



MHYF Vic Newsletter No. 63 November 2018

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MHYFVic AGM 2018

The MHYFVic Annual General Meeting was held on Thursday 30th August at Pacific Rim Thai Restaurant. The business part of the meeting included presentation of reports and election of office-bearers. The incumbents were re-elected except for our new secretary, Dr Cecelia Winkelman. Our retiring secretary, Dr Celia Godfrey, was thanked by President Jo Grimwade for her great work and her willingness to continue as a committee member.

The after-dinner speaker was Dr Lionel Lubitz, a specialist paediatrician with 35 years of experience at the Royal Children's Hospital managing Autism Spectrum Disorders and Intellectual Disability. He spoke about his current project to improve transition to adult care.

IACAPAP Congress in Prague

The following three reports were received from Suzie Dean.

“Dear members of MHYFVIC’s Indigenous Project Group,

As most of you know, together with the Canadians, and collaborating closely with Prof Chris Wilkes from Calgary, we have just held two Forums in Prague on enhancing mental health and well-being among indigenous children, adolescents and families world-wide.

Australia was represented by VAHS’ Clinical Coordinator, Dr Graham Gee (Clinical Psychologist) and Karina Thorpe (Aboriginal Health Worker and Counsellor) delegating for Joanne Dwyer, Koori Kids Team Leader.

Canada was represented by Niidanamska (Blackfoot Health Worker) from the Alberta Mental Health Service, and by Chris Wilkes himself. And New Zealand by Professor Hinemoa Elder, from Auckland Univ, who is the sole Maori Child and Adolescent Psychiatrist.

We had full 90 min sessions - dry moving, with some really good discussion. Very worthwhile with good feedback. Our own people made extremely meaningful presentations, as did the others.

At the Closing Ceremony I introduced the President of IACAPAP who officially announced the Declaration of Rights. I pointed out that while there was a lot of input from indigenous colleagues from several countries, this Declaration was on behalf of the

mainstream, rather than a position statement by indigenous people themselves.

Then the President announced an IACAPAP Working Party on the issues of Indigenous Children, Adolescents and Family, to be headed up by Hinemoa Elder. THIS IS A GREAT NEXT STEPTOWARD THE FUTURE.

Thank you to you all for your support with all this... and especially to Sarina for research and drafting and David for special drafting. I will of course be thanking Joanne Dwyer of Koori Kids again very, very much for her fantastic, comprehensive input.

Best wishes
Suzie

OUT OF THE SHADOWS FOR UNIVERSAL HUMAN RIGHTS IN CHILD AND ADOLESCENT MENTAL HEALTH: Dainius Puras, the United Nations Special Rapporteur on the Right to Health, inspired hope at the Prague Congress

By Suzanne Dean

For a number of delegates to the Prague Congress the highlight was the excellent State-of-the-Art presentation by Professor Dainius Puras, Head of the Centre for Child Psychiatry and Social Paediatrics at Vilnius University, Lithuania, who was appointed the UN Special Rapporteur on the Right to Health in 2014. Titled *“Right to mental health: opportunities and challenges for child and adolescent psychiatry on the way to its realisation”*, this paper reviewed global trends in child and adolescent mental health policy and services and argued that, in the light of a range of ongoing violations of human rights, a shift of paradigm is needed in the field.

Professor Puras began by affirming the centrality of universal human rights principles

for child and adolescent mental health, coupled with the importance of an evidence-based public health approach, but noted that these approaches and sets of principles are now globally under serious attack. He asserted that they need to be protected and enhanced both within and beyond CAP/CAMH policies and services. The time is ripe for a change, given the increasing world-wide recognition of mental health and wellbeing as vital to health and development.

Using both Bronfenbrenner’s Ecological Model and the bio-psycho-social model of development, Professor Puras went on to place the principles of mental health promotion, prevention, treatment, rehabilitation and recovery within a human rights framework, highlighting the rights to freedoms (from violence, social inequalities, poverty), participation and non-discrimination, and access to healthcare services, in the context of the obligations of nation states to be accountable for protection and service provision, and to cooperate on these issues at an international level.

