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

**Organisation Name**
N/A

**Name**
Dr Andrew  Wake

**What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?**
N/A

**What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?**
N/A

**What is already working well and what can be done better to prevent suicide?**
N/A

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

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

**What are the needs of family members and carers and what can be done better to support them?**
N/A

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

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

**Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?**
"Poor management of violence is the poison in people's lives.  Whether it be physical violence, sexual violence, verbal violence, or digital violence, actual violence or the threat of it is what prevents people coming together.  Threat leads to a control-combat-avoid approach to others, and

impairs the workings of one's mind and relationships. Melanie Klein thought that hatred was the source of all personality and interpersonal disturbance. Threat and its associated fear / anger leads to the inability to repair ruptures that occur between people, domestic settings and groups of people in general. Most relationship problems can be resolved by discussion if the parties have the skill to remain calm and manage the anger they may feel. The inability to manage one's disappointment and the associated emotion of anger that can lead to violence is a significant problem in our community for many people. The recent Victorian Government focus on domestic violence is a welcome intervention, as has the provision of services for sexual violence. Centers against sexual assault (CASA) and centres against violence (CAV) have important roles to play, and their adequate funding is important. I wish to suggest an expansion of these services. In my role as a clinical leader of a triage service of a metropolitan CAMHS, I hear about all the concerning cases that are referred to CAMHS. There are obvious management pathways for psychosis, bipolar, acute suicidality, eating disorders, school refusal, and other serious mental illness. But the one area that is serious in nature but for which we have no clear disposal pathway is violence within the family home by an under 18 child. Often there is no mental illness identifiable, but the distress it causes is immense. Whether it be a parent, the police who are at times called, to the emergency clinician who has seen the child after being brought into the ED, all are aware of the distress and dysfunction, but no one seems clear where the child and family can be sent to to access help both for the child, but more importantly for the parents involved. Some family support services have programs such as ""Teenage Aggression Responding Assertively"" (TARA), but these are not available in all jurisdictions, unlike CASA or CAV services. Yet the ongoing poorly managed aggression / violence in families by children causes enormous mental ill health for all involved. The child benefit from work on aggression and anger management. The parents need assistance in understanding the nature of aggression, and help to develop the confidence regarding how to respond assertively to that aggression. And service providers (police, school, ED, disability services) need a clear referral pathway for maladaptive aggression . REC'n: - As each area has a CAMHS for mental illness, each area should also have a centre for the management of maladaptive aggression and violence whether it be sexual, physical or threats. Such a centre would be the central coordinating point for addressing both the aggressive person whatever their age, those who are victims of violence who require support to recover, and for parents / adults involved with the responsibility to manage violent people if they are dependent on them. - Because of variable ages and the difference between perpetrators and those affected, there would likely have to be different physical waiting rooms for this work. - CASA / CAV's already present could expand in their size and function, and use and develop their expertise to work with children and the adults in their lives to better manage maladaptive aggression / violence. - I have no recommendations regarding how the adult perpetrators of violence should be assessed and managed, but I do think this needs to be addressed The important point is that just as public health provides for serious mental illness a central coordinating point in CAMHS / AMHS to try to ensure access, I believe that because serious maladaptive aggression (that is not caused by an obvious mental illness) is such a source of ill health for individuals, families and communities, that the public should provide a central coordinating point to help ensure expert help for families and individuals. CAMHS are a tier 3 service and have a role in managing the most serious and complex cases in their given catchment area. They are also required where tier 1 and 2 services are unable to effectively treat less serious illness for a variety of reasons such as parental mental illness / substance misuse, CALD, refugee, out of home care, and other priority areas. On top of this, they have leadership, training, consultation, supporting and up-skilling roles for tier 1 and 2 services. Tier 2 services such as Headspace, Take 2 (DHHS), Aboriginal services (Koorie Kids), disability services (unfortunately no longer Disability Client Services), family support agencies,

