“Because Mental Health Matters” Discussion Paper Response

Focus Area 1 : Prevention

Goals

1.1 Creating wider opportunities for promoting mental health in local communities

1.2 Strengthening social inclusion efforts to protect and reduce inequalities in mental health

1.3 Reducing the risk factors for poor mental health associated with substance misuse

1.4 Renewing Victoria’s suicide prevention focus through a wider range of government programs.

G 1.1 Questions

What are the most promising avenues for further work across families, schools, early childhood settings and workplaces?

Are there other settings that: should be considered?

What partnerships should be developed to support a coordinated approach to progress in the above settings?

G 1.2 Questions

What aspects of current work can most effectively be built upon to promote social inclusion and reduce inequalities in mental health outcomes?

G 1.3 Questions

Who are the priority target groups in the community for providing education and support on the mental health risks of substance misuse?

What are the opportunities for better integration of mental health and substance abuse prevention efforts?

How can relevant service systems be supported to identify and respond at an early stage to mental health risks arising from substance misuse?

G 1.4 Questions

What are the best opportunities to embed suicide prevention activities in universal and specialist services?

What aspects of the current approach to suicide prevention need further improvement?

Focus Area 1 : Prevention

Goals

1.5 Creating wider opportunities for promoting mental health in local communities

1.6 Strengthening social inclusion efforts to protect and reduce inequalities in mental health

1.7 Reducing the risk factors for poor mental health associated with substance misuse

1.8 Renewing Victoria's suicide prevention focus through a wider range of government programs.

Mental Health for the Young and their Families in Victoria (MHYFVic) strongly advocates the concept of promoting mental health in local communities. The greatest gains are probably achievable through universal services in State primary schools and Local Government-mediated services such as child care programs.

High quality universal and integrated early childhood services providing care, education, health and welfare services as a fundamental family support system will have the greatest impact on promoting resilience and well-being, the foundation of mental health promotion and prevention of mental disorders.

We therefore advocate for the future development of State primary schools to function as community facilities with kindergartens and community-owned child and family centers located in schools.

In order for such services to effectively reach the vulnerable families most in need of this support, it is also necessary to seek increased funding through Federal Government child care assistance including broadening of access to special child care benefits. It is also important to address critical skill shortages across the children's services sector due to poor pay and working conditions and inadequate recognition of the importance of these roles.

The new policies should aim for a partnership of local government/ health/ education/ welfare services which will not only build future integrated facilities but will coordinate existing networks to provide :

- State primary schools in local areas which have
    - an associated kindergarten, (see Note 1)
    - an associated child care centre, (see Note 2)
    - an associated maternal and child health centre, (see Note 3) and
    - an associated family counseling service. (see Note 4)
- Programs in state primary schools to promote respectful, considerate behaviour (see Note 5)
- Strengthening of programs such as Sure Start in kindergartens to promote developmental progress, especially in the language and social areas (see Note 6)
- Programs in child care centers to promote security and attachment (see Note 7)
- Follow through from maternal and child health to school and family support or specialist services such as CAMHS where necessary (see Note 8)
- Properly funded Mental Health Promotion Officers in CAMHS (see Note 9)

Notes

1. Recent initiatives to integrate kindergartens with state primary schools raised concerns that this was being done for the wrong reasons, such as simplification of teacher salaries and working conditions or the mistaken belief that this would result in an earlier start on teaching literacy and numeracy. The main kindergarten child developmental tasks that have been so well achieved under DHS governance could be at risk if the focus were to shift to "early schooling". The partnership of kindergarten staff and families in promoting developmental progress needs to be incorporated into the primary school ethos. The impetus for this will probably be greatly increased if the scope is further extended to include Child Care Centres. It is necessary to explicitly reject the notion that formal teaching is superior to social interaction, play and language enrichment that are the basis of quality child care programs.

2. Recent Federal Government advocacy for greater availability of community Child Care Centres, to enable parents to rejoin the workforce whilst being confident that children are properly cared for, suggests linkages with kindergartens. This dovetails with State moves to integrate kindergartens with

primary schools. It also dovetails with research that quality community child care promotes child development and improves opportunities for family support.

3. Maternal and Child Health Centres have typically been collaborative ventures between local government and DHS located separately from other agencies, but this policy review raises the possibility that such centers could be co-located with the newly created school/ pre-school/ child care facilities. Even if not co-located there could be firm functional linkages established under policy initiatives.

4. Family Counseling services have been provided by a variety of agencies including local government, non-government, and Commonwealth and State government services such as Community Health Centres, CAMHS and other and DHS services. This review offers the opportunity to enhance connections between those disparate service providers.