Many challenges and pitfalls emerge in current attacks on human rights. Child and adolescent mental health is subject to threats arising from selective implementation of relevant UN Conventions by states, proliferation of “fake news”, tolerance of various forms of violence, conspiracies and moral panic attacks (for example re gender and reproductive issues), assertion of facts alternative to evidence, demonizing of troubled youth, and the shrinking of civil society and NGO activities in many regions. Professor Puras graphically exemplified such challenges by reference to recent difficulties in Central and Eastern Europe, especially difficulties involving human rights and healthcare for children and youth.

Referring to his *June 2017 Report to the UN Human Rights Council**, Professor Puras noted that while CAMH is, overall, doing better with human rights and with balancing within the bio-psycho-social model than is general psychiatry, important challenges abound. The paper analysed these in detail, indicating a much-needed paradigm change. Professor Puras urged moving away from the “medical model” and overuse of biomedical/neurobiological models, especially with disabilities, he urged redressing of imbalances of power between clinicians and those they serve, and between medical and nonmedical approaches, and he urged less biased evaluation of research evidence and knowledge relating to available interventions.

The paper concluded with several key recommendations. Professor Puras emphasised the leadership potential of the CAP/CAMH field in revitalising a holistic model of healthcare, ending the ineffective tradition of over-medicalisation, and addressing the various imbalances and biases that interfere with good practice. “Quality of human relationships and promotion of enabling environments should be the main target in design and provision of CAP/CAMH services.” Child and adolescent mental health has a good future in a context in which the human rights of everyone are fully respected in both policy and practice.

*Report:

http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/35/21

Responses to the Report:

<https://www.ohchr.org/EN/Issues/Health/Pages/RightToMentalHealth.aspx>

IACAPAP COMMITMENT AT PRAGUE CONGRESS TO ADVANCING THE WELLBEING OF THE WORLD'S INDIGENOUS CHILDREN, ADOLESCENTS AND FAMILIES

By Suzanne Dean (Australia), Hinemoa Elder (New Zealand) and Chris Wilkes (Canada)

The 23rd World Congress in Prague saw significant strides in IACAPAP's commitment to the mental health and wellbeing of indigenous children, adolescents and families around the world.

IACAPAP is aware of the transgenerational trauma experienced by peoples whose lands and waters have been invaded and colonised during the period of European expansion, and whose language and traditional ways of life have been systematically marginalised. This trauma remains very marked where systemic oppression remains ongoing. The young of such communities suffer various combinations of loss of land, language, and culture, of racial discrimination, and of compromised access to appropriate education, health services and social services. Limited access to culturally informed and indigenous community-controlled mental health services is a great disadvantage, which can be life-threatening.

Expanding Discussion at IACAPAP Congresses between 2006 and 2018

The difficulties faced by indigenous communities have been brought to notice and discussed at IAVCAPAP Congresses since 2006. In that year, at the Melbourne Congress, Australian and New Zealand indigenous people came together for a full day Workshop and two Symposia to share with the mainstream field a whole spectrum of challenges encountered by their children, adolescents and families. Dr Helen Milroy, Aboriginal Child and Adolescent Psychiatrist from Western Australia and Mr Ross Morgan, an Aboriginal Counsellor and Community Leader from Victoria, Australia, were leading presenters.

The area was next raised at the Durban Congress in 2014, where a Workshop led by Prof Chris Wilkes of Canada discussed the

range of responses of non-indigenous child and adolescent mental health professionals to the special issues presented in indigenous communities.

