

POSITION PAPER

Improving the mental health of infants, children and adolescents in Australia

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A. Position Statement

AICAFMHA calls on the Australian Government to convene a National Mental Health Expert Group on Infant, Child, Adolescent and Family Mental Health including key stakeholders in order to develop a dedicated Infant Child and Adolescent Mental Health Plan to complement the National Mental Health Plan 2003-2008.

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.

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. These findings are comparable with findings internationally.

The prevalence of mental health problems and disorders in children and young people in Australia is significant and represents a large public health problem. AICAFMHA believes greater investment is required for infants, children, adolescents and their families within the mental health system.

Infants, children and young people need to be treated within a developmental framework, which addresses their unique needs. AICAFMHA believes that service arrangements for this population should be consistent with mainstream health service provision that broadly provides medical, hospital and community services around the age 0-18 years as evidenced by age criteria for child and youth services around the country and the world. In the United Kingdom the Department of Health has released a National Service Framework for Children, Young People and Maternity Services (2004). The UK Framework is a 10 year plan for the re-orientation of health, social and educational services which *“advocates a shift with services being designed and delivered around the needs of the child.”*

In response to the growing evidence regarding the importance of the early years, AICAFMHA supports investment within a promotion, prevention and early intervention framework commencing in the period prior to conception.

AICAFMHA also 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. This is particularly the case for young people in the 16-18 year age range.

AICAFMHA believes that only through a dedicated national plan can the unique needs of infant, child adolescent and family mental health issues be addressed in a strategic manner in this country.

AICAFMHA believes that a dedicated policy needs to involve recognition of the following principles and statements. [NB: Each item is supported by evidence contained within the attached Background Paper.]

PRINCIPLES

Recognition of Development and Specific Needs

- 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 children and young people that work within this framework and addresses their specific needs

Promotion, Prevention and Early Intervention (PPEI) Framework

- The promotion of mental health, prevention of mental health problems and disorders, and early intervention are key approaches for ensuring health, well-being and social inclusion in adult life. Investment within a PPEI framework is critical and should span the period prior to conception and encapsulate childhood and adolescence.

Consumer Participation and Advocacy

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

Children young people and their local ecology

- The health and well-being of infants, children and young people, more than any other age group is dependant on relationships with 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.

Accessible Services

- 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. Child and adolescent mental health services provide more specialized secondary and tertiary services that may include family and community interventions delivered 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.

Capacity Building Within Local Communities

- Every Australian State/Territory currently has an existing public and private infrastructure for mental health services for children and adolescents. Each has unique characteristics, and local knowledge regarding the development of the most appropriate service delivery models for children and adolescents in their regions in association and collaboration with other key local stakeholders and within a capacity building framework. Capacity building within communities increases the likelihood of sustainable practices that are responsive to local needs, and actively involves the private sector including NGOs.

SUPPORTING STATEMENTS

Prevalence

- Community- population based research has reported between 14-18% of children and young people (under 18 years) experience mental health problems of clinical significance. The burden of mental health problems in young people is far greater if at risk groups are considered including infants, children and adolescents with developmental disabilities, learning problems, those who have experienced some form of abuse, are in foster care, who have comorbid substance abuse or who live with parents themselves challenged by mental health symptoms, disability or substance abuse.

Equity and Cost Effectiveness

- Current research evidence emphasises the cost effectiveness of intervening in the early years. However the funding allocated to child and adolescent mental health does not currently reflect the proportion of the population comprising children and young people and is significantly less than funding allocated to adult services. There are significant socioeconomic inequalities in infant, child and adolescent mental health, including inequities in accessing services.

Stakeholders

- Effective mental health promotion, prevention and early intervention strategies targeting children and young people involve a range of stakeholders and settings that are different to those for the adult population. Environments and systems play an important role in child and adolescent mental health and include schools, childcare settings, childhood services, child protection agencies and youth services including drug and alcohol services, vocational and workplace settings. Parents play a critical role in children and young people's mental health and in the treatment of mental health problems and disorders.

Identified 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, indigenous youth, refugees).

Needs of Rural and Remote community and Service Response

- 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 to both service delivery and training in rural and remote areas that require priority action.

Accountability and Research

- Recent research has clarified priorities including evidence from the neurosciences looking at brain development highlighting that preventive interventions should begin in the antenatal period and continue through the early years of life. There are developmental transitions throughout childhood and adolescence that correspond with at risk periods for developing mental health problems. Extrapolating from this research specific indicators for progress against targets are required in the infant, child and adolescent mental health area. There is a need to plan further national mental health surveys to follow on from the work of *The Mental Health of Young People in Australia: The Child and Adolescent Component of the National Survey of Mental Health and Wellbeing*,

Sustainability and Duplication

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

B. Background to the Principles

Recognition of development and specific needs

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. 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 focussed models associated with adult mental health services.

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.

It is significant 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])

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

“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, Page 8)

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 its 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:

“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)

In recognition of the special needs of children, 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 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)

A review of international policy on child and adolescent mental health by Shatkin and Belfer (2004) ranked countries from A-D in terms of their levels of policy development for child and adolescent mental health. The study found that Australia ranked a B 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.

Typically, 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.

