Response to the Consultation Paper for the Third National Mental Health Plan 2003 – 2008

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A. Executive Summary

AICAFMHA appreciates the opportunity to comment on the Third National Mental Health Plan 2003-08. At the outset AICAFMHA welcomes the development of a Third Plan as it believes there is still much that needs to be done in the area of infant, child, adolescent and family mental health.

In reviewing the Consultation Paper 2003-08 it is clear that the document is written from an adult psychiatric perspective i.e. the predominant language presupposes that the reader is thinking about an adult person with a mental illness, their carers and family. This conceptualisation does not fit for the majority of the work undertaken by the Child and Adolescent Mental Health Services throughout Australia.

The Commonwealth has produced a number of excellent 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 Promoting the Mental Health and Wellbeing of Children and Young People and the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000.

The draft Mental Health Plan provides very limited reference to these documents. In reviewing these excellent documents it appears that many of the actions recommended have not been implemented. It would be very helpful if the Mental Health Plan 2003-08 made explicit the priorities for action. In addition it would be important to summarise the outstanding actions from existing plans such as the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000.

AICAFMHA's response to the National Mental Health Plan 2003-08 provides a brief overview on the Australian context, together with highlighting key international policy directions in the area of infant, child adolescent and family mental health.

AICAFMHA's position in no way is meant to detract from the need for reform in the adult mental health area. The draft Plan covers this issue very well. AICAFMHA's critique of the National Mental Health Plan 2003-08 essentially is making a plea for inclusiveness of infant, child, adolescent and family mental health issues.

AICAFMHA's simple plea is fourfold:

- **set up appropriate mechanisms so that the voice of infants, children, young people and their families can be heard**
- **ensure that specific plans for the infant, child and adolescent mental health area are developed**
- **ensure that funding models provide equitable funding for the mental health needs of the infant, child, adolescent and families of Australia**
- **ensure that policy statements recognise and reflect the unique needs and opportunities for intervention with infant, child and adolescent populations**

B. Background Information

B1. The Australian Context

Two landmark Australian studies 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, 1995). These surveys indicate that between 14 – 18% of children and young people experience mental health problems of clinical significance.

These findings equate with international data on the incidence of mental health problems in the infant, child and adolescent population.

B2. The need to distinguish the special needs of infants, children and adolescents

It is interesting to note that the lead editorial in the British Medical Journal, 26 April 2003, is titled, "The National Service Framework for Children: Cinderella is ready for the ball." The editorial, in its critique of the National Children's Services Framework noted,

"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])

Raphael (2000) in the document "Promoting the Mental Health and Wellbeing of Children and Young People," noted:

"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." (Raphael, 2000, Page 3)

In addition, Prof Albert Aynsley-Green made a powerful argument for recognition of children and youth in policy development and intervention planning in the British Medical Journal in 2000. He states:

"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". (BMJ 2000; 321:229-232 [22 July])

The US Surgeon General's Report on Mental Health (1999) noted:

"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)

The US Surgeon General goes on to say, *"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)

B3. International recognition of the need to develop plans specific to the infant, child and adolescent population

It should be noted that the US Surgeon General's Report on Mental Health attracted such interest that a separate conference was convened to look specifically at child and adolescent mental health issues. This Conference was held in September 2000. The outcome of that conference and its recommendations are contained in the document, "Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda". This report 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)

In addition, 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)

This charter statement has provided the Center with a strong platform for progressing developments in the field of child, adolescent and family mental health, with a number of key initiatives funded and ongoing nationally.

In the United Kingdom the Audit Commission completed a National Report, titled, "Children in Mind- Child and Adolescent Mental Health Services" Audit Commission 1999. More recently the United Kingdom's National Health Service (NHS) has developed a 10-year plan to reform the system. In respect to children, the NHS made the following introduction to 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)

The key issue here is that international policy direction has recognised the importance on focussing initiatives on the infant, child, adolescent and family mental health sector and have acknowledged that this area needs dedicated planning and implementation to ensure the needs of this population are not overshadowed by the general adult mental health services.