5. The Institute of Education recently workshopped at the Royal Childrens Hospital a program from the USA aimed at establishing a whole of school approach to enhancing respectful behaviour in staff and students. This was shown to abolish the escalating violence and anarchy disrupting educational and social progress which sometimes resulted in armed security guards in hallways and metal detectors at entrances to reduce the carrying of weapons. Although the distortions in our system are much less, the principles of this program warrant an adaptation of this for Australian schools, which would be a major preventive mental health initiative.

6. Research indicates improved whole of life trajectory for children exposed to a good quality pre-school enrichment program. The lifetime benefit to society (and the individuals involved) was many times greater than the cost.

7. Similar cost/benefit returns are obtained from quality child care programs as in Note 6, above. The aims of child care include more basic nurturance and socialization for younger children as well as kindergarten style programs which prepare children for more formal developmental programs. More extensive enrichment of this type may be essential in some marginally-coping families.

8 & 9. Mental Health Promotion Officers are needed in every CAMHS service. Although the existing system does very valuable work, there is a need for a much more comprehensive contribution provided by a significantly increased staffing. The precedent for this was in the 1974 Whitlam Government initiatives in forming Community Mental Health Teams, whose work was in providing mental health consultation to all agencies involved in services to children and families. This included tertiary consultation for implementation of universal and selective programs in agencies, secondary consultation about improving management of particular client special needs, and occasionally primary consultation for early detection of mental health disorders.

Such a diversity of work requires staff with high level skills, and is usually best achieved by work time being shared between the MHPO and clinical work. The essential requirement is that the funding for community work is protected by being segregated from funding for clinical work, with its own separate KPI. Failure to do this results in the gradual erosion of the community work by the ever-present demands of clinical work. The other essential requirement is the need for training and experience. In former times this was provided by seminars on the Consultation process. MHYFVic has full documentation on the Seminars and on past work undertaken by the CAMHS Community Mental Health Teams.

Focus Area 2 : Early Intervention

Goals

2.1 Strengthening capacity for early identification and intervention through universal services, including early childhood services and schools.

2.2 Providing earlier and age-appropriate treatment and support to children and young people with emerging or existing mental health problems and their families.

2.3 Delivering appropriate mental health support for particular groups of vulnerable young people.

2.4 Building stronger, more resilient families where there is risk related to mental health problems or a combined mental health and drug and alcohol problem.

G 2.1 & 2.2 Questions

What should be the respective roles of universal, secondary and specialist mental health services in a system of care focused on early identification and intervention? Why?

Should a stronger problem identification capacity be developed? If so, what should be its key features?

What are the appropriate and viable options for structuring services for adolescents and young adults:

Are there distinct groups, defined by age or type of mental health problem that need different interventions?

What service arrangements should deliver these interventions?

What would be the key features of accessible and effective service models? How

should such services be located in the broader service system?

How could family-centred practice be better embedded in models of care?

G 2.3 Questions

What would be the important key features and functions of a service offering dedicated mental health support to vulnerable young people?

G 2.4 Questions

What supports should be in place for young people who are carers of parents with mental health problems, or with combined mental health and drug problems?

What models would be most effective?

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2.4 Building stronger, more resilient families where there is risk related to mental health problems or a combined mental health and drug and alcohol problem.

MHYFVic supports the concept of promoting mental health in local communities. The greatest gains in overall mental health are probably achievable through universal services in State primary schools and Local Government-mediated services. For early intervention, however, the connection with specialist

Child and Adolescent Mental Health Services becomes more essential. Thus, MHYFVic proposes a **foundation of mental health promotion** programs in a network of universal service providers which is coordinated with a network of Tier Two service providers for the **selective and targeted interventions** for young people and their families who are seen to be at risk.

For mental health promotion in the universal services area MHYFVic proposes an underlying partnership network of local government/ health/ education/ welfare services to provide :

- state primary schools in local areas which have
    - an associated kindergarten,
    - an associated child care center,
    - an associated maternal and child health center and
    - an associated family counseling service.
- Programs in state primary schools to promote respectful, considerate behaviour
- Programs in kindergartens to promote developmental progress, especially in the language and social areas
- Programs in child care centers to promote security and attachment
- Follow through from maternal and child health to school and family support where necessary

(Notes 1-9 on the above service delivery components are submitted in the MHYFVic response to Focus Area 1 commentary on preventive mental health issues).

