Submission to the
Select Committee
on Mental Health

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1. Key Messages

AICAFMHA would like especially to note the following key themes addressed in detail throughout this submission:

- **The prevalence of mental health problems and disorders in children and young people in Australia is significant and represents a large public health problem.** In Australia, surveys indicate that between 14 – 18% of children and young people aged 4-16 years experience mental health problems of clinical significance. This equates to in excess of 500 000 individuals nationally.

- **Greater investment is required for infants, children, adolescents and their families within the mental health system to address the issue of funding inequity.** Currently the dedicated funding for child and adolescent mental health services is inadequate to service 30% of the Australian population. At a minimum 15% of the mental health budget should be dedicated to child and adolescent mental health services within 5 years, and 20% by 2015.

- **Children and young people are not small adults. Infants, children and young people need to be considered within a developmental framework, which addresses their unique needs.** Service arrangements for this population should be consistent with mainstream health service provision that broadly provides services that span medical, hospital and community based interventions and target the age range 0-18 years consistent with age criteria for child and youth services around the country and the world.

- **Children and young people have a right to participate in and provide input into decisions that are likely to affect them.** The DVD included with this submission is one method for young people to participate and "have a say".

- **The health and well-being of infants, children and young people, more than any other age group, is dependent on relationships** with parents and/or caregivers, other significant adults, and their peers, and is influenced by systems including the education, welfare, juvenile justice, disabilities, community services and workplace and training providers.

- **Research evidence points to the importance of the early years of life in terms of brain development.** Therefore a focus on prevention of mental health problems needs to start prior to birth and involve a strong family and interagency approach.

- **Most mental health problems and disorders experienced by children and young people can be effectively managed in a primary or secondary care settings by community based services close to where they live.** Severe mental health disorders require more intensive specialist service provision that should be adequately supported by primary and secondary care.

- **Capacity building within communities increases the likelihood of sustainable practices and models of service that are responsive to local needs.** Every Australian state/territory currently has an existing public and private infrastructure for mental health services for children and adolescents with unique characteristics, and local knowledge regarding the development of the most appropriate service delivery models.

- **Mental health services for adults often focus on the individual** without due recognition of the possible effect of the person's mental illness on their parenting role and their family.

AICAFMHA calls on the Australian Government to convene a National Mental Health Summit on Infant, Child, Adolescent and Family Mental Health including key stakeholders in order to develop a dedicated Infant, Child and Adolescent Mental Health Action Plan to complement the National Mental Health Plan 2003-2008 in line with other national initiatives.

2. Executive Summary

The Australian Infant, Child, Adolescent and Family Mental Health Association Ltd (AICAFMHA) was formally established to actively promote the mental health and well being of infants, children, adolescents and their families. It brings together professionals from a wide range of disciplines and consumers and carers in the one organisation. Further information is available at our website: http://www.aicafmha.net.au/ .

The following sections briefly summarise AICAFMHA's submission and correspond to the Terms of Reference (TOR) of the Senate Mental Health Inquiry 2005. References and a more comprehensive discussion of the issues can be found within the full submission. In addition to the written comments, this submission should be read in conjunction with the associated DVD which incorporates young people's perspectives of the Terms of Reference.

TOR a) National Mental Health Strategy (NMHS)

The NMHS and a number of its partner documents are largely written from an individualistic, adult psychiatric perspective. The predominant language presupposes that the reader is thinking about an adult person with a mental illness. However, children and young people are not small adults. They have particular emotional, social and physical needs that should be considered within developmental frameworks and family systems. Whilst AICAFMHA acknowledges the large needs of the adult population, the needs of infants, children, adolescents and their families should not be overlooked or overshadowed. This is especially the case given that research suggests that early intervention approaches starting as early as prior to birth can have a major impact on reducing mental health problems in later life.

AICAFMHA calls on the Australian Government to convene a National Mental Health Summit on Infant, Child, Adolescent and Family Mental Health including key stakeholders in order to develop a dedicated Infant Child and Adolescent Mental Health Action Plan to complement the National Mental Health Plan 2003-2008 in line with other national initiatives such as the National Agenda for Early Childhood and the National Public Health Agenda.

The prevalence of mental health problems and disorders in children and young people represents a large public health problem yet within the mental health funding system there is a lack of equity in the way funds are divided, with child and adolescent mental health services receiving approximately 7% of the mental health dollar to service 30% of the population.

AICAFMHA believes that, at a minimum, 15% of the mental health budget should be dedicated to child and adolescent mental health services within 5 years, and 20% by 2015.

TOR b) Modes of Care

AICAFMHA believes that service arrangements for infants, children and adolescents should be consistent with mainstream health service provision that provides medical, hospital and community based interventions for the age range 0-18 years, with services being designed and delivered around the needs of the child.

Most mental health problems experienced by children and young people can be effectively managed in a primary health care setting by community-based services close to where they live. Designated child and adolescent mental health services provide more specialised secondary and tertiary services that may include family and community interventions working in a range of settings. Only a relatively small number of infants, children and young people require

hospitalisation or access to hospital emergency departments for mental health problems.

Primary health care providers and GPs require specialist support from child and adolescent mental health services and AICAFMHA strongly encourages investment in community child and adolescent mental health services, where the majority of infants, children, adolescents and their families are currently treated.

AICAFMHA believes that inpatient services for children and young people should only be used where clinically indicated and the focus of the inpatient stay should be treating the patient to minimise the duration of their stay in hospital and developing discharge plans which focus on appropriate community follow up. Wherever possible the child or young person's problem needs to be viewed within the context of their family.

TOR c)&d) Coordination and Comprehensive Care

Partnerships for coordinated mental health care delivery for young people can be very different from those for adults and can include a broad range of government departments (e.g. education, child protection and youth services) as well as the private and non-government sector. Coordination with adult mental health service providers is essential where parents have a mental illness and is also vitally important for individuals in the transition from adolescence to adulthood (16-18 years). As with other developmental stages, specific services for young adults in the 18-25 age range, that takes into account their legal status as adults, should be developed to cater for young adults with serious mental health problems.

AICAFMHA supports the concept of greater coordination and cooperation within an interagency framework with other child and family focused services. Additionally, AICAFMHA believes that reliance on age as a sole criterion for transition between child and adolescent and adult services is inappropriate and that flexibility is required to enable appropriate transitions, particularly for young people in the 16-18 year age range.

TOR e) Support Services

It is well documented that many adverse psychosocial factors increase the health risks associated with people with a mental illness (e.g. poverty, homelessness and social isolation). When these people are also parents these psychosocial factors, in turn, impact on health and safety outcomes for their children. There are also many young people with mental illness who are homeless and require accommodation services.

Given the impact of parental health and well-being on infant and child development, AICAFMHA believes that current unmet un-met need in supported accommodation, employment, family and social support services are contributing barriers to achieving better mental health outcomes for infants, children, young people and families.

TOR f)&g) Special Needs Groups and Support for Primary Carers

Certain populations of children, young people and families have been identified as having a greater risk of developing mental health problems than their peers (e.g. children under the care of the State, indigenous youth, children of parents with a mental illness, refugees, siblings of children and young people with disability or chronic illness, children with parents who misuse drugs, children who are exposed to domestic violence, families in rural and remote areas). The utilisation of technological aids has been demonstrated as an effective means of enhancing services in rural and remote areas.

AICAFMHA supports investment in services for higher risk groups and the expansion of existing rural and remote mental health services for infants, children and youth.

AICAFMHA also supports improvements in the training and retention of primary, secondary and tertiary mental health service providers to effectively support special needs groups. Those who provide primary care for family members should also be supported (e.g. parents caring for children, sibling care and parental care by children).

TOR h) Promotion, Prevention, Early Detection and Primary Health Care

Recent evidence compiled by the World Health Organization (WHO) indicates that by the year 2020, childhood neuropsychiatric disorders will rise by over 50 percent internationally to become one of the five most common causes of morbidity, mortality, and disability among children. These childhood mental disorders impose enormous burdens and can have intergenerational consequences. They reduce the quality of children's lives and diminish their productivity later in life. According to the WHO, no other illnesses damage so many children so seriously. The potential for health promotion and prevention and early intervention strategies to reduce future adverse outcomes is significant.

AICAFMHA supports a greater investment in prevention, promotion and early intervention strategies relating to the mental health of children and families. Primary care providers have a critical role in the promotion, prevention and early detection of mental health issues and they should be trained and supported to enhance access to quality services for infants, children, young people and families.

TOR i) Consumer Participation

Children and young people have a right to participate in and provide input into decisions that are likely to affect them. Parents and caregivers also play a crucial role in advocating for children and young people.

AICAFMHA is committed to advocating for the "voice of children and young people" to be heard in the development of mental health policy, services, interventions and programs which affect them (see attached DVD from young people).

TOR j) Mental Illness and the Criminal Justice System

Studies have consistently found the rate of mental and emotional disabilities higher among the juvenile justice population than among youth in the general population. There is strong evidence regarding the relationship between early intervention and the potential to reduce crime.

AICAFMHA encourages the Australian Government to consider the impact adequate infant, child and adolescent mental health services may have on the juvenile and adult justice systems.

TOR k) Seclusion

AICAFMHA believes that alternatives to seclusion should always be considered prior to the implementation of a seclusion episode (eg medication, relaxation therapy, distraction) unless the presenting problem is considered imminently dangerous with resulting potential harm to self and/or others.

TOR l) Education

High quality education and community awareness programs play a critical role in reducing the

impact of negative community attitudes and misinformation relating to mental health and in increasing the capacity of the community to respond appropriately.

AICAFMHA believes that the concept of mental health literacy should not be confined to a sole focus on mental health problems and disorders but should include knowledge and awareness of what constitutes positive mental health and strategies that promote good mental health. Multiple education and community awareness strategies that promote knowledge and skill development are required to improve mental health literacy and need to be specifically designed within a developmental framework for target populations and settings.

Currently there are a number of high quality education and community awareness strategies implemented across Australia. However, their effectiveness is often limited by short term funding structures and a lack of coordination with other programs.

To have a sustainable impact on stigma associated with mental health it is crucial that a systematic and long term implementation strategy is developed. This will ensure that key information about mental health is consistently conveyed and changes in attitudes maintained by target populations and the community as a whole.

TOR m) Proficiency and Accountability of Agencies

The health and well-being of infants and children, more than any other age group is dependant on relationships with caregivers and other significant adults and is influenced by systems including the education, welfare, juvenile justice, disabilities, community services and workplace and training providers.