Following this, in Calgary in 2016, a Congress Forum was held where Canadian, Australian and New Zealand perspectives were raised by a group of six indigenous professionals working with child and adolescent groups. Outlining the problems facing Canadian First Nations young and their families were Dr Deborah Pace, a First Nations Clinical Psychologist leading indigenous concerns in the Alberta Child and Adolescent Mental Health Service, and Blackfoot community spokesperson – Ms Bonnie Healy, a Nurse and Executive Director of the Alberta First Nations Information Governance Centre (AFICG), Ms Amelia Crow Shoe, Communications Director for AFICG), and Mr Niidanamska Scout, Journalist and Knowledge Keeper with special responsibilities in Blackfoot Societies who also consults relevant organisations such as Child Intervention Services of Alberta Human Services. The Canadian experience led on to presentations by Mr Riwai Wilson, a Maori Occupational Therapist from New Zealand, and Ms Ruby Warber, an Australian Aboriginal Psychologist, both from the Victorian Aboriginal Health Service Family Counselling Team. They discussed challenges confronting indigenous people on the other side of the Pacific Ocean that were disturbingly similar to those confronting Canadian First Nations. This Forum was set within the conceptual framework of what Blackfoot Elder Reg Crow Shoe has named “an ethical space”, in which indigenous and non-indigenous persons can meet to talk productively.

Expansion of the Forum experience was further possible at the Prague Congress, where two Study Group sessions were held by indigenous professionals, convened by Drs

Suzanne Dean and Chris Wilkes. The first session was titled “Enhancing mental health among indigenous children and youth: sharing an ethical space to explore needs”, with the second subtitled “Rights and services promoting optimal mental health and wellbeing”. Mr Niidamanska Scout of Canada again contributed richly, amplifying the role of traditional healing ceremonies to help youth reclaim their heritage. He was followed by Dr Graham Gee (an Aboriginal Clinical Psychologist) and Ms Karina Thorpe (an Aboriginal Health Worker) from the Victorian Aboriginal Health Service, Australia, and by Dr Hinemoa Elder (a Maori Child and Adolescent Psychiatrist) from New Zealand. The emphasis of the Forums was very positive, underlining the critical importance of self-determination and self-governance by indigenous communities to the mental health of the young of traditional family group identification.

Preparing a Declaration to support indigenous children, youth and families

In Calgary in 2016, the IACAPAP President Prof Bruno Falissard approved the writing of a Declaration concerning the rights of indigenous children and adolescents to good developmental and mental health. This writing task was taken on by Dr Suzanne Dean (Clinical Psychologist) with the input of many IACAPAP colleagues, of mental health colleagues in Melbourne, Australia, especially research by Ms Sarina Smale (Social Worker and Early Childhood Teacher) and by Dr David Mushin, Child and Adolescent Psychiatrist involved in consulting to Aboriginal services over many decades, and comment by several indigenous mental health professionals, including Dr Hinemoa Elder (Child and Adolescent Psychiatrist). In this context, substantial input was received from Ms Joanne Dwyer, Family Therapist and Team Leader of the Koori Kids Child and Adolescent

Mental Health Service of the state-wide Victorian Aboriginal Health Service, an independent indigenous organisation.

Acknowledging the valuable indigenous contributions to the Declaration, the document stands as an official dedication by IACAPAP itself, and thus by the general field of child and adolescent mental health organisations across the world, to principles believed to enhance the wellbeing and life chances of indigenous children and adolescents everywhere.

Announcing the Declaration at the Prague Congress, 2018, on the 80th Anniversary of IACAPAP

The *IACAPAP Declaration on the Rights of Indigenous Children, Adolescents and Families to Mental Health and Wellbeing* was announced by President Falissard at the 2018 Prague Congress, a proud moment for IACAPAP.

It will be posted, along with the preceding fifteen IACAPAP Declarations, on the organisation's Website. This Declaration, like all of the others, is now an official document available to professionals around the world to use as a vehicle for advocacy.