For mental health early intervention MHYFVic proposes a specialist Tier Two network comprising :

- Community Health Centre counseling services (Note 10)
- Specialist Education Department School Support Centres (Note 11)
- Non-Government agency counseling services (Note 12)
- Primary Health Care services (GP and psychologist programs) (Note 13)
- CAMHS Consultative Services (Note 14)

Note 10 Community Health Centre counseling services. MHYFVic advocates that CAMHS should not have a direct intake referral service but that all referrals should be through Community Health Services (or out-of-hours CAT Teams) which have consultative services and clinical support links with the CAMHS services. Thus early intervention and many identified cases will be dealt with in the locally available and non-stigmatising health services whilst those requiring specific specialized psychiatric programs will be picked up through the consultative service links to CAMHS.

This proposal has already been made to Mental Health Branch by MHYFVic as a preferred answer to the problem of CAMHS having a confusing mixture of Tier Two and Tier Three cases. If all cases are seen initially at Community Health Centres then only Tier Three cases will attend CAMHS.

Note 11 Specialist Education Department School Support Centres Consultation to class-room teachers by educational psychologists, social workers and speech pathologists may lead to referral to therapeutic programs at Community Health Centres or CAMHS Consultative services.

Note 12 Non-Government agency counseling services may see families that are self-referred or through child protection services but may require CAMHS consultative services or specialist therapeutic programs. The area linkages should be able to facilitate such cross agency collaboration.

Note 13 Primary Health Care services (GP and psychologist programs). These programs are known to see a significant proportion of cases that have identifiable mental health needs but do not make contact with mental health services. Therefore it is important to have network linkages with these service providers, perhaps in a similar way to the adult service primary health project.

Note 14 CAMHS Consultative Services have a very important role to play in the collaborative network described above. It is alluded to in the diagram on page 62 as a 'Redeveloped Community Mental Health Service for C&A' to liaise with other agencies. This is an excellent proposal and is strongly supported by MHYFVic.

Without wishing to be negative, it is nevertheless important to say that it has been done before and fizzled out. In 1974 the Whitlam Government funded a CAMHS Community Mental Health Team at Observatory Clinic which had a very strong program of consultative services to a variety of schools, kindergartens, day care centers, school medical and other agencies that lasted for many years and was highly valued. It did precisely the kind of work envisaged by this discussion paper. It fizzled out because the specific program funding ended and the costs were then part of the general CAMHS budget but the DHS key performance indicators did not make allowance for this type of work. Gradually staff were required to do more and more clinical work at the expense of reduced consultative work until the program became invisible.

The lesson from this is that the importance of community-based work must be recognized by an appropriate time allocation in the funding model. Past experience suggests a minimum of 10% of staff time should be devoted to community consultative work *ie* one half day per week per full-time staff equivalent.

Additional Comments

In response to the question raised in 2.4 regarding support for young persons in carer role, MHYFVic agrees that support is needed for young people who are 'carers' of parents with D&A or other mental health problems, but wishes to point out that the young persons may not necessarily be be identified as carers. Therefore, for exactly the same reason as children of parents with a mental illness need to be included in the management plan of the identified patient, so too do the children of adults with a D&A problem.

Focus Area 3 : Access

Goals

3.1 Providing access to 'right time, right place' mental health care by making it easier for people to obtain mental health information, referral and advice.

3.2 Improving the efficiency and effectiveness of psychiatric triage in specialist mental health services.

3.3 Creating an integrated emergency service system that can respond effectively to people experiencing a psychiatric crisis.

3.4 Reducing the level of preventable crisis by providing a robust system of community-based primary and specialist mental health care

G 3.1 & 3.2 Questions

How do we enhance access points to the specialist mental health system and what critical issues should be considered? What role should GPs and other primary care providers play in this?

What reforms are required for the mental health triage functions in AMHS?

G 3.3 Questions

What reforms to mental health CAT services are needed?

Is it appropriate for CAT services to be both the gatekeeper to acute inpatient services and providers of acute care in community settings?

What reforms are required to support police and ambulance services' capacity to respond efficiently and effectively to people experiencing a psychiatric crisis?

Is it time for a concerted approach similar to that used with cardiac conditions, leading to possible initiatives such as focused staff training and designated mental health experts within the ambulance system?

What models of care and new processes should be considered in EDs to improve outcomes for people with mental health problems and other complex needs presenting in this service setting?

How can we reduce the number of non-urgent presentations to hospital emergency departments and the 'flow' of patients from EDs?

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MHYFVic supports access to ‘right time, right place” mental health care, makes the general recommendations that :

- Information about mental health services is readily available where families are likely to see it in the community, such that it can be readily communicated through universal services.
- Mental health information, referral and advice encompasses child and adolescent as well as adult mental health services.
- Information covers all areas of mental health and not be limited to ‘serious” mental health problems such as schizophrenia.
- Links be developed between other services providing advice to parents, such as Parent line, which provides counseling, information and support on a wide range of parenting issues.
- Increased information/training about mental health issues for child care workers, teachers, maternal and child health nurses to assist these workers who are likely to be the consulted initially regarding mental health problems and/or observe symptoms.