It is important for the Australian Government to consider how further dialogue, coordination, workforce training and integration could occur across critical areas of government in relation to infant, child and adolescent mental health and the development across portfolio areas of joint planning in respect to shared areas of concern.

TOR n) Mental Health Research

International evidence indicates that the 'best buys' for investment in mental health can be realised in the child and adolescent age group. In Australia a targeted approach to guide research activities is required.

Research priorities and specific indicators for progress against targets are required in the infant, child and adolescent mental health area.

TOR o) Data Collection, Outcome Measures

In Australia, there is not currently a uniform method of data collection or a uniform data set from which to effectively plan, develop and monitor child and adolescent mental health services.

AICAFMHA supports the development of a national child and adolescent mental health data set to enable effective benchmarking, monitoring and evaluation of child and adolescent mental health services in Australia.

TOR p) New Modes of Mental Health Care Delivery

There is now a wide range of technologies available that currently assist in the provision of mental health services. A number of other technologies also offer great promise, however in relation to online counseling services for children, careful consideration needs to be given to the ethics of providing counseling to children under the age of 16 years (or whatever the age of consent for treatment is in each jurisdiction) without parental consent.

3. Comments relating to the Terms of Reference

3.a   the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress.

The National Mental Health Strategy and a number of its partner documents are clearly written from an individualistic, adult psychiatric perspective i.e. the predominant language presupposes that the reader is thinking about an adult person with a mental illness. Similarly, the language of the terms of reference for this inquiry reflects this 'adult' terminology. This conceptualisation does not fit the majority of the work undertaken by the Child and Adolescent Mental Health (CAMH) Services throughout Australia and as such, can be identified as a barrier to progress for the infant, child, adolescent and family mental health sector. Whilst AICAFMHA acknowledges the needs of the adult population is large, the needs of infants, children, adolescents and their families should not be overlooked or overshadowed by the needs of the adult population. This is especially the case given that research suggests that early intervention approaches starting prior to birth can have a major impact on reducing mental health problems in later life.

There are however a number of National Mental Health Strategy (NMHS) documents that more accurately reflect the issues that are pertinent in the infant, child, adolescent and family mental health area. These documents include the work of Raphael (2000) and the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000. These documents clearly describe how infants, children and adolescents are different from adults.

Infants, children and young people are not small adults. They have particular emotional, social and physical needs that should be considered within a developmental framework. Services should be designed specifically for infants, children and young people that work within this framework and address these specific needs.

 "It is important to underscore the often heard admonition that 'children are not little adults'. Even more than is true for adults children must be seen in the context of their social environments, that is family, peer group, and their larger physical and cultural surroundings. Childhood mental health is expressed in this context as children proceed through development" (Surgeon General's Report on Mental Health, 1999, page 123). A number of characteristics of the infant, child and adolescent population groups are unique and require services that are responsive to these characteristics.

Why are children different? Infants and children are different because they are rapidly developing, dynamic organisms whose brains are making connections around birth at the rate of 30, 000 new connections per second, and whose life course is fundamentally influenced by this development: creating stable attachment patterns and relationships, mastering the regulation of emotions, behaviours, impulses and relationships. Further, infants and children exist in the context of crucial nurturing relationships that facilitate this mastery and work within broader learning and experiential contexts such as their local school, community and cultural groups. Failure of the fundamental early life tasks can lead to altered developmental trajectories across the lifespan.

The lead editorial in the British Medical Journal titled, "The National Service Framework for Children: Cinderella is ready for the ball" noted in its critique of the National Children's

Services Framework that:

"Children are different, need to be looked after by people who understand their particular needs, and should have services designed specifically for them. Most important of all, there must be someone at senior managerial level in every NHS organisation who takes the responsibility for ensuring that the children's voice is heard." (BMJ 2003; 326:891-892 [26 April 2003])

In a more recent article, Michaud & Fombonne (2005) note that: *"Applying such adult based definitions to adolescents and identifying mental health problems in young people can be difficult, given the substantial changes in behaviour, thinking capacities, and identity that occur during the teenage years. The impact of changing youth subcultures on behaviour and priorities can also make it difficult to define mental health and mental health problems in adolescents. Although mental disorders reflect psychiatric disturbance, adolescents may be affected more broadly by mental health problems. These include various difficulties and burdens that interfere with adolescent development and adversely affect quality of life emotionally, socially, and vocationally."* (BMJ 2005; 330, 835-838 [9 April 2005])

In the United Kingdom, there has been significant policy introduced recognising the specific needs of children. In 2003, the National Health Service introduced their future plans in the area by also coupling children's needs with aged care:

"Older people and children require services specifically designed to meet their needs. The NHS and social services are committed to delivering this because we recognise that in the past the needs of both groups have sometimes been subordinated to the demands of general adult mental health services." (NHS Modernisation Board Annual Report 2003)

Further to this, the UK National Services Framework for Children, Young People and Maternity Services (2004) released in September 2004 provides a blueprint for the development of services over the next ten years noting:

"The National Service Framework for Children, Young People and Maternity Services (Children's National Service Framework) is a 10 year programme intended to stimulate long-term and sustained improvement in children's health. It aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood. Experience before birth and in early life has a significant impact on the life chances of each individual: improving the health and welfare of parents and children is the surest way to a healthier nation". (NSF, p. 8)

The special needs of children have also been recognised in policy in the United States. The US Surgeon General's Report on Mental Health (1999) noted:

"adult criteria for illness can be difficult to apply to children and adolescents, when the signs and symptoms of mental disorder are often also the characteristics of normal development. For example, a temper tantrum could be expected behaviour in a young child but not in adult." (Surgeon General's Report on Mental Health, 1999, page 123)

Subsequent to this, the US convened a separate planning process for child mental health and subsequently released the Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.

In Australia, Raphael (2000) in the document "Promoting the Mental Health and Wellbeing of Children and Young People," notes: *"Underlying this paper is the belief that, in the area of mental health, as in their general health needs, children and young people require specific programmes to address their problems that are different to those for adults. Programmes for children and young people need to reflect the many complex factors that influence their mental health and development- including family, school, genetics, and socio-economic and cultural*

environments" (p 3), however this requirement for 'specific programming' is yet to be reflected in national policy action documents.

The World Health Organisation's document titled Child and Adolescent Mental Health Policies and Plans (2005) notes:

"A child and adolescent mental health policy should present the values, principles and objectives for improving the mental health of all children and adolescents and reducing the burden of child and adolescent mental disorders in a population. It should define a vision for the future and help establish a model for action. Such a policy would also underscore the priority that a government assigns to child and adolescent mental health in relation to overall health, social and other priorities.

It is important for the policy development process to culminate in the production of a written policy document. This is important for two reasons. First, it provides a reference point to which planners and other stakeholders can turn for assistance with decision-making or conflict resolution. Second, it serves a symbolic function as the concrete result of the policy development process, and establishes a basis for future improvements." (WHO 2005, p. 15)

A recent study reviewing international policy development on child and adolescent mental health by Shatkin and Belfer (2004) ranked Australia a B (on a scale from A-D) which reflected that Australia had national policies that recognised the unique needs of this population but did not enumerate a unifying plan of action. This finding is consistent with previous commentary by AICAFMHA on former drafts of the now current National Mental Health Plan 2003-2008.

The minimal recognition of the difference between child/adolescent mental health and adult mental health in the language of the National Mental Health Plans may also be a contributing factor in the National Mental Health Strategy policy areas being inadequately implemented in the infant, child and adolescent mental health fields.

Despite the commitment of funds to the NMHS, within the mental health funding system there is a lack of equity in the way funds are divided. Child and adolescent mental health services receive approximately 7% of the mental health dollar to service 30% of the population.

Research is increasingly describing a downward trend in psychopathology, demonstrating that mental health disorders are more common, more severe, and having their onset earlier in childhood and adolescence than was previously the case. Not only is this a disturbing trend, but it has implications across the lifespan. There is increasing evidence that many of the mental health problems that occur in childhood continue into adult life, including an increased risk of adult mental health disorder and associated adverse outcomes (reported in Raphael, 2000).

A recently published article, Bebbington et al (2004) examined data from the British National Survey of Psychiatric Morbidity that took place between March and September 2000. The study found lifetime victimisation experience had a high correlation with a range of adult mental health disorders including psychosis. Victimisation experiences during childhood included, sexual abuse, bullying, violence in the home and victim of serious injury, illness or assault. This study further highlights that experiences in childhood have a profound effect on mental health status in adult life.

The potential to reduce future adverse outcomes is a significant characteristic of the younger consumers of mental health services. A paper from the United States reports on the consequences of inadequate care for children and youth with mental health problems noting that those with severe disturbances that are unable to access appropriate family-based care, often end up in foster care or juvenile justice. It goes on to state that the costs of supporting these

individuals in alternative systems "*are many times higher than what it would cost to provide modest, preventative services and supports*" (National Council on Disability, 2002).

Earlier, Prof Albert Aynsley-Green in the British Medical Journal (2000) recognised this stating: "*Although healthy children become healthy adults, much adult disease has it origins in early life, and events in childhood and adolescence have long term sequelae that determine adult wellbeing…Although social policy interventions are important…other interventions in early life are likely to be more cost effective than at any other age*".

In 2005, the WHO noted with regard to funding inequities that: "*The bulk of funding for mental health services is devoted to adult services, which makes it difficult to develop appropriate child and adolescent mental health services. If child and adolescent mental health services were to be viewed as a distinct category of health care with unique requirements, specific funding arrangements and policy development would be facilitated*". (WHO, Page 8)

AICAFMHA recognises the cost-effectiveness of early intervention in mental health and is concerned by the relative under-funding of infant, child and adolescent mental health services within Australia. This under-funding may impact on the capacity of the infant, child and adolescent mental health system to meet the policy objectives of the NMHS.

AICAFMHA calls on the Australian Government to undertake specific child and adolescent national mental health policy and planning development with defined accountabilities and to target an increase of 15% of mental health funding by 2010 into the infant, child and adolescent mental health area with a further target of 20% of mental health funding by 2015 to facilitate servicing the 30% of the population who are in this target age range.

Between 14-18% of children and young people (under 18 years) experience mental health problems of clinical significance. This equates to in excess of 500 000 individuals nationally.