CASA / CAV / domestic violence services, drug and alcohol services, and private practice clinicians require access to psychiatric expertise for those cases that are complex, but could be managed if supported by secondary consultations into their service where the case is expertly discussed, and primary consultations where the patient can be assessed and a treatment plan developed that tier 2 can implement. Tier 1 services involve general services to the population such as GP's, schools, community health centers, etc. They are the source of some referrals to CAMHS triage, and are able to manage high prevalence and low acuity cases, though in low resourced areas are often required to take on more complex cases due to the lack of tier 2 and 3 services. The 3 tiers of mental health service providers need to work together to maximize the provision of services and the expertise within each. REC'n: There needs to be greater psychiatric presence within services like Headspace and Take 2 that are seeing complex cases that may require the availability of various bio-psycho-social treatment options, including the options of parent work, family therapy and expert medication management where it is appropriate. The Koorie Kids model of having a part-time embedded psychiatrist is a useful example of this in a tier 2 service. REC'n: There needs to be greater access to psychiatric input through primary consultations to other tier 1 and 2 services. Primary consultations could be increased by outpatient clinics, and able to be referred to by GPs, paediatricians or tier 2 clinicians. There could be neurodevelopmental / disability clinic as found at Monash, a behavioural clinic co-managed with the paediatric service as is found at RCH, or an eating disorder clinic co-managed with paediatrics as is found at the Austin. REC'n: There needs to be greater provision and untilisation of secondary consultations to assist tier 2 services and identified tier 1 services (such as special schools) to manage more complex mental health needs, and to help in the appropriate referral to tier 2 and 3 services. REC'n: The intake / triage aspect of CYMHS is an obvious place where primary and secondary consultations could occur, as well as providing a consistent interface between tiers 1,2 and 3. It could also provide brief interventions for those cases where short-term containment or expert assessment and treatment planning could be developed and passed on to tier 1 and 2 services. This would require a significant beefing up of most CYMHS triage services as they currently stand. With such an increased resourced service, perhaps a crisis assessment service with outreach could also be incorporated, for hard to engage youth or children who would not leave home. Rec'n: To do these latter roles effectively and maximize the influence of tier 3 expertise, adequate resources need to be ring-fenced to meet these community up-skilling and support roles. If this is not done, the pressure for direct work with patients and their families tends to take precedence. There needs to be education department run dedicated school refusal programs in each school to re-integrate students who are struggling to attend. This would require graded exposure programs, parent / family involvement, and dedicated mental health access within the program for those students with mental health reasons for their school refusal. Schools often find themselves dealing with the effects of poor mental health in their classrooms. Teachers describe themselves as poorly prepared for the emotional and behavioral challenges in the classroom, taking up to 30% of classroom time. The mainstreaming of children with disabilities adds to the challenges for teachers. Calmer classrooms is an excellent resource, but many teachers describe not knowing how to apply it in their classes. REC'n: Each school should have an ongoing development program for managing complex emotions and behaviors in the classroom. Not just the theory, but ongoing supervision to help put theory into practice. Though the digital age has brought many benefits, schools should consider the gathering evidence of negative effects of phone and internet access on academic learning, socializing in school, cyberbullying, and the disengaging effect such potentially addictive technologies can have on a proportion of students. REC'n: Urgent research is needed on the effect of technology on the mental health of developing young people, and in the meantime consider the banning of smart

phones and unlimited internet access during school hours.  If the research shows a strongly detrimental effect of digital technology on children, a public health campaign should be considered in a similar vein to that done for smoking, gambling, alcohol and other addictive activities  The NDIS has provided resources to a large number of families with disabled children.  However, it seems to have come at the cost of losing the skills and expertise found in DHHS Disability Client Services, and its associated case management approach to helping families who struggle to understand and manage their dependents complex needs, and often their own needs as well. REC'n: Case management needs to be returned to the disability sector for those families where more support is required to access and utilize appropriate services, particularly around maladaptive verbal, physical and sexual aggression.  Such disability services need clear processes to get primary and secondary consultations, and processes for when a transfer of case management to tier 2 or 3 mental health services is required.  Tier 3 services are well aware of the evidence base and importance of parent work and family work, and are skilled in the selection and utilizing of such treatments as appropriate.  Tier 2 services can be less aware of and able to provide these services and look more at treating the individual child, even though their dependence and immaturity can make the usefulness of such interventions of questionable effect. For example in anxiety disorders, family-based CBT is more effective in the under 15's than individual based CBT.  REC'n: At a population level, parenting programs like tuning into kids, circle of security and PPP are well researched and effective for mental health of developing children.  However, the availability of such programs is hit and miss in many parts of Victoria, and where they exist the long waits for such programs can be an impediment."

**What can be done now to prepare for changes to Victorias mental health system and support improvements to last?**
N/A

**Is there anything else you would like to share with the Royal Commission?**
N/A