MHYFVic considers that access to child and adolescent mental health services continue to be provided through the current three tiered scheme. However, MHYFVic argues that access to Tier Three (CAMHS) be triaged at the Tier Two level, principally at Community Health Centres, but with strong Tier Three consultation supporting the latter. In such a system :

- CAMHS should be resourced to provide on-site staffing to the Tier Two level for training, consultation, specialist assessment and treatment purposes.

- Tier Two services can be expected to form increasingly stronger partnerships with each other at the local level as well as with Tier One services.

An integrated emergency service system that can respond effectively to people experiencing a psychiatric crisis again needs to cover all age groups and all mental health problems. As those presenting with mental health issues may also require medical treatment or vice versa, specialist mental health workers located within Emergency Departments of major hospitals.

- Locating within already available ED's provides access to the community
- Mental health services in ED's can actively reduce stigma associated with mental health by becoming an accepted part of treatment of a range of health problems.
- It will support far more streamlined and coordinated treatment of those who require a response from both medical and mental health practitioners such as those who have self-harmed, eating disorder sufferers who require emergency medical treatment.

Focus Area 4 : Specialist Care

Goals

4.1 Building a more proactive system of specialist community-based mental health care that is geared to early intervention, relapse prevention and recovery.

4.2 Accessing a wider range of bed-based care options that are well integrated with both clinical and social supports.

4.3 Improving consumer and carer experiences, making sure that expectations with regard to access, rights, equity and respect are met.

4.4 Tailoring services for clients with particular needs, especially forensic clients, including both bed and community-based support.

G 4.1 Questions

How can we achieve a more integrated clinical and psychosocial rehabilitation response?

How can we strengthen the interface between GPs and the specialist mental health service system, particularly in the areas of shared care, assessment and referral?

What are the characteristics of our current community-based service system which promotes the use of CTOs? If we envisage a more consumer-focused, voluntary treatment system, what would need to change?

What reforms are required to improve the early identification and treatment and continuity of care of people of all ages with eating disorders?

How should we consider the respective roles of local, regional and statewide services in this area?

G4.2 Questions

What reforms are required to improve the efficiency and effectiveness of Victoria's specialist adult and aged mental health bed-based service system?

What are the characteristics of our current service system which results in recourse to practices such as seclusion? If we want a more consumer-focused, voluntary treatment system where the consumer is regarded as a partner in their recovery, what would need to change?

Should we consider reconfiguring the boundaries between CCU and PDRSS residential rehabilitation services?

G 4.3 Questions

What key policy directions should be considered over the next 5-10 years to achieve improved consumer empowerment and self determination?

What strategies/mechanisms are required to better support the active involvement of consumers in their treatment and care?

What are the best models for supporting a carer sensitive approach in the mental health system? What carer support models are most appropriate for Indigenous people and their families and CALD communities?

How can we best promote culturally sensitive practice within mental health services arid in broader social support services?

G4.4 Questions

What reforms are required to improve the efficiency and effectiveness of the community and bed-based forensic service system? How can AMHS and PDRSS better support and provide treatment and care for clients with a forensic mental health history?

Focus Area 4: Specialist Care

Goals

4.1 Building a more proactive system of specialist community-based mental health care that is geared to early intervention, relapse prevention and recovery.

4.2 Accessing a wider range of bed-based care options that are well integrated with both clinical and social supports.

4.3 Improving consumer and carer experiences, making sure that expectations with regard to access, rights, equity and respect are met.

4.4 Tailoring services for clients with particular needs, especially forensic clients, including both bed and community-based support.

MHYFVic agrees that proactive mental health service provision is vital. To this end, it proposes that :

- The current three tiered structure of service provision be retained but that Tier Three (CAMHS) be made readily available at the Tier One and Tier Three levels; and
- Tier Three (CAMHS) be resourced to provide substantial consultation to levels One and two concerning early intervention principles and support for young people who have received CAMHS services.

MHYFVic supports the rights of consumers and carers and their active involvement in areas of the mental health service and advocates :

- Public awareness campaigns to combat stigma towards mental illness in the community, including child and adolescent mental health.
- A recognition by government that the attitudes of those working in the mental health services

contribute to the stigma of mental disorders. Carers and consumers often find workers patronizing, critical, humiliating and coercive. There is often a lack of respect, dignity, compassion and empathy. Professional development programs are needed to change these attitudes.

- Appointment of Independent consumer and carer advocates and provision of information and support to users of CAMHS.
- Overhaul of standards of service delivery in CAMHS inpatient units after comprehensive review.