B4. The need to collate issues identified in other Commonwealth Reports and link them to the strategic direction of the Third National Mental Health Plan

The Commonwealth has commissioned many excellent publications, both describing the needs of the Australian population, together with an outline on how to address many of these issues. However the recommendations in these various reports are not collated in any central place, making it difficult to understand from a strategic planning perspective which priorities are being progressed. Also it would be helpful in the development of the Third National Mental Health Plan, if the many recommended actions from a wide range of Commonwealth mental health reports were ranked in terms of priority.

For example Sawyer et al (2000) in the 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)

Given this type of observation which could be linked across a range of other areas, it would be important for the Commonwealth to consider how further dialogue could occur across critical areas of government in relation to such issues and the development across portfolio areas of joint planning in respect to such issues.

For example in the United States, given the high co-morbidity between mental health problems and drug and alcohol abuse a joint authority has been established, the Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.samhsa.gov/). Only recently, SAMHSA has unveiled its new edition of Science-based Prevention Programs and Principles: Effective Substance Abuse and Mental Health Programs for Every Community. The SAMHSA Model Programs featured on this site have been tested in communities, schools, social service organizations, and workplaces across America, and have provided solid proof that they have prevented or reduced substance abuse and other related high-risk behaviours (http://www.modelprograms.samhsa.gov/).

Whilst AICAFMHA is not arguing for this level of system change, it is clear that in a National Mental Health Plan, such critical cross-sectoral and co-morbidity issues should be addressed in more detail at a strategic level. There is also a need to address the issue of not only young people who may have a drug or alcohol addiction, but also the impact on children if their parents have such an addiction.

C. Comments on each section of the Consultation Paper on the National Mental Health Plan

C1. Introduction Section

In the Introduction section, the document talks about "the mental health system is no longer based on large stand alone psychiatric institutions, but has moved to providing psychiatric care within the mainstream health system and through community care where possible." Whilst this statement is undeniably true for the adult mental health services, this proposition has never been the case for child and adolescent mental health services. In fact the opposite has been the case, with the majority of services provided in the community with limited appropriate dedicated inpatient services custom built for the unique needs of the child and adolescent population. Therefore a more accurate statement would read as below:

"the adult mental health system is no longer based on large stand alone psychiatric institutions, but has moved to providing care within the mainstream health system and through community care where possible. In the area of child and adolescent mental health, which has traditionally (and appropriately) provided the majority of its services in the community there has been a recognition that in addition to the community services that a small number of inpatient facilities dedicated to this population is also required"

The Introduction also goes on to talk about "while formal mechanisms for consumer and carer participation have been put in place, they do not comprise the meaningful participation that is required."

Again, this is undeniably true for adult consumers but at present there is no mechanism for children and young people to have their voice heard at a Commonwealth level. For adults at a Commonwealth level there are a number of formal mechanisms including the Mental Health Council of Australia.

At present it appears to be presumed that using consultation approaches for adult consumers can somehow also "represent" all consumers. This is clearly not possible.

It needs to be acknowledged that children and young people also have a right to put their view. AICAFMHA is currently working with the Mental Health Council of Australia, the Australian Division of GPs and Ausienet in the development of a position paper that will be forwarded to the Commonwealth for consideration on how to ensure that the voice of youth is heard in planning mental health services for Australia.

Therefore the above statement in the introduction would more accurately read:

"while formal mechanisms for consumer and carer participation have been put in place these do not comprise the meaningful participation that is required. In addition these mechanisms have predominately focused on adult consumers. Further work is needed to ensure that the voice of infants, children, adolescents and their families are heard as key stakeholders."