Forming the IACAPAP Working Party on Issues for Indigenous Children and Adolescents

Having stated the eleven clauses of the Declaration at the Closing Ceremony at Prague, President Falissard went on to announce the establishment of a Working Party to develop and focus upon ideas and practical matters that may improve things for indigenous children and youth around the world. He announced the Chair of the Working Party to be Dr Hinemoa Elder, a Maori Child and Adolescent Psychiatrist and Professor of Indigenous Health Research at Auckland University, New Zealand.

The Working Party will seek to engage and bring together champions of better life chances for indigenous children, adolescents and their families, especially including indigenous people working in the mental health area. The Working Party will aim to encourage indigenous voices from around the globe to inform policy and action by IACAPAP, through conference participation, presentations and discussion, as well as relevant advice to the Executive Committee and ongoing discussion of critical issues. The terms of reference of the Working Party are yet to be settled, but the tasks of the group are envisaged to include:

- providing a forum for sharing global indigenous experiences of resilience, wellbeing and self-determination;
- gathering information on global indigenous workforce development; and
- exploring the links between indigenous intergenerational child, family and community wellbeing, and the impact of compensation for and of reclaiming of indigenous lands, traditional practices and languages; and

Anyone interested in having contact with the Working Party in any way is encouraged to email Dr Hinemoa Elder at hinemoa@xtra.co.nz

Grattan Institute report:

Mapping primary care in Australia,

by Hal Swerissen and Stephen Duckett.

Strong primary care is central to an efficient, equitable and effective health system. Australia has good-quality primary care by international standards, but this report shows that it can and should be better. Too many poorer Australians still can't afford to go to a GP when they need to, or a dentist when they should. People in rural and remote areas still

find it too hard to get to a pharmacist or medical specialist.

Australians' access to general practice varies according to their means. Two-thirds of Australians are bulk-billed for all their visits to the GP. But for those who are not, the financial barriers can be high. About 4 per cent of Australians say they delay seeing a GP because of the cost.

Individuals or their private health insurer have to pay for the bulk of dental care. As a result, about one in five Australians do not get the recommended level of oral health care. Worse, people on low incomes who can't afford to pay often wait for years to get public dental services.

Access to allied health services such as physiotherapy and podiatry varies significantly according to the patient's address. Victorians are nearly four times more likely to use Medicare-funded allied health services than people in the Northern Territory.

More broadly, the funding, organisation and management of primary care has not kept pace with changes to disease patterns, the economic pressure on health services, and technological advances.

In particular, primary care services are not organised well enough to support integrated, comprehensive care for the 20 per cent of Australians who have complex and chronic conditions. Nor is primary care well organised to prevent or reduce the incidence of conditions such as type 2 diabetes and obesity. Broader community-level functions of primary health care – such as developing self-help groups and promoting healthy environments – are also being neglected. Primary care in Australia is typically delivered by many thousands of small, private businesses: the local dentist, pharmacist,

physiotherapist or GP clinic. Funding and payment arrangements are fragmented and variable. There is insufficient data to properly plan the distribution of services and monitor the quality of care. Governance and accountability are split between various levels of government and numerous separate agencies, making overall management of the system difficult. Primary care policy in Australia is under-done. Neither the Commonwealth nor the states have taken the lead. This report shows new policies are needed: Australia needs a comprehensive national primary care framework to improve patient care and prevention; formal agreements between the Commonwealth, the states and Primary Health Networks to improve system management; and new funding, payment and organisational arrangements to help keep populations healthy and to provide better long-term care for the increasing number of older Australians who live with complex and chronic conditions.

Primary care services and organisation in Australia need to be reformed. The Commonwealth and the states have made some progress through the National Health Reform Agreement. But these reforms are limited and piecemeal compared with the major reforms introduced in areas such as home care and support, and disability services.

Several recent reports (see Appendix) have made recommendations to improve primary care. The Productivity Commission, for example, says that more integrated, regionally flexible care is required if the needs of high-cost health users with complex and chronic conditions are to be met.¹⁹¹

The Commission suggests establishing regionally based prevention and chronic condition management funds to improve

population health, manage chronic conditions and reduce hospital admissions.