Focus Area 5 : Complex Clients

Goals

5.1 Promoting a more coordinated and tailored approach to people who require support from multiple services.

5.2 Improving access to stable and affordable housing, together with appropriate and scaled support to reduce homelessness and sustain tenancies.

5.3 Focusing on the needs of people from particular vulnerable and disadvantaged groups.

5.4 Maximising the individual's potential for recovery by supporting their social and economic participation in community life.

G 5.1 Questions

What key system reforms are needed to support the effective coordination of care across multiple service systems?

How could existing service platforms be used to support local partnerships and linkages in the delivery of age-appropriate coordinated care?

How can family or carer supports be most effectively incorporated into integrated care planning? What statewide guidance and support is required to support any new model of care coordination?

G 5.2 Questions

What are the key reforms required to improve access to social housing and private rental for people with mental health problems?

What role could or should Housing Associations and other areas, such as local government, play in the provision of social housing for various age groups with mental health problems?

How can we more effectively support people of all ages with mental health problems and/or psychiatric disability who are at risk of or are homeless?

What reforms can be implemented to improve responses to young people who are homeless and who require treatment and support from mental health services?

G 5.3 Questions

How can we better respond to the needs of people with mental health problems and co occurring substance misuse across the continuum of need? What are the areas for priority action and why?

If we were to develop a more integrated response to the needs of people with a dual diagnosis what would this response look like and who should it target?

How can we respond more effectively to the needs of Indigenous people at risk of or with a dual diagnosis?

How can we reduce the risk of offending behaviour by, and victimisation of, people with a serious mental illness (including those with a co-existing substance misuse, disability or other complex problems) and

their engagement with the criminal justice system?

How can we most effectively support people with serious mental health problems at each transition point in the criminal justice system to reduce the risk of them re-offending or being re-victimised?

What specific actions are required to improve the social, spiritual arid emotional wellbeing of Indigenous people, their families and communities?

How can we support the Specialist public mental health service system to better respond to the needs of Indigenous people experiencing poor social, spiritual and emotional wellbeing and their families?

What is the role of government in supporting Indigenous communities to draw on their own social and cultural resources to find and implement local solutions to the social, spiritual and emotional wellbeing needs of their community members?

How can we support both the specialist disability and mental health service sectors to better identify, treat and support people with mental health problems and co-existing disability?

What housing and support models would best support this group? What features would these models have?

Should a more centralised approach be considered for people with more severe mental health problems and co-existing disability? What would such a service response look like and who should it target?

How can we more effectively support refugees, including children and young people, who have, or are at risk of, mental health problems?

G 5.4 Questions

How can Victoria better support people with a mental health problem to become job ready and secure meaningful employment?

What role should the specialist mental health service system play in this regard? What role could local and regional partnerships play in achieving this outcome?

Focus Area 5: Complex clients

Goal 5.1 Promoting a more coordinated and tailored approach to people who require support from multiple services

MHYF Vic is acutely aware of how this goal relates to children and young people. Children and adolescents requiring multiple services generally need at least some of those services on a longer term basis than others. For many reasons, the complexity of their situations often results in their not receiving services unless crisis has arisen, services are not geared to the longer term, and the client's health and social difficulties escalate over time, frequently into adulthood, and other family members are always involved in the complex of problems experienced.

It may be argued that issues raised by complex cases involving children and adolescents are particularly urgent for the community in view of the social systems so closely surrounding the young.

Question 1: What key system reforms are needed to support the effective coordination care across multiple service systems?
Question 2: How could existing service platforms be used to support local partnerships and linkages in the delivery of age-appropriate care?
Question 3: How can family and carer supports be most effectively incorporated into integrated care planning? What statewidw guidance and support is required to support any new model of care coordination?

MYHF VIC recommends the establishment of a dedicated inter-service public system structure within which case planning and management for these children and young people can be vigorously pursued and monitored. The role of such coordination would involve:
(a) providing comprehensive assessment of the needs of such clients and their families, possibly requiring specialised evaluations by individual agencies to be included;
(b) ascertaining the pattern of services (both government and non-government) likely to be useful over the short and medium term, and make the appropriate referrals;
(c) supporting the family or young person in accessing the services recommended in a sensibly graduated sequence; and
(d) actively monitoring the usefulness of the services, and coordinate new referral or transfer to other services as necessary.

For such coordination to be successful:
(a) the clients themselves must be active partners at every step of actual decision making within the case management;
(b) all services involved must be alerted to the overall plan, and ideally involved in a joint planning meeting which includes the clients; and
(c) a principal case management worker must be assigned to the family, a person with whom the clients can reasonably expect to have an ongoing relationship for the foreseeable future.