C2. Suggested Aims and Principles Section:

Under the Aims section the document indicates that the original aims are considered to be as current today as they were in 1992. However, since that time there has been a significant amount of research evidence focusing on the efficacy of early intervention. In fact the Commonwealth Government has recently released a paper under the National Agenda for Early Childhood, called "Towards the Development of a National Agenda for Early Childhood". This paper emphasizes the need to intervene early and in this document the age range focus is 0-5 years.

AICAFMHA believes that it would therefore be helpful to add a fifth aim, namely:

"recognition of the importance on focusing on the early years to reduce the incidence of later mental health problems"

Under the Principles section:

The Rights of Consumers, and their families and carers, are an impetus for reform

This section presumes consumers are a homogenous group. AICAFMHA believes that a statement needs to be added to this section, which states that:

"it needs to be acknowledged that infants, children, adolescents and their families have the same rights as adults to participate in policy, planning and in their own care. It therefore needs to be acknowledged that ensuring meaningful participation for children and adolescents will require special efforts and different approaches and structures than those established for adult mental health consumers"

Mental Health requires a population health approach

AICAFMHA strongly supports this population health approach, however the second paragraph could be strengthened by reference to the importance of the early years and ensuring there is some targeting of interventions in infants and childhood. Revised wording of the paragraph could read:

"…interventions to promote mental health particularly in the early years, prevent the development of mental health problems and mental illness, intervene early when mental health problems or mental illness develop, …"

All Australians should have access to effective mental health care

AICAFMHA supports the principle in the document that "financing of health care should be equitable." This is a very important principle. It should also be acknowledged that within the mental health funding system there is a lack of equity in

the way funds are divided with the child and adolescent mental health services receiving approximately 7% of the mental health dollar to service 30% of the population. Therefore an additional statement could read:

Financing of health care should be equitable. In addition funding should be directed equitably on a population basis thereby ensuring that areas such as infant, child and adolescent mental health services receive funding more based on the population they are required to serve and in line with the latest research evidence which emphasizes the cost effectiveness of intervening in the early years.

Mental health care should be responsive to the needs of consumers, families and carers, and communities

AICAFMHA agrees that mental health care needs to be responsive. This is particularly important during childhood and adolescence where the opportunity for successful outcomes is maximal. The statements in the plan assume mental illness in the adult context. AICAFMHA would encourage the Plan to incorporate the notion of promotion and prevention to help avoid the development of a mental illness. The statement "It should be responsive to the needs of consumers as they vary across the course of an illness" could be re-worded such as:

"It should be responsive to the needs of infant, child, adolescent and adult consumers in promoting good mental health and as they vary across the duration of a mental health problem or the course of an illness."

A recovery orientation should underpin service delivery

AICAFMHA acknowledges that this is an important concept for adult mental health services, however the opening statement that "For too long mental health services have been delivered without a positive focus on recovery" does not fit for infant, child adolescent and family mental health services whose whole underpinning is based on prevention of mental health problems.

A more accurate wording for this statement may be:

"For too long adult mental health services have been delivered without a positive focus on recovery."

Workforce development is fundamental to reform

This section contains broad statements about the mental health workforce. However, again the document presumes homogeneity in the workforce. The National Practice Standards for the Mental Health Workforce (NMHETAG 2002) make frequent reference to mental health "across the lifespan", but similarly overlook specific recognition of infant, child and adolescent requirements. An additional qualifying statement in the Third National Mental Health Plan would be helpful:

In training the mental health workforce there needs to be a clear acknowledgement

that across the developmental age range specialized skills are required. That is, the skills required to work with infants, children, adolescents, adults and the aged are very specific. Therefore there needs to be a clear acknowledgement of these differences in order that training can be appropriately tailored to the specific needs of the workforce.

In addition, in relation to University and accredited College programmes (for post-graduate medical training), better training at an undergraduate and postgraduate level for the disciplines that have responsibility for providing help for children and adolescents with mental health problems should be given a very high priority. In many instances little training specifically relevant to the treatment/management of children and adolescents with mental health problems is provided during the undergraduate training of these disciplines. Even at a postgraduate level, training is often provided only in the context of generic programs that focus primarily on the provision of care for adults. This greatly limits the effectiveness of services providing help for children with mental health problems.