It says data collection, reporting and presentation needs to be improved, so patients, providers and researchers can get better-quality information. The Commission suggests moving beyond fee-for-service funding, to stimulate innovation in service delivery. And it recommends reconfiguring health care delivery around the principles of patient-centred care.

Other reports, including by Grattan Institute,¹⁹² have argued that integrated care to improve services for people with chronic and complex conditions will require much better data and information on the characteristics of patients, the services that are provided for them and the outcomes that are achieved.

We have also argued that regional governance for primary care needs to be strengthened by renegotiating the National Health Reform Agreement between the Commonwealth and the states and introducing trilateral agreements between the Commonwealth and the states for each of the 31 Primary Health Networks.

Future directions

This mapping study of primary care suggests that variable access, poor service integration for complex conditions, and inadequate risk-factor prevention are major problems that need to be fixed. These problems are exacerbated by a range of systems constraints, including data and information gaps, weak systems management and the absence of national institutions to guide the development of primary care.

The Commonwealth and the states need to develop a comprehensive national primary

care policy framework that is implemented through the National Health Reform Agreement. The framework should aim to reduce access barriers, prevent or at least reduce risk factors for chronic disease, and enhance the quality of care for people with chronic and complex conditions (see below).

Systems reforms

Systems reforms are also needed to improve the quality, outcomes and efficiency of primary care in Australia. Primary Health Networks should be strengthened, so they have the authority to plan, coordinate and manage regional primary care services jointly with the states and territories. This will require changes to their governance and accountability; it will require tripartite agreements between the Commonwealth and the relevant state or territory for each Primary Health Network.

Priorities for primary care

Priority aims

- Reduce barriers to accessing services, including out-of-pocket costs, capacity constraints and geographic maldistribution of services
- Increase emphasis on prevention and early intervention to reduce the incidence and prevalence of chronic disease
- Improve the quality of care and support and the efficiency of services for people with chronic and complex conditions living in the community

Priority systemic changes

- Establish Agreements between the Commonwealth and state governments and Primary Health Networks to improve system management
- Review and strengthen Primary Health Networks to ensure they have the

authority to develop and manage regional primary care systems

- Establish a national data set and performance framework for primary care
- Develop new funding, payment and organisational arrangements for integrated care, particularly for people with complex needs
- Adopt the overarching principles of universality, comprehensiveness, localism, integration and patient-centred care.
- Set clear objectives and measures for access, prevention, quality, outcomes and patient experience.

News from the National Mental Health Commission

The September newsletter of the Commission included a message from Maureen Lewis, Interim CEO, reporting:

“I am very pleased to welcome four new Commissioners who were appointed by the Australian Government this week - Ms Kerry Hawkins, Rabbi Mendel Kastel OAM, Ms Christina McGuffie and Professor Maree Teesson AC. I am also pleased that Professor Ngaire Brown has been reappointed as a Commissioner.

In June we farewellled Dr Peggy Brown AO, and in July we farewellled two Commissioners - Professor Ian Hickie AM and Mr Samuel Hockey. Professor Hickie was appointed when the Commission was established in 2012. He helped to establish the foundation that the Commission operates from today and contributed to creating the Contributing Life Framework. Mr Hockey was appointed in 2017. His contributions as a representative of young Australians and those with a lived experience of mental illness were highly valued at the Commission.”

The newsletter also reported an announcement by Greg Hunt, Minister for Health, which said:

“The Commission is pleased to announce the commencement of four new Commissioners, along with the extension of a current Commissioner.

Ms Kerry Hawkins is the current president of Western Australian Association for Mental Health. She has previously worked as a senior program manager for the National Disability Insurance Scheme and the WA Mental Health Commission, and as a carer consultant for North Metro Adult Health Service. Her board appointments include Vice President of Helping Minds and WA Director for Emerging Minds.