In the US, the document, Blueprint for Change: Research on Child and Adolescent Mental Health noted (2002) noted:

"*Recent evidence compiled by the World Health Organization (WHO) indicates that by the year 2020, childhood neuropsychiatric disorders will rise by over 50 percent internationally to become one of the five most common causes of morbidity, mortality, and disability among children. These childhood mental disorders impose enormous burdens and can have intergenerational consequences. They reduce the quality of children's lives and diminish their productivity later in life. No other illnesses damage so many children so seriously.*"

Two landmark Australian studies undertaken relatively recently are the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing (Sawyer et al., 2000) and the Western Australian Child Health Survey: Developing Health and Wellbeing in the Nineties (Zubrick et al, 1997). These surveys indicate that between 14 – 18% of children and young people experience mental health problems of clinical significance. These findings are comparable with findings internationally.

Raphael (2000) defines the terms **mental health problems** as a broad range of emotional and behavioural difficulties that may cause concerns or distress. They are relatively common and encompass **mental disorders** which are more severe and/or persistent mental health conditions.

Mental health problems and disorders in children and young people left untreated can have far-reaching and long-term implications for the individual and the community as a whole. Insufficient appropriate interventions impacts on children's and young people's social, academic and emotional development and can create instability in their families (Rutgers University, US

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Dept of Health and Human Services & Annie E Casey Foundation, 2002). Sawyer et al (2000) in the National Survey also found that children and young people with mental health problems and disorders reported a lower quality of life.

The prevalence of mental health problems and disorders in children and young people in Australia is significant and represents a large public health problem. Only a minority of child and adolescents in Sawyer's survey had access to mental health care even when they suffered with mental health disorders.

AICAFMHA acknowledges that children are different from adults and believes specific policy recognition and greater investment is required for infants, children, adolescents and their families within the mental health system.

3.b   the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care.

The various modes of care for people with a mental illness aged less than 18 are under resourced and do not provide adequate coverage for Australia's young people. Sawyer and Patton (2000) identified the extent of unmet need in child and adolescent mental health service delivery and focused on identifying needs, treating disorders and prevention as the key strategies to improve the adequacy of mental health care.

A comprehensive system of care requires a cascade of services of varying intensity across the age ranges 0-17. A comprehensive system of care has not yet been developed to address the needs of 500 000 young Australians. In practice, modes of care are characterised by scarcity, poor integration partly because of this scarcity, service gaps, provision of care late in the course of illness and gross unmet need.

Raphael (2000) described a comprehensive service system (discussed later in this section) for children and young people. However this document is not supported by an action plan, appropriate accountabilities and resource commitments by the various levels of government to ensure its implementation.

This Term of Reference (3 b) is written largely from an adult and very individualistic perspective rather than viewing a person's mental health as being part of a family system or wider system in which all members of the system are involved. Aynsley-Green (2000) argues that "*children are not young adults: their special health needs should be acknowledged*". For this reason, child and adolescent mental health models of service differ significantly in philosophy, structure and responsiveness from traditional illness and individual focussed models associated with adult mental health services. There is a need to move to a new paradigm in children's mental health as highlighted by Weist (2003) who noted:

 "*As children's mental health issues move to a more central position on the public agenda, there should be a frank dialogue about moving beyond limited, passive disorder focussed approaches that are not supported by evidence of effectiveness....The new paradigm in children's mental health involves mental health promotion for all, family centred care, early identification and intervention, moving care into natural settings such as schools.*" (page 18)

Effective mental health promotion, prevention and early identification and intervention strategies targeting children and young people involve a range of stakeholders and settings, which are different to those for the adult population. Environments and systems play an important role in

child and adolescent mental health and include schools, child care settings, child protection agencies and youth services. Parents play a critical role in children and young people's mental health and in the treatment of mental health problems and disorders.

AICAFMHA, through its Children of Parents with a Mental Illness (COPMI) Project, has been successful in working with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in developing a Position Statement (Position Statement #56) which acknowledges the effects of parental mental illness on family and also recommends that any assessment of an adult psychiatric patient must take into account the impact of the parental mental illness on any children within the family and ensure that appropriate supports are available for the family. Such family focused strategies can improve the adequacy of service delivery.

Most mental health problems experienced by children and young people can be effectively managed in a primary or secondary health care setting by community-based services. Child and adolescent mental health services provide more specialised secondary and tertiary services that may include family and community interventions working in a range of settings. Only a relatively small number of infants, children and young people require hospitalisation or access to hospital emergency departments for mental health problems, but servicing this group demands, and depends on, health systems that can provide intensive responsive care acutely. The spectrum of intensive community based care options require further development in Australia.

Raphael (2000) noted: *The majority of children and young people have good mental health with positive psychosocial development, the capacity for effective learning, and good social and family relationships. Of those young people who experience mental health problems and disorders, most experience problems and disorders that are relatively short lived and respond to brief interventions. Some however, experience more complex and severe difficulties which affect their ability to enjoy life and to meet age-appropriate developmental milestones.* (Raphael, 2000, Page 4)

In most states/territories, the investment in community clinics or intensive community-based services is inadequate. Given the high incidence of mental health problems in the community, this under-investment in child and adolescent mental health community services translates to long waiting lists and untimely service access for clients. There is also a need to invest in community outreach and day programs for children and adolescents where more intensive treatment is required. The need for inpatient services within the child/adolescent population is small. Service development, in conjunction with adequately funded early intervention services can reduce the duration of inpatient admissions and on occasions, prevent them. However, when acute, after hours, respite and recovery/rehabilitation programs are required, timely access to them is frequently barred by a range of factors operating in the health care environment.

AICAFMHA strongly encourages investment in community child and adolescent mental health services where the majority of infants, children, adolescents and their families are treated. Primary health care providers and GPs require specialist support from child and adolescent mental health services.

There has been considerable debate within the Australian community on how best to structure services particularly for young people. AICAFMHA believes that an appropriate framework has been suggested within the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, Raphael 2000, where a developmental approach across the lifespan is taken including:

- Perinatal and Infants (0-2 years)
- Toddlers and Preschoolers (2-4 years)

- Children (5-11 years)
- Young People (12-17 years)
- Young Adults (18-25 years)

This framework provides a useful guide as to how services can be provided to match these developmental levels, and can apply to the full range of modes of care.

While primary health care might focus on promotion/prevention/early detection and chronic care management a poorly developed mode of service delivery is early intervention. Effective early intervention can be delivered in a range of settings with the support and assistance of the specialist mental health care sector.

Few structured specific early intervention programs are being effectively implemented in the Australian health care environment for children and young people. Specific early intervention should include:

i)   Early intervention for conduct problems;
ii)   Early intervention for anxiety and depression;
iii)   Early intervention for perinatal mental health problems;
iv)   Early intervention for early psychosis;
v)   Early intervention for drug and alcohol misuse;
vi)   Early intervention for PDD (Pervasive Developmental Disorder);
vii)   Early intervention for mental health sequelae of abuse;
viii) Early intervention for co-morbid and complex mental health problems;
ix)   Early intervention for deliberate self harming behaviour;
x)   Early intervention for early childhood disorders;
xi)   Early intervention for eating disorders;

which may be delivered by GPs or in schools, by child and family health services, youth services, mental health services, drug and alcohol, child protection services, paediatric services.

Further to this, schools are an under-utilised mental health care setting in Australia. Programs specifically addressing primary and secondary schools and their students' mental health should be expanded.

Targeted early intervention for young people is not adequately available. Early intervention services should target a wide variety of potentially preventable adverse mental health outcomes of persistent problems and disorders to ameliorate their impact on young Australians.

Recognising their developmental needs and vulnerabilities, the rights, welfare and safety of infants, children and young people (0-17 years of age) are protected by a number of state Acts and Statutes, including but not limited to child protection, education and juvenile justice. In contrast, young adults aged over 18 years are subject to a different level of legal responsibility particularly in relation to judicial and privacy requirements. This legal distinction between young people and young adults is also important when considering appropriate models of service.

There are a group of young people with persistent mental disorders who require ongoing reliable assertive case management and care coordination with ready access to intensive levels of service provision if required. Their numbers are small but their needs can be considerable. Treatment of early psychosis has received considerable attention in Australia. A first episode of early psychosis often has an onset in young adulthood with a peak in disability for this age group occurring at age 22. Therefore some models such as ORYGEN work across the age range from 15-25 years, however it should be noted that other models exist, which involve providing

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services which are developmentally appropriate. A range of community based models for treating early psychosis have been developed in Australia, both inside and outside of Victoria.

AICAFMHA acknowledges the importance of early psychosis, however it should be noted that early psychosis is only one disorder of a range of disorders treated by child and adolescent mental health services. A recent article by Michaud & Fombonne (2005) quoted a range of prevalence data indicating that early psychosis had a low prevalence rate of 0.5% among adolescence whereas other disorders in adolescence had much higher prevalence rates such as depression (3-5%), anxiety (4-6%) and conduct disorder (4-6%).

Whilst it is acknowledged that the treatment cost of early psychosis is high, AICAFMHA strongly supports a broader view of mental health problems in adolescence. The current strong national focus on early psychosis has the effect of overshadowing the other significant mental health issues prevalent in child and adolescent mental health. An important issue is that early intervention for psychosis should not be confused with early intervention for infant, child and adolescent mental health problems (which can commence prior to birth).

Typically however, interventions with children and adolescents are sporadic and recovery focused, direct contact with specialised mental health services usually occurring only at times of acute behavioural and/or emotional need. The aim of intervention is usually to ameliorate the problems experienced, maximise the coping skills and resiliency of the individual and minimise the need for extended ongoing contact with the specialist mental health service. One outcome of this is that the membership of the consumer group for child and adolescent mental health services is largely short-term.

Currently, state/territory funded child and adolescent mental health services together with some private companies provide inpatient services to people in the age range 0-18 years. In some Australian states, the majority of admissions for child and adolescents mental health disorders occur in general health settings. It is rare that such inpatients are nursed by staff with specific mental health skills. With nursing shortages this will increasingly become an issue related to appropriate quality of care.

In the United Kingdom, the Royal College of Psychiatrists (London), in the position paper "Acute Inpatient Psychiatric Care for Young People with Severe Mental Illness" made the following key recommendations in relation to young people being admitted to adult psychiatric wards:

 "young people aged under 16 years should not be admitted to psychiatric wards... those aged 16 or 17 years can be considered for admission to psychiatric wards when:

- no suitable specialist adolescent psychiatric bed is available
- they have severe mental illness
- acceptable standards of care are met
- health commissioners need to develop appropriate services
- inappropriate admissions should be considered as a sign of inadequate resources and treated as an untoward or critical incident."

AICAFMHA supports the position of the Royal College of Psychiatrists and believes that a developmental approach will provide flexibility to meet the needs of young people.