Therefore an additional statement might be:

"in workforce development it is important to liaise with the University training programmes across the disciplines involved in mental health service provision to ensure appropriate education is provided. This is particularly important in the area of infant, child and adolescent mental health"

The safety and quality of mental health care must be assured

AICAFMHA strongly supports the appropriate funding and implementation of suitable data collection systems.

Innovation must be strongly encouraged and supported

AICAFMHA strongly supports innovation, however would recommend that the early years also be included in the list of suggested priority areas.

The National Agenda for Early Childhood whilst released by the Minister for Children and Youth Affairs was co-released by the Minister for Health and Ageing. It would therefore seem very important to ensure that there is some integration of these concepts into the proposed Mental Health Plan 2003-08 given that one of the outcomes of the National Agenda for Early Childhood is "fewer children with social and emotional problems".

Sustainability must be assured

AICAFMHA fully supports the concept of sustainability.

The level of resources appropriated for mental health care will determine outcomes

AICAFMHA strongly supports the paper's assertion that there needs to be substantial resource commitment. As mentioned previously in our response, child and adolescent mental health services receive approximately 7% of the mental health dollar to service around 30% of the population. Up to the present time there has been a lack of appropriate investment in the early years and in other programmes that have research evidence to support their application in the older child and adolescent area compared with the investment that has been put into the treatment of chronic mental health illness.

Mental health reforms must not occur in isolation, but in concert with other developments in the broader health sector

AICAFMHA strongly agrees with this proposition. It recommends that mention should be made in this section on the National Agenda for Early Childhood. In addition this principle should be expanded to include reference to national infant, child and adolescent health policies in the broader health sector.

As stated earlier, in the Child, Adolescent and Family Branch of the Federal Center for Mental Health Services charter, community based interventions and systems of care are critical for infants, children and adolescents with intersectoral collaboration underpinning outcomes. Similarly, Raphael (2000) identifies a range of community based health services and welfare services that are critical to consider in the provision of a quality, effective service for infants, children and young people. This concept is discussed further under Service Responsiveness.

C3. Suggested Priority Areas Section

1. Improving Population Mental Health

AICAFMHA, given its focus on infants, children, adolescents and their families, strongly supports the Improving Population Mental Health section of the plan. However, the majority of the material in this section is a condensation of material that has been more expansively stated in the Promotion Prevention Action Plan 2000.

It would be important to state how the Promotion Prevention Action Plan 2000 is going to be advanced as part of the Third National Mental Health Plan or whether it is again going to be updated. The Promotion Prevention Action Plan 2000 is an exemplary document and provides clear detailed action across the age spectrum. Further thought is required in how to appropriately resource, implement and monitor many of the recommendations for action that have been made in this Promotion Prevention Action Plan 2000. The National Mental Health Report 2002 makes an attempt at summarising progress against the Action Plan 2000, however the 'adult focussed' nature of this document reduces it's appeal for reporting achievements in infant, child, and adolescent mental health fields.

Population health should target child and adolescent mental health because of the risk of the developmental trajectory impacting throughout the life span: particularly the

case for disruptive behaviours and to a lesser extent, internalising problems. The role of schools should also be highlighted.

A number of the other recommendations in this section such as preventing mental health problems and mental illness, identifying population need and developing a scientific evidence base will require considerable financial investment to operationalise these laudable action statements.

A separate operational plan which identifies each of these suggested Action Areas, together with priorities for implementation, stakeholder responsibilities (i.e. who is going to be responsible for operationlising these actions,) together with time frames and suggested budget allocation would go a long way to clarifying the implementation of these suggested action areas.