Rabbi Mendel Kastel OAM brings extensive experience in community welfare work and is highly respected for his achievements in dealing with problems amongst youth. He has worked with people with disability, assisted those suffering from addiction and offered counselling services for the bereaved. His skill, knowledge and interest spans across the broad spectrum of mental health including trauma, homelessness, youth, suicide prevention, economics, social investment and innovation.

Ms Christina McGuffie has lived experience as both a consumer and a carer. She has an in-depth knowledge of government and has established good working relationships across the sector, including state and territory governments and key leaders in mental health. After 11 years in federal politics, she has developed extensive knowledge about how governments function and what they need from bodies such as the Commission. She also has 28 years’ experience in journalism and government advisory work.

Professor Maree Teesson AC is currently a director at the NHMRC Centre of Research Excellence in Mental Health and Substance

Use and NHMRC Principal Research Fellow at the National Drug and Alcohol Research Centre and Professorial Fellow at the Black Dog Institute, UNSW. She is also a Fellow at the Australian Academy of Health and Medical Sciences and Fellow at the Australian Academy of Social Sciences.

And finally, Professor Ngiare Brown will continue her role as a Commissioner. Professor Brown is a senior Aboriginal medical practitioner with qualifications in medicine, public health and primary care, and has studied bioethics, medical law and human rights. She is currently convening a governance council for a newly established biorepository for Indigenous genomic research.

We are delighted to have such extensive and wide-ranging expertise within the Commission. The individual and collective input from our Commissioners helps steer our work as we continue to monitor and report on Australia's mental health and suicide prevention system."

HISTORY CORNER, 1970

Feedback to this column is sparse, but has come in three forms: why bother? History is interesting, but does it matter? And, by contrast, "I really value being reminded of where we came from and how we got here".

I usually return such comments with the Santayana quote: "those who cannot learn from history, are doomed to repeat it".

Child and adolescent mental health practitioners world-wide have various versions of these responses. My history posters at the recent IACAPAP were enjoyed as pre-historic matrices by some and others saw them as informing professionals of past they have not known.

I had gone to the Prague conference with an expectation of celebration of the Czech contribution to this history. I sat next to my posters and asked viewers if they knew who were the two famous people born in Moravia who have had a profound effect upon the course of our professions. Only an Australian who had just visited Austria, and the conference chair could name one of them. The other had been mentioned at the history session as coming from Switzerland: he was one of the founders, but Moritz Tramer was born in Ostrava, Moravia in 1880. He was an engineer and mathematician who went to Switzerland to further his work on the mathematics of engineering, but then re-trained in medicine.

The other was born in 1856, about sixty kilometres from Ostrava in the small town of Pribor, known by the German name of Freiberg. He left there as a three-year-old and his family found their way to Vienna: Sigmund Freud! There are three Freud museums in Europe: in Pribor, his birthplace, Vienna, where he lived and developed psychoanalysis, and London, where he lived his last days. Each was his residence.

I felt sad that these substantial contributors to child and adolescent mental health professions and practice were not recognized by the conference or their countryfolk. So, history is often put aside.

An understanding of history can inform practice; but here again, there are three versions of how history happens. Some see history as a matter of constant improvement with the latest thing being a refinement of those things that have gone before: this is the hubris of empiricism. Others see history as simply irrelevant to what they do now. This is like the former position, but it is a perception rather than a reasoned argument. Freudians, by contrast, see history as formative of current experience where trauma has shaped

life's pathways and is re-enacted in the present.

Then there is history as serendipity: chance events that lead to discoveries or revelations, which can then be built upon empirically or strategically. With psychopharmacology, serendipity has been a common event in the course of drug development.

John Cade developed lithium salts to treat mania during the 1940s at Royal Park Hospital. It is not really clear how he happened upon such a treatment, but it is one of the most successful of drug treatments for mental health conditions. Haloperidol has been shown to be very useful in treating Tourette's. And, stimulants, especially Ritalin (methylphenidate) have been very useful with attention deficit disorders.