AICAFMHA believes that inpatient services for children and young people should only be used where clinically indicated and the focus of the inpatient stay should be treating the patient to minimise the duration of their stay in hospital and develop discharge plans which focus on appropriate community follow up. Wherever possible the child or young person's problem

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needs to be viewed within the context of their family case management, care coordination and recovery planning are core components of discharge planning.

In Australia, the majority of CAMH inpatient facilities have an age criteria of 0-18 years. AICAFMHA believes that state governments in the respective jurisdictions should seriously consider allowing flexibility with this upper age range and where appropriate allow a young person to continue to receive services from the child and adolescent focussed facility until they attain the age of 19 years.

In a similar way AICAFMHA believes that adult mental health services also need to be able to exercise some flexibility to allow young people over the age of 16 years who are developmentally mature, early access to an adult mental health facility, in line with the criteria outlined by the Royal College of Psychiatrists. AICAFMHA recognises that this has funding implications and therefore further analysis of the number of young people that are likely to utilise these more flexible arrangements would need to be determined.

Specific services for young adults in the 18-25 age range, that takes into account their legal status as adults, should be developed to cater for young adults with serious mental health problems.

Recent developments in relation to treating depression in children and adolescents illustrate the dangers of responding to young people as though they were adults. A combination of the relative unavailability of CAMH services, lack of access to skilled providers of psychological interventions, aggressive promotion by the pharmaceutical industry, and a belief that SSRIs (selective serotonin reuptake inhibitors) were safe led to a striking increase in SSRI prescribing in under 18's in the decade leading to 2004, especially by general practitioners. However, recent reviews of the published and unpublished literature have established that a number of SSRIs have been insufficiently researched to demonstrate their effectiveness or otherwise in young people under 18, or for those SSRIs with adequate research data available the cost/benefit ratio (when patient safety is taken into account) is at best marginal or in some cases inadequate in the treatment of mild and moderately severe adolescent depression (Jureidini et al 2004, Whittington et al 2004, March et al, 2004). This outcome illustrates some of the dangers of adopting standards that do not represent best practice in research, clinical practice, and disclosure by pharmaceutical companies to address the specific mental health needs of younger age groups.

AICAFMHA believes that reliance on age as a sole criterion for transitioning between child and adolescent and adult services is inappropriate and that some flexibility needs to be built into state run services to enable appropriate transitions. This is particularly the case for young people in the 16-19 year age range. Protocols need to be developed between child and adolescent and adult mental health services to ensure appropriate coordination for young people transitioning services.

Mental health care modes require the flexibility to support parent-child and family relationships, especially where a mental health consumer is the parent of a dependant child.

Where parents have a mental illness, the action of seeking help for their mental illness can jeopardise their relationship/s with their child/ren and other family members. AICAFMHA believes that the following services need to be considered for inclusion in the planning and provision of mental health services to support parents with a mental illness and their families:

- safe 'family friendly' visitor facilities;
- family residential facilities and services for consumers in order to facilitate attachment, and to assist the parent–child relationship and subsequent child development;

- planned care and flexible respite care services for both children and parents (separately and together as requested and/or appropriate) during parental crisis and at other times;
- supported, targeted and evidence-based early intervention programmes of sufficient duration and intensity to prevent or minimise the longer term consequences of disrupted or dysfunctional child–parent relationships;
- support for, and recognition of, the parenting role within rehabilitation and recovery service planning for consumers;
- policy, practice and procedures which recognise and support the importance of secure attachment for infants' health and future wellbeing;
- information, counselling and financial support to informal and formal temporary carers who care for the children during periods of parental illness or as a preventative strategy to maintain the parent's health;
- practical and 'family friendly' domestic help to assist families to remain intact and supported during parental hospitalisation and in transition/rehabilitation periods, and also as a preventative intervention service.

3.c   opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care.

Improvement in the coordination of services to infants, children, young people and their families is welcomed. However it is important to recognise that coordination of care will differ across the developmental age range. As illustrated in our response in 3.b this developmental approach spans the lifespan and includes:

- Perinatal and Infants (0-2 years)
- Toddlers and Preschoolers (2-4 years)
- Children (5-11 years)
- Young People (12-17 years)
- Young Adults (18-25 years)

This means that when considering improved coordination of services it is critical to understand this developmental approach. Infants, children and adolescents require a range of different services depending on where they are in their developmental trajectory. Key service foci include; schools, school counselors, welfare agencies, GPs, and pediatricians. Outcomes for children and young people are optimised when mental health services collaborate within an interagency framework with other child and family focused services. This collaborative approach is particularly important in the first two years of life where for example, programs such as Universal Home Visiting can identify infants and families at risk at an early stage.

In respect to funding issues, it is important that wherever possible funds are provided to existing services and infrastructure whether these be government or non-government as this reduces duplication of services.

AICAFMHA supports the development and expansion of a system of care that addresses the needs of infants, children and young people along the developmental spectrum and across different service sectors, both government and private. AICAFMHA also believes that wherever possible young people should be treated within the context of their family within a community setting. These issues are discussed further in sections 3.f, 3.h and 3.j.

3.d   the appropriate role of the private and non-government sectors.

Private practitioners include child and adolescent psychiatrists and a variety of allied health professionals. Together they provide a range of counseling services within the non- government sector. Given the high incidence of mental health problems in infants, children, adolescents and their families AICAFMHA supports the need for this range of services from the private sector, but would argue that there needs to be enhanced collaboration between the private, non-government and government sector for those cases that will require more intensive treatment from the child and adolescent mental health services.

The level of service provision by the private and non-government sectors is difficult to quantify utilising existing reporting methods. The National Mental Health Report 2004 includes a chapter updating private mental health services which relates information solely regarding inpatient beds and psychiatric use under the Medicare Benefits Schedule. There is no reporting of data for services for children or youth, or for the aged for that matter.

3.e   the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes.

Supported accommodation is primarily thought of only in the context of adult consumers of mental health services. However there are many young people who are homeless who also require accommodation services. In general these services are offered by the non-government sector, but there is a need for further services for young people particularly those who are homeless and suffer from mental illness. The majority of these young people have been in inpatient care and need access to supported accommodation. There is also a significant issue with children who are abandoned by their parents as often foster placements are not available. On some occasions children remain in hospital because there is no viable accommodation option. The limited supported accommodation options for young people in country regions has resulted in short term accommodation services such as youth shelters becoming defacto mental health step down facilities, with a significant number of their clients having serious mental health problems.

Parental and family mental health and wellbeing are significant determinants of children's health and wellbeing (AICAFMHA, 2004). Feedback from consumers has highlighted that where intersectoral collaboration has been achieved there has been a more positive outcome for the family as a whole. The need for broad intersectoral partnerships has been identified and this includes services outside those traditionally used by adult mental health services eg preschools, kindergartens, education system, paediatricians, justice, child care, child protection and the non-government youth services.

The US Department of Health and Human Services Center for Mental Health Services has the following charter for it services to children.

 "The Child, Adolescent, and Family Branch of the Federal Center for Mental Health Services promotes and ensures that the mental health needs of children and their families are met within the context of community-based systems of care. Systems of care are developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around these principles: child-centered, family-driven, strength-based, and culturally competent with interagency collaboration." (http://www.mentalhealth.org/cmhs/ChildrensCampaign/default.asp)

It is well documented that many adverse psychosocial factors increase the health risks associated with people with a mental illness (e.g. poverty, homelessness and social isolation). When these people are also parents these psychosocial factors, in turn, impact on health and safety outcomes for their children (Falkov, 1998).

Given the impact of parental health and well-being on infant and child development, AICAFMHA believes unmet need in supported accommodation, employment, family and social support services are contributing barriers to achieving better mental health outcomes. The provision of supported accommodation for young people remains a critical issue given the relative lack of accommodation available.

3.f the special needs of groups such as children, adolescents, the aged, indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence.

AICAFMHA has previously demonstrated the importance of recognising that children are different from adults and that models of service need to reflect their developmental pathways (sections 3.a and 3.b). However AICAFMHA recognises that within the infant, child and adolescent population there are particular subgroups that have special needs or may be more at risk due to family or environmental factors. An effective mental health service system needs to consider and accommodate these 'at risk' groups.

Certain populations of children and young people have been identified as having a greater risk of developing mental health problems than their peers (e.g. children of parents with a mental illness, children of parents with drug and alcohol misuse, indigenous youth, refugees).

A subgroup of the infant, child and adolescent population is children of parents with a mental illness. This group of children and young people present a special challenge for services as they themselves will not necessarily access or require a mental health service. They do however have particular needs around support, respite, information and protection, as identified within the National Practice Standards for the Mental Health Workforce, 2003 (Commonwealth Department of Health and Ageing, 2002) and the Principles and Actions for Services and People Working With Children of Parents with A Mental Illness (AICAFMHA, 2004).

Drug and alcohol service delivery for young people, especially in their late teens and early adulthood are inadequate. Opportunities for effective prevention programs (targeting early adolescence) have been poorly realised nationally and effective early intervention programs are yet to be made generally available in the community. This is a major gap. The significant overlap of risk factors for drug and alcohol and mental health disorders in young people suggest some potential synergies for prevention / early intervention programs for children and adolescents.

The adverse consequences for children with parents who misuse drugs are typically multiple and cumulative and will vary according to the child's stage of development. They include a wide range of emotional, cognitive, behavioural and other psychological problems (Hidden Harm: UK Advisory Council on the Misuse of Drugs, 2003, p.2). There is a strong need to improve the coordination between drug and alcohol services and mental health services given the high morbidity associated with these issues.

Research shows that more children under the care of the State ("looked after children") have more mental health problems than other young people, including severe and enduring mental illness (The Mental Health of Looked After Children, UK 2001 p. 2). In Australia in 2003

children in care numbered 20 297, an increase of 45% from the 1997 figure of 13 979 (Australian Institute of Health and Welfare, 2004). These children have unique difficulties which make them highly vulnerable and at extreme risk of developing serious and long-term mental health problems. McIntyre and Kessler (1986) found evidence of psychopathology in nearly 50% of a random sample of 158 children in care. A comparative study of children in care as to children living with birth parents in the U.K found that 45% of children in care had some sort of mental disorder. When compared to children living with birth families the following emerged:

- The incidence of emotional disorder was 12% in care compared to 6% in birth family.
- Conduct disorder was 40% in care compared to 6% in birth family and
- Hyperactivity disorder was 7% in care compared to 1% in birth family. (Hutchinson et al, 2003)

Beautrais, Ellis & Smith (2001) reviewed the New Zealand mortality database 1994-1998 for suicides of adolescents 12-16 years and found young people in contact with the Department of Child, Youth and Family ("the Welfare") were 10 times more likely to die by suicide then young people who had never had contact with the Department. The risk was 23 times higher for females and 5.4 times higher for males.