2. Service Responsiveness

This section again talks about the "mental health system" as if it was homogenous and then goes to describe characteristics of the adult mental health system. There is no dispute that the description in this section fits for what has happened in the adult mental health system, but the statements are not leading to inclusivity for other groups within the age range. For example where it states: "the mental health system is no longer based on large stand alone psychiatric institutions, but has moved to providing psychiatric care within the mainstream health system and through community care where possible."

As suggested in our comments on the Introduction section, a more accurate statement might read:

"the adult mental health system is no longer based on large stand alone psychiatric institutions, but has moved to providing care within the mainstream health system and through community care where possible. In the area of child and adolescent mental health, which has traditionally (and appropriately) provided the majority of its services in the community there has been a recognition that in addition to the community services that a small number of inpatient facilities dedicated to this population is also required"

In addition this section is found wanting given its exclusive focus on adult mental health when it describes partnerships. The statement: "Clinical Service delivery through the mental health sector includes the specialist mental health sector and elements of the primary care sector" leaves the reader to deduce which elements are involved.

Raphael (2000) in "Promoting the Mental Health and Well-being of Children and Young People" clearly identifies those involved in care in the following statement:

"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)

Whilst AICAFMHA appreciates that the National Mental Health Plan cannot go into great detail about individual age populations it is believed that the document would be more inclusive if it at least provided the reader with some context as to what are the issues and contexts of practice for other age groups within the population. Unfortunately it is all too easy for those implementing national plans to assume that in fact there is only one model of service delivery and that somehow the priority issues for one population group are the same for all groups. The document would benefit from referring to such excellent publications such as Raphael's (2000) document.

2.1 Access to mental health care and service mix

AICAFMHA supports the proposition that 'Access should be equitable for all population groups within Australia and should be commensurate with identified population needs."

However a natural corollary of this statement is that there needs to be an additional qualifying sentence after the proposition that reads:

"Therefore funding allocations also need to be equitably divided across the age range.

In terms of the issue of determining "reasonable prices per unit of service" it is important that 'apples are compared with apples' and that considerable thought is put into ensuring that per unit costs are worked out bearing in mind the different service approaches (both direct and indirect) that are required across the age range.

The statement: "The appropriate mix of specialist mental health services (public and private), primary care (including general practice) and other support services, including accommodation, disability support, and domiciliary care, should be provided" fails to again be inclusive of other areas of the mental health system. Child and adolescent mental health services have partnerships with a range of other key services as outlined by Raphael (2000) above. Almost every example in the Plan quotes General Practitioners as an example of primary care. Whilst it is acknowledged that General Practitioners play a central role, this point is well made throughout the document. Unfortunately no other examples of Primary Care services are provided in the Plan. The Plan would be strengthened by using a variety of example of the areas of the Primary Care sector that are used by mental health services across the age range, including education and community health. It would also model an important point - the provision of mental health services across the age range is a complex enterprise which requires the utilization of a *wide range of primary care providers*.

The statement: "It is now recognized that general practitioners are usually the initial point of contact in the health sector for people with mental health problems and mental illness" is not entirely consistent with the data available. Whilst the Mental Health of Australians (Andrews et al, 1999) found the majority of adults sought help via a General Practitioner, the report also found that 62% of adults did not seek any professional help. This is not mentioned in the Plan, yet it is an important area for consideration.

In addition, 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).

AICAFMHA believes that based on the available evidence that the statement that general practitioners are usually the initial point of contact is an oversimplification of how people access care across the age range. Sawyer's work clearly identifies that young people access care in different ways depending on their age. AICAFMHA's concern is that a possible unintended outcome of this oversimplification of how people access care is that plans and resources are put into assuming that GPs are essentially the only point of initial contact. A statement acknowledging the data that young people access care through other areas such as school counsellors would be helpful. The first step is to acknowle dge the other primary care workers, the second step would be then to set up plans to support these other groups in the same way GPs are being focussedupon.

This section also makes broad statements that "mental health services are often centralized and should become more widely available." These broad statements are not very helpful in operationalising how to deal with the issue.