American psychiatrist Charles Bradley started to use Benzedrine (an amphetamine) with hyperactivity disorder in children in the early 1930s at an inpatient psychiatric hospital for neurologically impaired and behaviourally disordered children. This is called a moment of serendipity in the available literature. Bradley had been trying to ameliorate headaches by stimulating the nervous system; the headaches were unchanged, but many of the children showed spectacular improvement in behaviour and academic performance. Bradley's work then extended to include other stimulant medications for the treatment of behavioural problems. However, the research was not recognized widely for another twenty-five years; perhaps due to the dominance of psychodynamic explanations of behavioural difficulties.

Ritalin was first synthesized by Leandro Panizzon in 1944 but was not identified as a stimulant until 1955. He called the drug after his wife Rita. Initially the drug was used to help with the slowing down effects of depression, narcolepsy, and drug induced

coma. It was also used to help with memory loss in elderly patients. By the 1960s it was being used with young paediatric patients and was extended to adolescents.

Ritalin was available from chemists in Australia during the 1960s in little steel boxes (source: my GP brother-in-law). But it was banned for use among adults in 1970, because it was being used by addicts and causing great harm to users and others.

Use with adults in Australia was possible after 2009, but only by prescription from specifically registered psychiatrists. The problem was that children who had been on the drug, suddenly were not able to gain access upon turning 18 years. While there are children who "grow out of" ADD, many do not.

There was a lapse in time from Bradley's discoveries to its systematic use in treatment. There has been another lapse of nearly forty years, world-wide, where an understanding of the benefits of stimulant medication for adults with attention deficits, have gone undocumented.

This is just another lesson in the doom of repeating failure to learn from history. There is much human suffering that might have been averted. Prisons might not be so large or numerous. It is estimated that ten per cent of prisoners are undiagnosed ADHD sufferers.

Opportunities exist to learn. Avoiding history entails missed opportunities.

Jo Grimwade

2018 MHYF Vic Committee

- * President : Jo Grimwade
- * Vice-President : Jenny Luntz
- * Past President: Allan Mawdsley
- * Secretary : Cecelia Winkelman

- * Treasurer : Anne Booth
- * Membership Secretary:Kaye Geoghegan
- * Projects Coordinator, Allan Mawdsley
- * WebMaster, Ron Ingram
- * Newsletter Editor, Allan Mawdsley
- * Youth Consumer Representative, vacant
- * Members without portfolio:
Suzie Dean, Miriam Tisher, Celia Godfrey.

MEMBERSHIP SUBSCRIPTIONS

Annual membership of MHYFVic runs for the Financial Year. Only paid-up members are entitled to vote at our AGM, normally held in August each year. Friends and associates who are not paid-up will still receive our electronic newsletters and notices because it is our mission to promote improvements in mental health for the young and their families.

However, it is important to reflect upon the difference between paid-up and non paid-up members.

Membership subscriptions of \$50 per annum enable the organisation to maintain its website, mailbox, telephone service and to undertake its administrative tasks. If you value the work that MHYFVic does, we need your financial as well as your ethical support.

Our mail address is PO Box 206, Parkville, Vic 3052. If you prefer to pay by Direct Funds Transfer, the BSB is 033 090 A/C Number 315188 with your name in the Reference tab. It would be appreciated if you could also send a confirmatory email to admin@mhyfvic.org

OUR UPDATED WEBSITE

After much thought our website has been significantly revised to give casual visitors immediate information about what we do and what we stand for, whilst at the same time allowing members to go straight to specific sections such as Projects or Newsletters or Events, without having to navigate past reams of information.

Now that the main revision has been implemented we are working on tasks of development of Projects to give us the evidence base for our advocacy. There are quite a few items under development at the present time which are not yet reflected in the website but over the next few months we expect to see a burgeoning of activity.

Visit us on **mhyfvic.org**