Currently, individual agencies may take on the responsibilities outlined above, and with varying degrees of rigour. Ideally, the dedicated structure recommended here could be a unit placed in each region to actually conduct assessments and coordinate services in that region in respect of child and adolescent clients identified by individual service delivery agencies. Such a unit would employ a range of appropriate human services staff, including case managers experienced in mental health issues for children, young people and families.

Alternatively, within each region a program for multi-service use could be headed up by a small, dedicated region-wide unit which would provide direction and support for services in the region in carrying out a coordinated/collaborative approach to children and young people with complex needs. Core tasks of this unit would be to:
(a) run regular information sessions to services and clients of services concerning the challenges faced by complex clients and concerning their needs for coordinated services;
(b) provide high-level in-service training to key staff in all relevant services concerning coordination processes and the special responsibilities relating to complex clients;
(c) provide ongoing support to service staff involved in case management of complex clients;
(d) maintain a register of multi-need families and the services they receive;
(e) set up data-gathering for much-needed evaluation research in this area; and
(f) serve as an information resource for families in the region.

Focus Area 6 :Workforce

Goals

6.1 Building a knowledgeable, skilled and sustainable specialist mental health workforce with an ensured supply.

6.2 Embedding a culture of service quality, responsive to evidence-based practice and client need.

6.3 Systematically improving the capability of the broader health and community services workforces

through education and training.

6.4 Strengthening leadership within the mental health service system and across the broader health and community services system.

G 6.1 Questions

What other means could be used to grow the Victorian mental health workforce, both in the short and long term?

How can we encourage more workers to practice in rural areas?

What incentives do we need to attract experienced and trained staff back to mental health services?

How can public mental health services work better with private providers to improve client care and enhance workforce development

G 6.2 Questions

How can we facilitate adoption of best practice in client care by mental health workers? What could we do to strengthen direct care governance in mental health services?

How can we facilitate continuous quality improvement in mental health service provision?

G 6.3 Questions

How can we support workers in other health and community services to better respond to mental health problems and achieve better recovery for people affected by mental illness?

G 6.4 Questions

Are there other ways that we can strengthen leadership within mental health services and across the broader health and community services system?

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MHYF Vic considers that, to be appropriately responsive to community needs and to enhance evidence-based practice, CAMHS must include certain critical workforce dimensions, and therefore advocates:

- adequate numbers of staff for the population of children and adolescents being served on a regional basis (Note 1);
- employment in each agency of a full range of disciplines, permitting the multidisciplinary team approach which is essential to child and adolescent mental health work;

- a breadth of theoretical orientations, of specialist assessment and therapeutic skills, and of special expertise relating to particular groups (eg. CALD, indigenous communities), and to less common case presentations (eg counter disaster, sexual abuse); and
- incorporation of staff skilled in evaluating outcomes of interventions.

Further, MHYF Vic identifies problems with recruitment and retention in several professions in the specialist child and adolescent mental health workforce, especially in rural areas. Major issues revolve around training and professional development, and remuneration patterns and career path provision. Each of these domains is addressed below.

Training and professional development

There needs to be greater recognition of standards of expertise and acknowledgement that, in general, basic undergraduate degrees do not provide a suitable structure for specialised program-based services. In particular:

- further training is required in all disciplines to meet standards required for best practice in CAMHS (eg. family therapy training, psychoanalytic training, specialist program training);
- such specialised training should be supported by time allowance and, as possible, by remuneration;
- a centralised training facility, such as Mindful, should be expanded to provide in-service training, continuing professional development and support to both city and rural workers; and
- ongoing supervision of clinical work by experienced and well-trained clinicians of the same discipline is essential for quality improvement in each discipline as laid down in professional ethical codes, and where necessary can be provided by audio/videoconferencing.

Remuneration patterns and career path issues

All government mental health workers need greater career and financial incentives to remain in the public sector (Note 2). This is especially true for rural professionals, who need adequate supports to work in more isolated situations. Attracting well-trained staff to CAMHS, and attracting experienced professionals back to the public sector, may be achieved by:

- allowing staff to use the facilities for some private work, as already occurs for some medical practitioners;
- giving them teaching, supervisory and consultative roles with appropriate remuneration (Note 3);
- providing them with medico-legal coverage, so that experienced allied health professionals do not have to work under the cover of a less experienced psychiatrist;
- better promoting shared care between public and private practitioners, which is also invaluable for complex cases requiring multidisciplinary input;
- review of career path patterns for most disciplines within mental health, followed by the devising of new systems (and possibly job descriptions) in which advancement is linked to expertise gained by experience and further training; and
- provision of a career path for program management with training in program management provided, such that the best person for the job is judged on the basis of skills, and it is not assumed that the person with the medical degree is best qualified to manage the service.

