS CALLAGHAN: I think how we should take them into account in mainstream services is to go back to looking more at co-design. Because I think things like - you know, I was saying, well, we use translators and we have information available that's translated. I'm still not sure that that's actually, if we went to a co-design process, if that's what they would like or they would need or what would be more engaging for them.

So again, just from that short experience, what we're seeing is more - it's actually bigger shifts than that. It's, you know, instead of seeing us in an office, come out to our, you know, community. Instead of talking to the family members, you need to talk to the Elder, you need to talk to the church leader, you know.

So, one of the projects we're doing is looking at Muslim young women, for example, because that group of 15 young people particularly identified that as an area that is not - you know, those young people are not going to come into your mainstream service necessarily.

So, we kind of need to be thinking bigger, I think, and I don't have the answers around that, so I think it is about then co-design and what does that - going back to those communities and what would that look like for them.

COMMISSIONER McSHERRY: Thanks very much.

THE CHAIR: And Sandra, do you want to comment on that before I go to Professor Fels?

ASSOCIATE PROFESSOR RADOVINI: Yes. I can give an example. One of the Headspace centres in Melbourne that related to a CALD community decided they would go and meet with the Elders, and they would say to the Elders, "What is it that your young people need? How can we assist you to help your young people?" And the answer on that particular occasion was, not about "mental health services", but language: you know, teach our community, come via a learn English and, in that way, embed things around wellbeing.

Just an example that I recall, because it was very powerful at the time, and that's what they did.

THE CHAIR: Fantastic, thank you Sandra. Professor Fels.

COMMISSIONER FELS: Thanks to all of you for excellent statements and evidence. A quick one to Paul about the role of families, and I acknowledge everything you've said, and all of you have said, about their importance, involving them in consultations.

I think that you also need to embed or give families and carers a voice in governance. So, not only co-design, co-production, but give them some authority in health systems that sort of force, shall we say, somewhat recalcitrant workers to take some account of them, to give them a bit more power in health systems than they have at the moment. Any comments?

DR DENBOROUGH: I actually fully agree with you. So, I think even - I mean, we try and do that, but it's not as effective as we'd like.

So, obviously we have our family - so, we've got a team of family peer workers and we have a person in charge of it and she is on our executive. But even then it's hard - she's obviously paid a lot less than everyone else around the table, and so, I feel like her power is not, as you would say, I don't think she even in that situation - we try and give her power; but I think power in organisations like ours is hard to get if you're paid less for one thing, if you're a family peer worker - I just don't know, it's hard to change that.

So, I actually agree with you though. I don't know if you have any ideas about how to do it, but I think with this Collaborative Centre in the adult area - which I will jump in and say, I don't understand why we can't have that same thing for teenagers and children as well, and I don't know why it's only adult, but anyway, that's another thing. But let's just say, I'll add that in there.

Because Marie Piu from Tandem, who I'm sure you know well, actually also feels like she's not sure why it's not all age, because that does sound like a very exciting thing, if I understand what it's supposed to do. And I guess, running a service like that, I would have thought it would need someone like Marie or that to be equally in power with a clinician and a - so currently our - I don't know if you're alluding to this with this idea of not being run by The Alfred; if it was a community-based system which had a family person and a consumer person in charge with the clinician, a collaborative leadership or something like that, that would - may be one way to do it.

COMMISSIONER FELS: Thank you.

MS CALLAGHAN: I have something here. So, I think there's also an added complexity here with young people because their family - a lot of the family members don't see themselves in this sort of chronic or longer term carer-type function. So, I think there is also a challenge in this particular youth area that's about, how do we get a range of families that have a range of experiences and, even if they're often dealing with quite serious mental illness, they don't necessarily see themselves as having that role in terms of governance of.

I completely agree with you that it's needed. I think the challenge we face here though, which is distinct from adults, is you often then have someone who's identified as being a carer for someone with a chronic mental illness, whereas for young people I think it's a bit different.

So, I think it's, yeah, how do we apply that principle of having families and carers and significant others have a role within governance and what would that look like in this space.

THE CHAIR: Thank you very much. Can I just, before we finish up: Amelia, you mentioned an NGO, and I must say, I hadn't thought of an NGO running an Early Psychosis service or a Headspace, so I just say on notice, we'd be interested to get extra information about what type of organisations those are and what's involved in that, because it's something I certainly individually hadn't thought of before either, so that would be helpful.

Thank you all very much for your time. I said at the very beginning, your witness statements were fabulous for each of us to read. The conversations we have had today have been absolutely fabulous, and Georgina, thank you as Counsel Assisting for moving us through all of that material and making sure the key issues were brought out, including a little bit of disagreement amongst our panelists, but not much in terms of their perspectives, but it's been fabulous and so on our collective behalf thank you all very much.

I do really acknowledge that we've asked you to do that when there's been lots of other pressures that you've all been under, but we have found this hearing process a really helpful way for us to grapple with some of the very challenging issues within this space.

Probably, we left our commentary in relation to the infant child and youth system to the final report because it's been so vexed for so long; we have to find a way through it and trying to work out what the right way to do that is really important and today's discussion has been incredibly helpful for our process, so thank you all very much.

AT 1.00PM THE COMMISSION ADJOURNED