The children who are in care of the state usually reside in either foster care or residential/ group homes. The foster parents and staff who care for these children require specific support and skills to enable them to manage the complex needs of these children and prevent repeat placement breakdowns.

Siblings of children and young people with disability or chronic illness are another hidden risk group. There are over 200 000 people under the age of twenty five years with significant special needs (disability or chronic illness) in Australia. Similar numbers have mental illness. These families can experience considerable stress, evidenced by the large rate of family breakdown (some anecdotal evidence suggests up to 80-90% of these families experience separation or divorce of parents). Parents often receive insufficient support in the early stages of diagnosis to deal with the myriad of feelings they experience. Their needs are often unrecognised and many families feel isolated. The siblings in these families often lack the cognitive and emotional maturity to deal with their experiences. Without support they can develop a range of emotional and mental health problems (Siblings Australia Inc, 2004).

Children who are exposed to domestic violence are also at high risk. In July 2004 an Access Economics report prepared for the Prime Minister, "Cost of Domestic Violence to the Australian Economy", refers to domestic violence costing $8.1 billion dollars a year and that approximately 181 200 children in Australia during 2002-03 witnessed domestic violence (The Weekend Australian, October 23-24, 2004). The report indicates that the major element of the $8.1 billion is the $3.5 billion cost of physical and mental suffering as well as premature mortality. Also found was that during 2002-03 there were almost 37 500 years of "healthy life" lost associated with women suffering domestic violence (The Weekend Australian, 23-24/10/04).

Of particular significance relating to infant mental health is the presence and effect of domestic violence - "a stressful life event" - experienced by women ante-natally and post-natally and her risk of developing post-natal depression. A mother's emotional availability and ability to respond sensitively to her infant are severely compromised and are influential in limiting the infant's secure attachment leading to early development of poor mental health.

"Aboriginal and Torres Strait Islander (ATSI) people experience disproportionately high rates of mental health and social and emotional well being problems" and the *"frequency of child, youth and adult mental health disorders in the community are higher"* as stated in the Consultation Paper for the National Strategic Framework for Aboriginal and Torres Strait

Islander Mental Health and Social and Emotional Well Being 2004-2009, (2003). The delivery of mental health services to ATSI children and youth needs to consider cultural and belief system differences. Geographical issues also affect the accessibility of appropriate mental health services for this 'at-risk' subgroup.

Zubrick et al (2005) in the recently released Western Australian Aboriginal Child Health Survey (WAACHS) — *The Social and Emotional Wellbeing of Aboriginal Children and Young People* found that some 24% of Aboriginal children were at high risk of clinically significant emotional or behavioural difficulties and in addition :

 "The children of Aboriginal carers who had been forcibly separated from their natural family by a mission, the government or welfare:
- *were 2.3 times more likely to be at high risk of clinically significant emotional or behavioural difficulties after adjusting for age, sex, LORI (level of relative isolation) and whether the primary carer is the birth mother of the child.*
- *were more likely to be at high risk of clinically significant emotional symptoms, conduct problems and hyperactivity.*
- *had significantly higher rates of overall emotional or behavioural problems in the 6 months prior to the survey.*
- *had levels of both alcohol and other drug use that were approximately twice as high as children whose Aboriginal primary carer had not been forcibly separated from their natural family."* (page 26 –Summary document)

There is an increasing body of literature surrounding the effects of re-location on the mental health of children and youth, particularly those as refugees. The Professional Alliance For The Health Of Asylum Seekers And Their Children Submission to the HREOC Inquiry (2002) states, "*Current practices of detention of infants and children are having immediate, and are likely to have longer-term, effects on their development and their psychological and emotional health.*" The submission goes on to note that "*in young children, disruptions of attachment relationships, such as removal from a primary carer or multiple changes of carer, are severe stressors and may produce immediate symptoms of distress and behavioural disturbance.*" The absence or limited availability of mental health services for these infants, children and adolescents compounds the issue for these families.

The needs of rural and remote communities with respect to mental health services have been well known and documented for over a decade. Since that time there have been a number of innovative approaches developed to both service delivery and training in rural and remote areas that require sustained investment.

The Report into the National Inquiry into the Human Rights of People with Mental Illness (1993) repeatedly received evidence regarding the inadequacy of mental health services in rural Australia.

 "The irony is that in many of the areas where the need is greatest the services are fewest. This is particularly the point in small country communities where mental health services - and certainly mental health services for children and adolescents - are almost entirely non-existent." (p.678)

The Report also noted that training and support for mental health, health and other professionals involved in working with children and adolescents with mental health problems, in rural and remote areas, was totally inadequate.

The efficacy of using innovative training and service delivery methods such as Telehealth, have been well described in the literature, yet there are no concrete recommendations on how this

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technology could be used to assist rural clients and practitioners (Mitchell, Robinson, McEvoy, Gates (2001); Mitchell, Robinson, Seiboth, Koszegi (2000), Kowalenko et al (2003)). The US President's New Freedom Commission on Mental Health (2003), "Achieving the Promise: Transforming Mental Health Care in America", also highlights the need to more fully utilise this technology as a critical element of reform.

There is a need to recognise that the staffing levels in country areas are in general inadequate to meet the needs of the rural community. Special formulas need to take into account travel and other factors such as the remoteness of the location in determining staffing levels. There is also a need to ensure that country mental health staff are provided with appropriate training and development opportunities which includes travel to major cities on a regular basis for collegial support and targeted training and development activities.

3.g   the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness.

It is important to acknowledge that 'primary carers' in the adult population differ from those in the infant/child/adolescent population. Primary carers for adults are typically partners, family members or paid carers. Primary carers for the infant/child/adolescent populations include parents, other extended family members, school, child care and other workers/adults with whom the child routinely interacts. As such, training and support requirements are significantly different from those for adult populations.

Whenever possible, child and adolescent mental health services view the child within the context of their family. As such, parental/caregiver 'training' occurs as part of the intervention process. A large majority of child and adolescent mental health problems involve providing therapy not only to the child but also to the parents. Given this broader "systems" view, other systems relevant to the age of the child and young person also need to be involved in problem conceptualisation and the treatment plan.

Further to comments in section 3.f regarding children in care, training and support for foster parents is essential, particularly as the complexity of the needs of the young people they care for increases. Similarly workers in Government welfare departments frequently have limited knowledge of the mental health needs of the foster children they provide support to and training for this group is also essential.

Many children and young people provide a major care-giving role for their parent with a mental illness, especially in single parent families (Carers Australia, 2001). Those providing care require respect for that role, including the ability to participate in decision-making regarding their family. They also require practical and emotional support in caring for their parent to ensure that the provision of care does not negatively impact upon their own well-being and participation in education, the workforce or social activities.

3.h   the role of primary health care in promotion, prevention, early detection and chronic care management.

AICAFMHA believes primary care providers have a critical role in the promotion, prevention and early detection of mental health issues. AICAFMHA has developed a strong relationship with the Australian Division of General Practice (ADGP) as it sees GPs as a key initial point of contact for infants and children particularly. AICAFMHA and ADGP have developed a

Communiqué which outlines best practice in the provision of services by GPs for this population. Whilst GPs are often best placed to identify many mental health concerns at an early stage, GPs report that they need ongoing education and clinical support to deal with infant, child and adolescent mental health problems which often have a substantial psychosocial component. Child and adolescent mental health services are well placed to provide training and education as well as clinical support if they are appropriately financially resourced to employ clinical staff to undertake these duties. Currently there are a number of innovative programs that highlight effective partnerships between child and adolescent mental health services and GPs. Further consideration should be provided in how these services can be strengthened. AICAFMHA also recognises however, that GPs are not the sole primary care providers especially for populations of young people.

Raphael (2000) in "Promoting the Mental Health and Well-being of Children and Young People" clearly identifies those involved in care stating: "*Primary health care provides the first point of contact for people in the community seeking help. It includes care from services such as general practitioners, school counsellors, paediatricians in some instances, community health centers, and other community- based health maternal, child, family and youth health and welfare services.*" (page 40)

In relation to children and adolescents, the Mental Health of Young People in Australia (Sawyer et al 2000) found that:

 "*Those in different age groups appeared to access somewhat different services. For example, 4–12-year-old children with mental health problems most frequently attended paediatricians and family doctors. In contrast, school-based counselling was the service most frequently used by adolescents.*" (Sawyer et al 2000, Page 28).

Effective mental health promotion, prevention and early detection strategies targeting children and young people involve a range of stakeholders and settings, which are different to those for the adult population. Environments and systems play an important role in child and adolescent mental health and include schools, child care settings, child protection agencies and youth services. Parents play a critical role in children and young people's mental health and in the treatment of mental health problems and disorders.

The "Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda" introduces a blueprint for addressing children's mental health needs in the United States. The overarching vision of this US blueprint is reproduced below:

 "*Mental health is a critical component of children's learning and general health. Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority. Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals. To achieve these goals, the Surgeon General's National Action Agenda for Children's Mental Health takes as its guiding principles a commitment to:*
1. *Promoting the recognition of mental health as an essential part of child health;*
2. *Integrating family, child and youth-centered mental health services into all systems that serve children and youth;*
3. *Engaging families and incorporating the perspectives of children and youth in the development of all mental healthcare planning; and*
4. *Developing and enhancing a public-private health infrastructure to support these efforts to the fullest extent possible.*" (Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda)

There has been a significant amount of research evidence focusing on the efficacy of intervening early in childhood. In fact the Commonwealth Government has released a paper under the National Agenda for Early Childhood, called "Towards the Development of a National Agenda for Early Childhood". This paper emphasises the need to intervene early and in this document the age range focus is 0-5 years.

Raphael (2000) also supports early action stating: "*Where effective treatments and interventions are available, intervening in the early stages, when difficulties of symptoms first start to appear, can prevent problems from becoming entrenched and thereby minimise the impact of these problems or disorders on the lives of young people*" (page 1).

The US President's New Freedom Commission on Mental Health (2003) titled "Achieving the Promise: Transforming Mental Health Care in America" noted the following:

 "*Early childhood is a critical period for the onset of emotional and behavioral impairments….*

Emerging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability…..

Without intervention, child and adolescent disorders frequently continue into adulthood. For example, research shows that when children with co-existing depression and conduct disorders become adults, they tend to use more health care services and have higher health care costs than other adults." (page 57)

Support for and augmentation of existing infant, child and adolescent mental health services to further engage in mental health promotion and prevention activities will contribute to community capacity building and ultimately the sustainability of effective programs while avoiding inefficient use of funds through duplication of existing services.