Rural services have more limited options/ less specialists available/ limited if any psychiatrists etc and hence take on broader clinical roles and tend to work solely with more complex clients. The cost of service to clients and expectations of rural CAMHS workers is greater than metropolitan therefore equity based solely on population basis fails to pick this up and rural services will continue to stagnate/go backwards.

The issues with respect to the provision of rural and remote mental health services have been well articulated for over a decade.

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 technology could be used to assist rural clients and practitioners. (Mitchell, Robinson, McEvoy, Gates (2001); Mitchell, Robinson, Seiboth, Koszegi (2000)).

A stronger statement in respect to rural and remote service provision should be included along the following lines:

The needs of rural and remote communities with respect to mental health services have been well known and documented for over a decade (Burdekin (1993). Since that time there have been a number of innovative approaches to both service delivery and training in rural and remote areas which require which require priority action over the life of the Plan.

2.2 Responsiveness to a wide range of mental health problems and mental illnesses

AICAFMHA agrees that the mental health system should be responsive and it is encouraging to see the "capacity to respond effectively to both high and low prevalence disorders" mentioned. In addition, the ability of mental health services to have the capacity to be more responsive to mild, moderate and severe degrees of mental health problem or illness warrants mention.

It is noted with concern that findings from major surveys are not often then translated into definitive action. For example, Sawyer et al (2000) found that the prevalence rate of ADHD was 11.2%, however there has been little national action recommended in progressing this issue. In a similar way Sawyer found higher rates of mental health problems in lower-socio economic areas, however few national initiatives addressing these identified matters have been developed.

2.3 Early Intervention

AICAFMHA clearly supports the focus on Early Intervention, but would again recommend some cross-referencing with the National Agenda for Early Childhood.

In terms of specific comments about words, the sentence- "Early intervention may occur at any stage of life, from childhood to older adulthood…."would be enhanced by changing the sentence to read:

"Early intervention may occur at any stage of life from infancy to older adulthood…"

This wording change clearly increases the emphasis on the need for early intervention and that some of that intervention needs to occur pre-natally and immediately post-natally to support parent-infant attachment. There are examples of best practice programmes that identify women at risk prior to the birth of their child in order that appropriate resources can be put in place to reduce later problems.

2.4 Continuity of care across the lifespan

AICAFMHA strongly supports the focus of this section with its recognition of diversity and the need for different treatment approaches across the lifespan. The Plan would be enhanced by including this philosophy throughout the Plan rather than in only a couple of sections of the entire Plan.

2.5 Continuity of care across the course of disorder

The use of the term "developmental trajectory" is welcomed. However the document then goes on to state: "For some consumers, mental illness leads to chronic disability." This section would be strengthened with some reference to early intervention and providing hope to consumers that intervention may lead to the prevention of a disorder.

Raphael (2000) makes this point very clearly:

"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" (Raphael, 2000, Page 1)

2.6 Access to support from intersectoral services

This section talks about a range of intersectoral services that largely have an adult focus. It is suggested that other intersectoral services essential for children and young people also be included. These services include Education, Family, Youth and Welfare services.

Another critical issue is the needs of children whose parents have a mental illness. AICAFMHA has been funded by the Commonwealth to progress this area and in the context of the National Plan believe that it requires mention. (AICAFMHA has produced a report, "Children of Parents with a Mental Illness- Scoping Project, March 2001 and is currently implementing a number of recommendations of this Report.)

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 mental health services eg justice, child care and child protection.

2.7 Coordinated and integrated care

Another key issue that needs to be added to this section is the need for mental health services to take a more family oriented approach. Feedback from consumers, their children and carers has indicated that there is a strong need to include relevant members of the family in all stages of care for the adult consumer. There is a further need to ensure that when young children are involved that appropriate care plans for their safety are also developed. In addition, in the case of children or adolescents with mental health problems, appropriate support and consideration for issues affecting other family members, including siblings, needs to occur.