Note 1 Reference to population-based staff-population ratios would assist this process.

Note 2 Experienced staff are increasingly able to work privately when the public system does not recognize and reward their skills and experience.

Note 3 The provision of on-going consultation services to other health and community services can be invaluable for strengthening services and expanding skills of their workers.

Focus Area 7 : Partnerships

Goals

7.1 Designating local area partnerships to drive population-based service planning and coordination across the continuum of mental health.

7.2 Reconfiguring public mental health service structures to align age-related and PDRSS components, facilitate links with general health structures and allow specialist roles to develop.

7.3 Embedding accountability for outcomes associated with mental health into funding and reporting systems at all levels, including general health and social support services.

7.4 Creating an organised statewide research and knowledge management capacity to provide a robust evidence-base on mental health interventions.

7.5 Driving continued strategic policy development, alignment and accountability at the statewide level.

G 7.1 Questions

Which are the most important and useful functions that local mental health partnerships could perform and at what geographic scale?

Who should lead and participate in such structures?

Which existing structures could be built on to better meet mental health needs (taking into account differences between metropolitan and rural areas)?

What kind of statewide guidance and support would such local partnerships require to operate effectively?

G 7.2 Questions

What should be the priority for governance change in mental health services—alignment of age related services, clearer alignment with hospital structures or other issues?

Is it better for PDRSS services to be integrated with Area Mental Health Services or with wider primary and community service structures such as community health?

In the shorter term, should we move to identify a single lead or consortium PDRSS provider for each mental health service area?

What benefits would be achieved from broader clustering of mental health services on either a regional or multiregional basis?

What other factors should be considered in rethinking mental health service governance?

G 7.3 Questions

What should be the dimensions of a broad outcomes framework for mental health, and *at* ~-hat level should it operate?

What cross-agency governance mechanisms are required to implement such a framework? What support would local services and programs need to implement the outcomes framework?

What other mechanisms might we use to embed accountability for mental health support across the health and social care system?

G 7.4 Questions

What should be the scope and priority of a collaborative Centre for Mental Health Intervention?

How should Victoria develop a stronger network of researchers and those involved in program design and service delivery to share information on mental health research findings and generate ideas for projects?

What other strategies for enhancing Victoria's applied mental health research effort would you recommend?

G 7.5 Questions

What kind of overarching high level body or bodies should oversee the continuing development and implementation of the Mental Health Reform Strategy? Who should be involved in such a body?

Do you support the concept of a set of partnership groups at statewide level and, if so, what is the best way to divide responsibilities between the groups?

Focus Area 7: Partnerships

Goal 7.1 Designating local area partnerships to drive population-based service planning and coordination across the continuum of mental health

MHYF Vic is concerned that this very important goal takes into account the need for local services to remain abreast of advances in mental health research and knowledge. For example, in the child and adolescent sphere, understanding of the value of early intervention is progressing extremely rapidly, with important implications for treatment service planning and coordination, and for prevention. Leadership of such partnerships must be in touch with the latest relevant information, and hence is likely best to be an agent of the Mental Health Branch. Also MHYF Vic recognises the great value of taking a layered approach to the partnerships. These issues are spelt out in response to the questions asked.

Question 1: Which are the most important and useful functions that local mental health partnerships could perform and at what geographic scale?
Question 2: Who should lead and participate in such structures?
Question 3: Which existing structures could be built on to better meet mental health needs (taking into account differences between metropolitan and rural areas)?
Question 4: What kind of statewide guidance and support would such local partnerships require to operate effectively?

MYHF VIC recommends that local mental health partnerships in the child and adolescent mental health field embrace all government and nongovernment services delivering health and social services directly to children, to youth and to families, as well as consumer/carer representatives. An obvious guide to geographic area would be the regions designated to Child and Adolescent Mental Health Services, the provider of the most specialised mental health services in any community. Each CAMHS could be partnering with the health (including adult mental health), education and social welfare institutions, to be performing CAMHS region-wide local research and service planning functions in which CAMHS takes the lead. At the same time, however, there should be provision for larger or smaller partnership groups to form in relation to particular issues.

It is advised that child and adolescent matters be granted independent consideration at this stage of the development of mental health services in Victorian communities. When subsumed under the generic mental health services, the specific concerns of child and adolescent mental health tend to be swamped by specifically adult concerns. This does not deny, of course, that close liaison with adult services is essential – both in relation to children with a parent with mental illness and in relation to young people moving from CAMHS to adult services at a certain point.