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 states: "*a whole of community response is required to maximise the mental health potential of all community members*". At a local level, the ability of a community to embrace and embed effective mental health promotion, prevention and intervention strategies contributes to positive mental health outcomes for all members of the community.

The National Action plan goes on to quote Wood and Wise (1997) who identified factors "*that may support sustained promotion, prevention and early intervention activities among health and mental health services*". These include "*strong support from a robust health promotion infrastructure, staff commitment, professional development and education, and systems that identify and disseminate good practice*".

This term of reference does not suggest a major role for early intervention in the primary care sector. This may unnecessarily limit the capacity of primary care services. Early intervention for children and young people should occur across both the secondary and primary care sector. The importance of early intervention is discussed in more detail in section 3.b.

3.i opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support, and education of the mental health workforce, and for services to be consumer-operated.

AICAFMHA is an organisation made up of a partnership between professionals and consumers and has been a long term advocate for supporting consumer involvement. In the child and adolescent context, the type of involvement and who is involved often depends on the age of the

child or young person. In respect to children, child and adolescent mental health services engage with parents, since given the systemic approach taken by child and adolescent mental health services, parents and families are seen as central to the provision of service. While consumers have a role in planning and developing services their involvement is always undertaken within a clear framework of support and respect to ensure good consumer outcomes.

Children and young people have a right to participate in and provide input into decisions that are likely to affect them. Parents and caregivers also play a crucial role in advocating for children and young people.

While infants and children may find it difficult to speak for themselves, it is also commonplace that young people are not given the opportunity to express their views.

Raphael (2000) noted:

 "Advocacy for and on behalf of children and young people requires recognition of their rights and needs to ensure that appropriate responses and systems of care are provided. It involves providing opportunities for children and young people to have a say in decisions that are likely to affect them. Parents and other caregivers also play a crucial role in advocating for children and young people" (Raphael 2000, Page 1).

Aynsley-Green (2000) supports this in his list of proposed strategies for improving the status of children and adolescents stating "*the views of parents, children and adolescents together with those of clinicians dealing with young people urgently need to be incorporated into the formulation of strategy and delivery of services*".

AICAFMHA is committed to advocating for the "voice of children and young people" to be heard in the development of mental health policy, services, interventions and programs which affect them. In 2003 AICAFMHA negotiated with the Australian Government to ensure that young people were consulted during the development of the Third National Mental Health Plan. Consequently AICAFMHA supported a group of young people (12-18 years of age) to be involved in sharing their experiences and providing feedback. The experience was positive for both the Department of Health and Ageing and the young people. In 2004 AICAFMHA was commissioned by the Australian Government to develop a National Youth Participation Strategy (NYPS) for Mental Health, informing projects under the NMHP and the National Suicide Prevention Strategy (NSPS). A scoping report detailing models of good practice will be available in July 2005. For an overview of draft models please go to http://www.aicafmha.net.au and click on 'Youth'.

The NYPS Project is guided by the belief that young people have the right to participate in the development, implementation and evaluation of programs which affect their well being. AICAFMHA recognises the need for this process to be facilitated in a respectful manner using a developmental framework, which embraces diversity. With this in mind, the following principles apply:

1. Youth participation strategies must be clear and transparent about their aims and processes to ensure valid consent to participate is provided. This will also result in an increased awareness of the benefits of participating.

2. Workers and the young people must agree on the issue of confidentiality at the beginning of the project. This is to ensure that the privacy of young people is protected.

3. A diverse group of youth needs to be represented. Attention should be given to sampling relevant groups of young people who are represented in the activity. If the group needs to be

divided into smaller groups, the appropriate groupings should be considered to enable young people to participate actively in their groups.

4. There is a need to look at young people's:

   a. Developmental level,
   b. Social-emotional wellbeing and,
   c. Potential for participation when designing activities.
   These factors should be matched with the tasks young people are expected to do.

5. Activities for young people should be fun and engaging. Group sessions, break-in activities, shorter activities, and games can be used to make the project more enjoyable for young people. When young people are not enjoying themselves, getting bored, or dropping out, methods must be changed and adapted to the young people's interest.

6. A structured framework is adopted where:

   a. Roles are defined,
   b. Available supports and resources are highlighted,
   c. Project goals/outcomes are specified,
   d. Skills and experiences of all involved (young people/adults) are recognised.

7. Skills development needs to be specifically designed and implemented to suit the needs of youth and adult service providers. This can target a range of areas including peer education, communication skills, problem solving, negotiating, team work, group norms and public speaking.

8. Accountability mechanisms need to be incorporated throughout the participation process. These should be negotiated with the young people directly involved in the project and aim to provide them with an awareness of the end product and formally acknowledge their involvement so they feel appreciated. (Johnson V. 1996; Woolcombe 1996; Theis 1997; ECPAT 1999) (Office of Employment and Youth 2000; NSW Commission for Children and Young people 2002; Office for Youth 2003; The Australian Youth Foundation 2003; NSW Department of Education and Training 2004; Office for Youth 2004; Youth Affairs Council of Victoria 2004; Youth Affairs Council of Victoria 2004; Youth Affairs Council of Victoria 2004)

Through the NYPS Project, AICAFMHA has researched how youth are involved in service delivery by talking to over 100 young people, workers and organisations and reviewing the literature. This information has highlighted that youth take on a variety of roles and operate at various levels of decision making throughout the community. Examples include youth as:

Administrators: participating in the day-to-day operations of agencies through bookkeeping, typing, research, and data collection.

Advocates: making policy papers and join unions, rallies, campaigns, and public debates on issues relevant to their lives. They can also join conferences that discuss children and young people's issues, sit at children's hearings where they can pose questions to an adult panel, and make public presentations of the issues they are concerned about.

Counselors and peer support: where they listen to others and provide support on various issues.

Decision-makers: sitting as members of the board of youth serving NGOs.

Mentors or educators: teaching younger children. For instance, in child-to-child projects, younger children can pass health messages not only to their peers but also to adult members of their community.

Income generators: helping generate income for their families and their organisations.

Monitors and evaluators: assessing and evaluating the effectiveness of their programs.

Managers of their environment: including households, school and school grounds, or community resources. Young people can ensure the daily care of the environment and create diverse landscapes for their household, school, or community

Researchers in participatory action research projects: where they can identify their research problem, design the research methodology, implement the research, analyse the data, and make conclusions from the analysis. They can also join national surveys and contribute to a national research project. (Child and Youth Foundation of the Philippines (CYFP). 1996; Hart 1997) (Checkoway (2003)) (Holdsworth 2004)

Through discussions and review of case study projects under the NMHP and NSPS, AICAFMHA believe the following might be required so young people can become active participants in the development and implementation of their programs:

The development of child-conscious thinking should be the top priority when training service providers. The training should be aimed at competence building, awareness raising, and challenging attitudes towards young people. The training should focus on youth and gender consciousness and on rethinking their relationship with young people.

Training on collecting youth-specific information should address policy makers, planners and researchers. The training should stress the definite inclusion of research in programming and youth-specific indicators in reports produced by the case study projects.

Training of researchers and educators in participatory action research with young people is necessary. The assigned field workers have to make it a point to find out about the young people's background and environment enabling young people to be treated differently as unique individuals with their own personalities.

There is a need to restructure existing programs to enable young people's participation. Consolidating and improving existing structures and/or commencing new structures to increase youth's level of participation can do this.

Attitudes and beliefs. Special consideration should be given to the willingness of the staff to change, as this is a precondition to involve young people in programming. (Van Beers 1995)

3.j the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which the environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people.

In the area of crime prevention, there is strong evidence for preventative approaches across the developmental trajectory. The Commonwealth produced an excellent publication titled, "Pathways to Prevention: Developmental and early intervention approaches to crime prevention in Australia" (Homel R [Ed] 1999) which drew together compelling evidence regarding the relationship between early intervention and the potential to reduce crime.

The 2002 US report "The Well Being of Our Nation: An Inter-Generational Vision of Effective Mental Health Services and Supports" includes substantial detail with regard to mental health

problems and juvenile justice issues. The report states:

"Studies have consistently found the rate of mental and emotional disabilities higher among the juvenile justice population than among youth in the general population. As many as 60-75% of incarcerated youth have a mental disorder.

Many youngsters have committed minor, non-violent offenses.... These non-violent offenders are better served by a system of closely supervised community-based services, including prevention, early identification and intervention, assessment, outpatient treatment, home-based services, wraparound services, family support groups, day treatment, residential treatment, crisis services and inpatient hospitalisation.

Intensive work with families at the early stages of their children's behavioural problems can also strengthen their ability to care for their children at home. These services... are most effective when planned and integrated at the local level with other services provided by schools, child welfare agencies and community organisations."

Further to this, the July 2004 US House of Representatives paper "Incarceration of Youth Who are Waiting for Community Mental Health Services in the United States", reports on the health systems failure to ensure effective mental health care for the one-in-five US youth with debilitating mental disorders. The consequence of which is the inappropriate incarceration of youth who are waiting for community mental health services to become available. The paper goes on to state:

"Without access to treatment, some youth with serious mental disorders are placed in detention without any criminal charges pending against them. In other cases, such youth who have been charged with crimes but are able to be released must remain incarcerated for extended periods because no inpatient bed, residential placement, or outpatient appointment is available. This misuse of detention centers as holding areas for mental health treatment is unfair to youth, undermines their health, disrupts the function of detention centers, and is costly to society."

Preceding this report, Rogers et al (2001) investigated mental health referral in juvenile justice and found inconsistent referral patterns for mental health with variations dependent on youth race and sex, and worker type. The findings of this paper have clear implications for the training in mental health problem identification for a range of workers within juvenile justice systems.

Templin et al (2002) investigated rates of mental health disorder in a population in excess of 1800 youths in juvenile detention. Results indicated rates of disorder as high as 66% in males and 73% in females, with females more likely to rate on multiple disorder scales. Disorders most highly identified included substance abuse, disruptive behaviour and anxiety disorders.

In Australia, there is a very serious gap in the provision of evidence based crime prevention mental health strategies despite evidence pointing to the effectiveness of prevention and treatment of childhood and adolescent aggression and anti-social behaviour (Bor, 2004).

Prof Steve Zubrick has recently completed work in disadvantaged communities in Perth, Western Australia, with Prof Mat Sanders demonstrating the capacity of psychological interventions delivered in the community to significantly decrease conduct problems across a population of pre-schoolers. Details of such preventive initiatives should be disseminated across our nation.