2.8 Responsiveness to diverse needs within the Australian population

AICAFMHA recognises the diversity of the Australian population. The suggested action is supported but it is very ambitious and would require appropriate resources to be allocated.

2.9 Responsiveness to consumers with complex needs

Consideration should be given to supporting the parenting role of some adult consumers to enhance prevention and early intervention in relation to their children. This includes the recognition of the need for appropriate support and family friendly treatment environments, including where possible the provision of hospital in the home treatment.

2.10 Recovery, rehabilitation and relapse prevention

As indicated elsewhere in our response, this terminology is very much oriented to adult mental health services.

As noted by Raphael (2000),

"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)

Therefore it would be important to add some qualification along the following lines:

"in the case of children and adolescents, the majority of this population has good mental health with a number experiencing mental health problems or disorders of short duration. The concepts of recovery, rehabilitation and relapse prevention are relevant for the small number of children and young people who are experiencing a major mental illness."

2.11 Recognition and support for carers, community support services and non-government organisations

AICFMHA is pleased to see the recognition of the needs of children as carers and the whole issue of children of parents with a mental illness being mentioned in the document. AICAFMHA has made comments on this matter in other sections of the document.

3. Safety and Quality

3.1 Consumer Rights and legislation

AICAFMHA strongly supports consumer rights and relevant legislation. This section talks about the United Nations Resolution 98 B, but fails to talk about the United Nations Convention on the Rights of the Child, which entered into force in September 1990.

AICAFMHA believes that any Plan, which includes children and talks about consumer rights, needs to acknowledge the United Nations Convention on the Rights of the Child.

In addition, under Suggested Action a dot point along the following lines:

"In line with the United Nations Convention on the Rights of the Child, the Commonwealth Government and all State and Territory Governments ensure that the that children who have mental health problems are treated in line with the Convention and that their rights are acknowledged and respected."

3.2 Consumer and Carer Participation

As noted earlier, "while formal mechanisms for consumer and carer participation have been put in place, they do not comprise the meaningful participation that is required."

Again, this is undeniably true for adult consumers but at present there is no mechanism for children and young people to have their voice heard at a Commonwealth level. For adults at a Commonwealth level there are a number of formal mechanisms including the Mental Health Council of Australia.

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)

At present it appears to be presumed that using consultation approaches for adult consumers can somehow also "represent" all consumers. This is clearly not possible.

As pointed out by Raphael (2000) and supported by AICAFHMA it is clear that children and young people also have a right to put their view and be heard. AICAFMHA is currently working with the Mental Health Council of Australia, the Australian Division of General Practice, and Auseinet in the development of a position paper to the Commonwealth on how to ensure that the voice of youth is heard in planning mental health services for Australia.

Therefore the above statement would more accurately read:

"while formal mechanisms for consumer and carer participation have been put in place these doe not comprise the meaningful participation that is required. In addition these mechanisms have predominately focused on adult consumers. Further work is needed to ensure that the voice of infants, children, adolescents

and their families are heard as key stakeholders."

3.3 Training, education and workforce development

This section again primarily is focussed from an adult perspective.

The statement: "the role of primary care (specifically general practice) is now acknowledged as a critical element." As mentioned previously in this response, the sole example of general practice equating to primary care is inconsistent with the evidence for the child and adolescent population group whereby a range of other areas of primary care are involved. It is important to acknowledge that young people with mental health issues seek other service providers, such as school counsellors, out. A failure to acknowledge these groups means that such groups are easily overlooked when workforce development plans are being put in place.

This section would benefit from an acknowledgement that different skills and therefore different training experiences need to be developed across the lifespan.

Suggested Action dot points might include:

"Ensure that service providers working with infants, children, adolescents and their families are provided with training which is tailored to the specific population with whom they are working."

"Ensure that the different access points for care for young people are acknowledged eg through school counsellors and that such groups are also provided with appropriate training to assist them work with this population."

3.4 Standards and Monitoring

It is important in the development of standards and monitoring that these standards are also developed to reflect the needs of infants, children and young people.