To achieve a flexible structure with respect to partnerships, a local child and adolescent mental health partnership council chaired by CAMHS could be charged with the following core functions:

(a) mapping local services, identifying complementary, overlapping and missing areas of activity, in relation to needs expressed locally ;
(b) reviewing consumer/carer responsiveness among services;
(c) facilitating coordination of services across the local area in a general sense;
(d) recommending and facilitation of services to address unmet need; and
(e) orgainising education and information sharing in child and adolescent mental health promotion and treatment, within broader partnerships formed for that purpose, eg involving Schools, General Practitioners, and/or the general public.

Such structures would require solid Mental Health Branch support. State-wide briefing, coordination and ongoing advice would be necessary. CAMHS would need a budget allocated to this process.

Focus Area 7 : Partnerships

Goals

7.1 Designating local area partnerships to drive population-based service planning and coordination across the continuum of mental health.

7.2 Reconfiguring public mental health service structures to align age-related and PDRSS components, facilitate links with general health structures and allow specialist roles to develop.

7.3 Embedding accountability for outcomes associated with mental health into funding and reporting systems at all levels, including general health and social support services.

7.4 Creating an organised statewide research and knowledge management capacity to provide a robust evidence-base on mental health interventions.

7.5 Driving continued strategic policy development, alignment and accountability at the statewide level.

MHYF Vic supports the current model of tiered services delivery of child and adolescent mental health service delivery, but proposes that partnerships, as suggested by Goal 7.1, could do much to improve the effectiveness of existing systems. Most importantly, it is advised that child and adolescent matters be granted independent consideration at this stage of the development of mental health services in Victorian communities (Note 1). In addition, two concrete proposals are made here. The first is at the level of service planning and coordination, and the second at the level of service delivery.

<u>At the level of service planning and coordination</u>, MHYF Vic recommends:

- a layered approach to partnerships, which should embrace all government and non-government services delivering health and social services directly to children, to youth and to families, as well as consumer/carer representatives;
- an obvious guide to geographic area is the current regional structure, each including a Child and Adolescent Mental Health Service, the provider of the most specialised mental health services in any community;
- leadership of partnership groups are probably best led by the Mental Health Branch, and actively coordinated at a state-wide level, and should be linked with all other policy development forums addressing child and adolescent needs.
- each CAMHS could be partnering with the health (including adult mental health), education and social welfare institutions;
- a structure of partnerships should be resourced to perform region-wide research on service needs and current service, and recommend associated planning solutions (Note 2);
- leadership of such planning should be particularly attentive to the advice of CAMHS professionals and clients, who have special knowledge about service gaps;
- larger or smaller partnership groups could be developed from this base in relation to particular issues, with state-wide briefing and advice as needed.

<u>At the level of service delivery partnerships</u>, MHYF Vic recommends:

- CAMHS be resourced to extend the access of the community to quality mental health service at Tier 2 (Note 3), by providing regular overall consultation to local community health centres, in terms of:
    - in-service training of health centre staff;
    - secondary consultation via group and individual supervision and case conferencing; and
    - primary consultation in cases of more complex presentation, incorporating in-service training of health centre staff (Note 4).

Note 1 When subsumed under the generic mental health services, the specific concerns of child and adolescent mental health tend to be swamped by specifically adult concerns. This does not deny, of course, that close liaison with adult services is essential – both in relation to children with a parent with mental illness and in relation to young people moving from CAMHS to adult services at a certain point.

Note 2 Partnerships should be charged with the following core functions:

- mapping local services, identifying complementary, overlapping and missing areas of activity, in relation to needs expressed locally ;
- reviewing consumer/carer responsiveness among services;
- facilitating coordination of services across the local area in a general sense;
- recommending and facilitation of services to address unmet need; and

- organising education and information sharing in child and adolescent mental health promotion and treatment, within broader partnerships formed for that purpose, eg involving Schools, General Practitioners, and/or the general public.

Note 3 Community Health Centres already provide family counseling services that have the capacity to undertake bio-psycho-social assessments and a variety of appropriate therapeutic interventions. The services are non-stigmatising and are well integrated with general health and welfare approaches. They are capable of dealing with Tier Two work and collaborating with specialist CAMHS staff in the treatment of Tier Three cases on-site or by transfer to CAMHS locations. MHYFVic believes that this is the preferred portal for intake of child and adolescent mental health referrals.

Note 4 Child and Adolescent Mental Health Services have dealt with a mixture of Tier Two and Tier Three cases for many decades. The involvement of clinicians with relevant special expertise when cases are found to require it is a well-established process in CAMHS and could readily be instituted in Community Health Centres if CAMHS staff regularly contributed to the CHC staffing.