Hearn (1992) in Victoria identified that "*While some young people have significant mental health problems, they are often not able to access adolescent psychiatric services because they are deemed not to have a 'diagnosed illness'…many of these young people, denied support through the mental health system, can find themselves in contact with the criminal justice*

system". Hearn also quotes a South Australian study which found "*that young people in an Adelaide youth training centre had emotional and behavioural disorders at a comparable level to young people attending adolescent psychiatric services*" (Kosky et al, 1990).

The 2003 NSW Young People in Custody Health Survey: A Summary of Some Key Findings paper (Allerton et al, 2003), included results from 242 young people in custody. This survey assessed youth on a range of health scales and found that in conjunction with high rates of literacy disability, language and hearing disorders and poor IQ scores, young people in custody also exhibited high levels of adolescent psychopathology. 84% of those surveyed reported symptoms consistent with a clinical disorder and 55% with two clinical disorders. Disturbing rates of psychosocial problems, suicidal ideation and self-harm ideation were also evident.

Similarly, a Queensland paper, "A Collaborative Approach to the Delivery of Mental Health Services to Juvenile Offenders" (McCormack & Hicks, 2003) found that "*67 of these 121 (55%) young people met the diagnostic criteria for one or more psychiatric disorders and a further 18 (14%) had attempted suicide*".

AICAFMHA encourages the Australian Government to consider the impact adequate infant, child and adolescent mental health services may have on other sectors such as juvenile justice. As stated by Hearn (1992) "*the cost of keeping a young person in a youth training centre is high. Some of these young offenders go on to serve time in adult prisons. Therefore, the long-term expense that can result from not providing services that prevent people with mental health problems from entering the criminal justice system, or by not addressing young offenders' health needs once they are within the system, can be astronomical. Most importantly, the human costs can be devastating*".

3.k   the practice of detention and seclusion within mental health facilities and the extent to which it is comparable with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion.

Unlike other behavioural strategies seclusion is seen as an emergency measure (Tardiff and Mattson, 1984), the purpose of which is to reduce overwhelming environmental stimulation and to protect the patient, staff, and other patients from injuring themselves or others. In particular, seclusion has been found to be an effective means of preventing violent, self harming or destructive behaviour and reducing agitation (Lendemeijer and Shortridge- Baggett, 1997).

The use of seclusion appears to relate "directly to the perception of personal threat" (Crichton 1997, p.52) and "*nursing staff use seclusion because they perceive themselves, or others to be under threat. Usually in the case of actual or threatened violence*" (Mason 1995, p 82). Whenever seclusion is implemented it is reviewed on a regular basis and ongoing attempts are made to release the patient from the seclusion episode as soon as it is safe to do so. In South Australia, if a patient has remained in seclusion for a period of 60 minutes they must receive a face to face review by a medical/psychiatric registrar before seclusion can continue.

AICAFMHA believes that alternatives to seclusion should always be considered prior to the implementation of a seclusion episode (eg medication, relaxation therapy, distraction) unless the presenting problem is considered imminently dangerous with resulting potential harm to self and/or others.

3.l   the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers.

Stigma and discrimination associated with mental illness and disorder is well recognised and their impact on individual's who experience mental health problems can be significant. Additionally it is important to note that the stigma associated with mental illness invariably affects family members as well as the person with the illness. A range of service sectors can assist in meeting the information needs of carers, including children of family members with a mental illness (for examples, see page 14 "Principles and Actions for Services and People Working With Children of Parents With A mental Illness", AICAFMHA, 2004).

High quality education and community awareness programs play a critical role in reducing the impact of negative community attitudes and misinformation relating to mental health and increase the capacity of the community to respond appropriately.

Successful education programs will result in improved mental health literacy in individuals who experience mental health problems, their families and in the general community. Mental health literacy has been defined as:

 "the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking" (Jorm et al, 1997, p. 182).

Increasing mental health literacy has been identified as a key outcome in the National Action Plan for Promotion Prevention and Early Intervention for Mental Health 2000 and the current National Mental Health Plan 2003 - 2008.

AICAFMHA believes that the concept of mental health literacy should not be confined to a sole focus on mental health problems and disorders but should include knowledge and awareness of what constitutes positive mental health and strategies that promote good mental health. Education that focuses only on mental illness may increase the stigma associated with mental health, as it may not be considered to relate to individual's experience. A broader focus, that includes both good mental health and mental health problems and disorders, introduces a framework where mental health is relevant to all members of the community.

Multiple education and community awareness strategies that promote knowledge and skill development are required to improve mental health literacy and need to be specifically designed within a developmental framework for target populations and settings. Initiatives such as Mindmatters provide one example of programs designed to increase awareness and promote skill development in adolescents in a school based setting. Other complementary initiatives such as the Headroom Project provide a range of mental health information that has been developed by young people and designed to increase the knowledge and skills of young people in relation to mental health. Health Insite and the South Australian Department of Education and Children's Services have identified Headroom as a reliable and relevant resource for this target population.

While it is important that there are educative programs and information relating to mental health for children and young people there is also a need for education programs to target parents and other caregivers. Such programs could provide parents with a framework in which to understand the emotional, social and cognitive developmental trajectories of infants, children and adolescents and assist them to respond and seek help early for a range of difficulties relating to their children that may be concerning them.

Currently there are a number of high quality education and community awareness strategies implemented across Australia. However their effectiveness is often limited by short term funding structures and a lack of coordination with other programs. To have a sustainable impact on stigma associated with mental health it is crucial that a systematic and long term implementation strategy is developed. This will ensure that key information about mental health is consistently conveyed and changes in attitudes maintained by target populations and the community as a whole.

Help seeking and knowledge of professional and support services are important components of mental health literacy. It is necessary for state and local communities to have a mechanism to monitor, review and update information about the availability, accessibility and role of services. This is a challenging task given that there are often long waiting lists for professional services and an ever changing mix of services that are reliant on short term funding.

3.m   the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness

AICAFMHA believes it is critical for policy relating to mental health to reflect the range of cross-sectoral services relevant to infant, child and adolescent mental health and acknowledge that these services may vary from those of the adult population.

The health and well-being of infants and children, more than any other age group is dependant on relationships with caregivers other significant adults and is influenced by systems including the education, welfare, juvenile justice, disabilities, community services and workplace and training providers.

It is important for the Australian Government to consider how further dialogue, coordination and integration could occur across critical areas of government in relation to such issues and the development across portfolio areas of joint planning in respect to infant, child and adolescent mental health.

Sawyer et al (2000) in the Mental Health of Young People in Australia, noted: *"Adolescents with mental health problems do not have problems that are limited to a single aspect of their lives. Rather, their problems are wide-ranging and include suicidal ideation, smoking, alcohol use and drug abuse. There is consequently a need to develop joint policies and strategies across the different services that provide help to young people with mental health and related problems (e.g., school-based services, paediatricians, family doctors, mental health services, and drug and alcohol services)."* (Sawyer et al, 2000, page xii)

As reported in AICAFMHA's "Principles and Actions for Services and People Working with Children of Parents with a Mental Illness" (2004), p.15, government can facilitate high quality service provision for families and children affected by parental mental illness in partnership with a range of relevant stakeholders (mental health services, community service providers, child protection services, community policing, the justice sector, the education sector, families and other key stakeholders) regarding enhancement of family and individual mental health and wellbeing in families where a parent has a mental illness and the care and protection of children (where concerns are identified). The strategies to enhance partnerships espoused in the 'Principles and Actions…' document include workforce training, service reorientation and shared protocol and policy development.

The field of child protection is one domain that has long been linked with mental health and within child and adolescent mental health services, there are often a high number of consumers who will have had some contact with the relevant welfare or child protection service. This issue has also been discussed in section 3.f. In 2000, the report "Preventing child abuse and neglect: findings from an Australian audit of prevention programs" was published by the Australian Institute of Family Studies. Interestingly, the report states:

"For prevention programs developed to meet the needs of children residing with a parent living with a mental disorder, the issue appears to be first, to obtain access to one of a limited number of services, and then, to ensure funding is sufficient to allow the service to be used for as long as needed. Despite some small increases in the mental health sector's recognition of the needs of children with a mentally ill parent, greater service development appears to be required."
(Tomison & Paul, 2000, page 6)

Homelessness, particularly amongst young people is a significant community concern. Links between homelessness and mental health have regularly been made in the literature. The 2001 Consultation Paper, "Working Towards a National Homelessness Strategy and the subsequent "Working Towards a National Homelessness Strategy Response to Consultations" (2004) identified that *"...factors that contribute to youth homelessness include physical, sexual and emotional abuse, feelings of depression and anxiety...".* The Response to Consultations report goes on to identify goals to address these issues including *"improving access to community support for children and young people and getting first-to-know agencies to focus on the early detection of factors that contribute to the risk of homelessness".*

There are many other areas in which inter-sectoral collaboration and integration must occur to promote better mental health outcomes for infants, children and youth. Within health, these include departments of maternal and foetal medicine, and outside of health include disability, juvenile justice and police, employment and vocational rehabilitation services.

AICAFMHA strongly recommends that joint planning and policy development occur across sectors relevant to infant child and adolescent mental health. This planning process should commence with a dedicated Infant, Child, Adolescent and Family Mental Health Action Plan, which should be developed through a National Summit on Infant, Child, Adolescent and Family Mental Health.

Every Australian State/Territory currently has an existing public infrastructure for CAMH services with unique characteristics and local knowledge regarding the development of appropriate service delivery models for children and adolescents in their region in association and collaboration with other key local stakeholders within a capacity building framework. Capacity building within communities increases the likelihood of sustainable practices and models of service that are responsive to local needs.

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 identifies key locations for action in the early childhood and childhood years as *"childcare settings, preschools, primary health care settings, community, sport and recreation settings, schools, child and family welfare services and mental health services"*. This document recognises the need to design interventions that are available and linked to the multiple environments that a child or young person may access. Building the capacity of these communities to respond appropriately and effectively to children and young people who may be experiencing mental health problems will enable delivery of the most effective intervention.

One of the key areas for activity contained within the Ottawa Charter for health promotion (WHO, 1986) – strengthening communities, states: *"This requires health promoters to*

encourage the creation of strong communities to protect and promote their own health; such communities would have the power to define their own health problems and determine what solutions they would select." (Baum 1995, p.3)

AICAFMHA believes that national child and adolescent mental health strategies are generally best implemented through locally based child, adolescent and family mental health service providers working in collaboration with key local stakeholders.