For example in the implementation of the National Mental Health Standards, consumers and carers are required to be involved in the Review of such standards. The effect of this requirement for child and adolescent mental health services is to involve young people in detailed review of services for up to one week. AICAFMHA strongly supports consumer and carer involvement, but uses this example to highlight that special consideration should be given to the *most appropriate manner for participation of young people in these processes*.

Therefore under Suggested Actions additional dot points could be considered:

"Ensure that in developing standards they also take into account the acknowledged different service models required across the lifespan"

"that further consideration is given as to the most appropriate way to involve children and young people in national standards reviews"

4. Innovation and Sustainability

4.1 Research, development and evaluation

AICAFMHA strongly supports the principles outlined in this section. However it believes that 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.

4.2 Implementation and sustainability

AICAFMHA believes that innovative pilot programmes etc that have been one off funded should be funded on a recurrent basis if they are proved to be effective. There would also need to be an audit of a range of innovative programmes with a research base that have *never been implemented due to no funding being made available to trial them*. The example of the SAMHSA Model Programs online database is relevant here (http://www.modelprograms.samhsa.gov/). The National Action Plan for Promotion Prevention and Early Intervention for Mental Health 2000 outlines many evidence based programmes that could be implemented across the entire lifespan, yet many of these programmes have not been uniformly rolled out across Australia.

5. Accountability

AICAFMHA strongly supports the need for accountability. It also 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, due to data collection methodologies, this document is primarily focussed on the activities of adult mental health services.

However, 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 GPs when an equal amount of their work should be with School Counsellors.

Another dot point:

> ***"Ensure that the performance measures set up are relevant to the context of service delivery. Whilst it is acknowledged that there will be a number of common measures, it should equally be recognised that specific services such as the infant, child and adolescent mental health services will have specific goals to achieve relevant to their area of practice which requires appropriate performance measures."***

D. Other considerations

AICAFMHA believes there are a number of additional areas for consideration, some of which have been alluded to earlier in this document.

Crime Prevention

In the area of crime prevention, there is now 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), however there is no mention in the Third Plan as to how such critical issues, which cost Australia huge amounts of money each year, are going to be addressed.

Child Protection

The field of child protection has long been linked with mental health and within child and adolescent mental health services, there is often a high number of consumers who will have had some contact with the relevant welfare or protection service. 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." (page 6)

In addition, the importance of intersectoral collaboration is again recognised in this report stating that:

"…there is also some evidence of the professional recognition of the benefits of interagency and cross-sectoral collaborations in the prevention of a variety of social ills, including child maltreatment. Similarly, at the service provision level, the coordination and collaboration between agencies and sectors in the development, and the provision of prevention programs, requires an understanding of current directions in prevention, and knowledge of existing service models and programs that have already demonstrated their effectiveness." (page 7)

AICAFMHA would support the Third Plan making active statements supporting and facilitating intersectoral collaboration across the range of service areas and sectors which impact on the mental health and well being of infants, children and adolescents.

Youth Homelessness

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", produced by the Commonwealth Advisory Committee on Homelessness recognises these links stating:

"Homeless people have significantly poorer health than the general community — mental health problems are particularly prevalent." (page 29)

This paper goes on to outline a series of goals for addressing the needs of homeless people across a range of priority areas, including health. Specifically, the paper identifies goals including:

"To develop agreed Commonwealth–State plans for improving the health of homeless people through the National Public Health Partnership and the National Mental Health Working Group."

and,

"To make specialist mental health services, drug and alcohol treatment services, and dental health services available to homeless people."

Once again, it is clear that intersectoral collaboration and recognition of the need for cross-sectoral policy development must be priorities to produce effective outcomes.

It is understood that some of these areas are linked in to other sectors of government such as the Commonwealth Department of Family and Community Services, however indicating through the Mental Health Plan how these areas could work together on these critical issues would be very helpful.

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