3.n the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated.

Research priorities and specific indicators for progress against targets are required in the infant, child and adolescent mental health area. A national action plan for dissemination of best practice monitoring and reporting on its uptake is required.

AICAFMHA believes that innovative pilot programmes that have been one off funded should be funded on a recurrent basis if they are proved to be effective. There also needs to be an audit of a range of innovative programmes with a research base that have never been implemented due to insufficient funding being made available to trial them. In the US, the SAMHSA Model Programs online database provides an excellent example of recognising and sharing information about effective programs (http://www.modelprograms.samhsa.gov/). In Australia, the National Action Plan for Promotion Prevention and Early Intervention for Mental Health 2000 outlines many evidence based programs that could be implemented across the entire lifespan, yet many of these programs have not been rolled out. International evidence indicates that the 'best buys' for investment in mental health can be realised in the child and adolescent age group.

At the present time in Australia there has been significant research investment in the area of early psychosis. Further research needs to be undertaken in other areas associated with infant, child and adolescent mental health.

A more targeted approach to guide research activities is required. For example, in the United States, the National Institute of Mental Health has established a blueprint for research priorities in the area of child and adolescent mental health (Hoagwood & Olin, 2002). This targeted approach to developing a clear research agenda would be an excellent action step to complement the broad statements made in this section.

In Australia, AICAFMHA has taken on the role of sharing information on programs in specific areas of its work including children of parents with a mental illness. Auseinet also undertakes this role with a broader range of programs. Further investment in this sharing of information is sorely needed.

The gap in Australia and internationally between research and practice has been identified as a contributing factor in the limited implementation of existing, evidence-based good practice activities. Limited information networks contribute significantly to the duplication of programs or the 're-invention of the wheel'. Similarly, targeted funding for programs that address only a small part of the infant, child and adolescent mental health consumer spectrum may be inefficient due to the programs failure to capitalise on existing mental health services and expertise.

AICAFMHA supports commitment to community capacity building to enhance sustainability of effective mental health promotion, prevention and early intervention programs through a capable and supported worker base, enhanced by systems which identify and disseminate good practice within the existing mental health promotion

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framework. In addition, AICAFMHA supports the development of a targeted research approach through the development of a national research agenda.

3.o   the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards.

AICAFMHA supports the development of specific indicators for progress against the Mental Health Plan 2003-08. AICAFMHA recognises that the National Mental Health Report provides a comprehensive overview of mental health service activity in Australia, however this document is primarily focussed on the activities of adult mental health services. Child and adolescent mental health service indicators need to be specifically developed and implemented.

Implicit in measuring progress is the need to ensure that indicators are appropriate across the lifespan. For example there would be little point in just asking child and adolescent mental health services to report on primary care with general practitioners when an equal amount of their work should be with school counsellors.

Data also needs to be collected which reflects family mental health in addition to that pertaining to the health of individuals. A clear example of a need in this area is for adult mental health service providers to systematically identify and record if a new client has a parental role and to explore the impact of parental mental illness, if any, on family members (see AICAFMHA 2004, page 13).

In the UK, the 1999 Audit Commission report, 'Children in Mind' highlighted the general weakness of data on child and adolescent mental health service provision. At this time, there was no regular data collection apart from data on hospital activity and waiting times. The importance of child and adolescent mental health services was recognised in 1999 by the NHS Modernisation Fund and the Mental Health Grant and in the NHS Plan. The profile of child and adolescent mental health services was further elevated by the publication of the Children's National Service Framework in 2004. In 2001, CAMHS mapping was piloted for the Department of Health to contribute to the monitoring of the expansion and development of mental health service provision for children and adolescents. Implemented in 2002, the National CAMH Service Mapping has become an annual exercise for the collection of data.

The National CAMH Service Mapping exercise aims to improve mental health services for children and young people by:

- Assisting the bid for resources at a local and a national level by providing accurate information on service provision against population size and deprivation;
- Supporting the development of joint commissioning strategies and children's trusts;
- Informing and supporting the implementation of the Children's National Service Framework;
- Providing data for the monitoring of NHS plan implementation;
- Facilitating local and national benchmarking;
- Contributing to a comprehensive needs assessment.

Information is collected via an internet based environment. More detailed information about this UK project can be found at http://www.dur.ac.uk/camhs.mapping.

In Australia, there is not currently a uniform method of data collection or uniform data set by which to most effectively plan, develop and monitor child and adolescent mental health services.

The model of data collection now established in the UK warrants consideration in a modified format for Australian conditions. The national information strategy is commencing this process in part. CAMH service mapping, outcomes for zero to 3 years olds, and systems to monitor prevention and early intervention programs, regardless of the setting in which they are delivered, require further development.

AICAFMHA supports the development of a national child and adolescent mental health data set to enable effective benchmarking, monitoring and evaluation of child and adolescent mental health services in Australia.

3.p   the potential for new modes of delivery of mental health care, including e-technology.

There is now a wide range of technologies available which can assist in the provision of mental health services. Mental health services have led the way in the use of videoconferencing or tele-psychiatry around the world. This technology has been used for:
- One to one clinical consultations;
- Professional consultation;
- Training and development.

As mentioned in section 3.f, the efficacy of using innovative training and service delivery methods such as Telehealth, have been well described in the literature (Mitchell, Robinson, McEvoy, Gates (2001); Mitchell, Robinson, Seiboth, Koszegi (2000) & Kowalenko (2003)).

In addition websites have been used for a range of services including:
- Information on services (eg Division of Mental Health, WCH - see http://www.wch.sa.gov.au/services/az/divisions/mentalhealth/index.html)
- Mental health promotion (eg Headroom – see http://www.headroom.net.au/)
- More targeted programs on specific areas such as MoodGYM – A free self help program to teach cognitive behaviour therapy skills to people vulnerable to depression and anxiety- see http://moodgym.anu.edu.au/)
- Online counseling services such as Kids Helpline- see http://www.kidshelp.com.au/)

Some regional health authorities have also set up call centres to facilitate consumer access to information.

A number of these technologies offer great promise, however in relation to online counseling services for children, careful consideration needs to be given to the ethics of providing counseling to children under the age of 16 years (or whatever the age of consent for treatment is in each jurisdiction) without parent consent. In most states a Medical and Dental Treatment Act exists which indicates that parental consent is required for ongoing counseling. In any circumstance clinical best practice would suggest that young people should wherever possible be treated in the context of their family.

An excellent publication titled, "Using the internet for suicide prevention: a guide" produced by the Ministerial Council for Suicide Prevention (Miller, K.M., Cugley, J.A. & Ministerial Council for Suicide Prevention 2004) clearly sets out the many ethical issues associated with the use of online counseling.

4. Additional Comments

AICAFMHA was established to actively promote the mental health and well being of infants, children, adolescents and their families. It brings together professionals from a wide range of disciplines and consumers and carers in the one organisation.

Given this partnership between consumers and professionals an integral part of AICAFMHA's submission to the Senate Committee is the accompanying DVD which includes the views of three groups of young people.

AICAFMHA, through funding by the Australian Government, is currently developing a National Youth Participation Strategy for Mental Health. An underpinning of this Strategy is that the voice of young people needs to be heard in the development of mental health policies affecting young people. The first chapter of the DVD presents the views and opinions of two groups of young people. One group are young people who have attended an intervention service due to significant mental health issues, and are now managing independently in the community. The other young people have significant mental health issues and are currently actively participating in an intensive, intervention program.

AICAFMHA is also funded by the Australian Government to manage and implement the Children of Parents with a Mental Illness National Initiative. The second chapter of the DVD incorporates the views of a group of young people who have a parent with a mental illness. For each of these young people, participation in a local support program has been of significant benefit due to the high degree of parental care they each undertake.

The young people participating in the production of the DVD have been fully informed of the scope of the Select Committee inquiry. While this written submission may be made public at the Committees' discretion, the young people, or their guardian/s, have given their consent for participation on the understanding that the DVD remain confidential to the inquiry.

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6. Appendices

Appendix 1: About The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA)

The Australian Infant, Child, Adolescent and Family Mental Health Association Ltd (AICAFMHA) was established to help meet the needs of workers and consumers in child and adolescent mental health. Incorporating in June 2000 the association actively promotes the mental health and well being of infants, children, adolescents and their families. AICAFMHA is committed to ensuring its activities are relevant and accessible to all people with an interest in the fields of infant, child, adolescent and family mental health. The association is unique in that it brings together professionals from a wide range of disciplines and consumers and carers in the one organisation. AICAFMHA has developed strong cross-sectoral contacts and a strong consumer constituency.

Activities of AICAMHA during the past 12 months include:

- successfully hosting with TheMHS a joint Mental Health Conference on the Gold Coast in Sept 2004, incorporating mental health issues from infancy, youth, adult and aged perspectives;

- provision of national representation for infant, child and adolescent mental health issues on the Mental Health Council of Australia Board;

- development of a Position Paper on Improving the Mental Health of Infants, Children and Adolescents in Australia (2004);

- success in securing Australian Government funds for an extension of the Children of Parents with a Mental Illness National Initiative and funding to explore the potential to develop a National Youth Participation Strategy in Mental Health;

- launching of the Key Document and Resource Materials from the Children of Parents with a Mental Illness National Initiative, available from http://www.copmi.net.au ;

- provision of ongoing management for the Children of Parents with a Mental Illness National Initiative (COPMI Project) including fortnightly updates about progress on the website;

- maintaining national networking and communication via the fortnightly online publication, News In Brief, with over 2100 subscribers;

- in conjunction with the RANZCP and Melbourne Convention Centre, successfully bidding to host the 2006 IACAPAP congress;

Additional information about AICAFMHA is located at http://www.aicafmha.net.au/.

Appendix 2 – Glossary

ADGP   Australian Divisions of General Practice

AICAFMHA   Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

Auseinet   Australian Early Intervention Network

ATSI   Aboriginal and Torres Strait Islanders

BMJ   British Medical Journal

CAMHS   Child and Adolescent Mental Health Service

CAMH   Child and Adolescent Mental Health

COPMI   Children of Parents with a Mental Illness

GPs   General Practitioners

NHS   National Health Service (UK)

NMHP   National Mental Health Plan

NMHS   National Mental Health Strategy

NSF   National Service Framework (UK)

NSPS   National Suicide Prevention Strategy

RANZCP   Royal Australian and New Zealand College of Psychiatry

SSRI   Selective Serotonin Reuptake Inhibitor

TOR   Term of Reference

UK   United Kingdom

US   United States

WHO   World Health Organisation