Intervention with infant, child and adolescent populations experiencing mental health problems or disorders needs to be appropriate to the developmental level of the individual. The mental health needs of infants, differs from those of children which are different from adolescents. Prevention and intervention strategies therefore need to reflect approaches that are appropriate and applicable to each population group.

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 CAMHS services, lack of access to skilled providers of psychological interventions, aggressive promotion by the pharmaceutical industry, and a belief that SSRIs 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 ineffective 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, disclosure by pharmaceutical companies to address the specific mental health needs of infants, children and adolescents.

AICAFMHA calls on the Australian Government to form an Expert Reference Group on Infant, Child, Adolescent and Family Mental Health involving all key stakeholders to develop a specific Infant, Child Adolescent Mental Health Plan to complement the National Mental Health Plan 2003-08.

Promotion, Prevention and Early Intervention (PPEI) Framework

The promotion of mental health, prevention of mental health problems and disorders, and early intervention are key approaches for ensuring health, well being and social inclusion in adult life. Investment within a PPEI framework is critical and should span the period prior to conception and encapsulate childhood and adolescence.

“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)

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.

There is also 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)

The recently released document by 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)

In the area of crime prevention, there is also 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) which drew together compelling evidence regarding the relationship between early intervention and the potential to reduce crime.

In the area of substance abuse disorders, many risk factors for onset are shared with child and adolescent mental health problems. Prevention and early intervention across the developmental trajectory, but especially in childhood and early adolescents can reduce substance abuse problems.

In Australia AusEinet and Mind Matters have commenced initiatives to support such a new paradigm, but significantly more resources are required to implement such a paradigm change nationally

AICAFMHA encourages investment within the promotion, prevention and early intervention framework to enable effective and appropriate promotion of mental health and prevention of mental health problems and disorders. Such a framework is critical and should span the period prior to conception and encapsulate childhood and adolescence.

Consumer participation and advocacy

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. The commissioning of AICAFMHA by the Australian Government to develop a youth participation strategy for Mental Health projects under the auspice of the Australian Government is an important first step in this recognition.

Children, young people and their local ecology

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 *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)

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 is often a high number of consumers who will have had some contact with the relevant welfare or child 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.” (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 and include, within health departments of maternal and foetal medicine, outside of health with disabilities, 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 Policy, which should be developed through leadership from the Expert Group on Infant, Child, Adolescent and Family Mental Health.

Accessible Services

Most mental health problems experienced by children and young people can be effectively managed in a primary health care setting by community-based services. Child and adolescent mental health services provide more specialized 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.

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)

It should be noted that unlike adult mental health services where there is a higher need for inpatient beds, the majority of child and adolescent mental health problems can be treated effectively in community settings, including clinic-based and more intensive outreach models.

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 already exists within the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, 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.

Recognising these 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.

Currently, State 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 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:

“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.

In Australia, the majority of CAMHS 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.

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

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 needs to be viewed within the context of their family.

AICAFMHA also believes that reliance on age as a sole criterion for transitioning between child and adolescent and adult services is inappropriate and that some flexibility 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.

Capacity Building Within Local Communities

Every Australian State/Territory currently has an existing public infrastructure for mental health services for children and adolescents. Each child and adolescent mental health service has unique characteristics, and local knowledge regarding the development of the most appropriate service delivery models for children and adolescents in their regions in association and collaboration with other key local stakeholders and 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.*”....[Baum1995, p.3.]

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

C. Background to the Supporting Statements

Prevalence

Between 14-18% of children and young people (under 18 years) experience mental health problems of clinical significance.

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. This equates to in excess of 500 000 individuals nationally. 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 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. AICAFMHA believes greater investment is required for infants, children, adolescents and their families within the mental health system.

Equity and Cost effectiveness

Current research evidence emphasises the cost effectiveness of intervening in the early years. However the funding allocated to child and adolescent mental health does not currently reflect the proportion of the population comprising children and young people and is significantly less than funding allocated to adult services.

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.

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 its 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*”.

This view is increasingly supported by 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).

In 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. Victimization 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).

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.

Stakeholders

Effective mental health promotion, prevention and early 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.

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 and child protection.

The US Department of Health and Human Services Center for Mental Health Services has the following charter for its 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>)

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)

Primary health care providers require specialist support from CAMHS services. 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 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. AICAFMHA also believes that wherever possible young people should be treated within the context of their family within a community setting.

Identified 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, 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).

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)

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).

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)

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. 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” (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.

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.

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.

Needs of Rural and Remote communities and Service Responses

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 to both service delivery and training in rural and remote areas that require priority action.

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)).

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.

AICAFMHA supports investment in the effective expansion of existing rural and remote mental health services for infants, children and youth. The utilisation of technological aids has been demonstrated as an effective means of enhancing services.

Accountability and Research

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

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 programmes that could be implemented across the entire lifespan, yet many of these programmes have not been rolled out. International evidence indicates that the 'best buys' for investment in mental health can be realized in the child and adolescent age group.

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.

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.

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

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 this document is primarily focussed on the activities of adult mental health services. CAMHS service indicators need to be specifically developed and implemented. In addition, the international evidence indicates that the 'best buys' for investment in mental health can be realised in the child and adolescent age group.

Sustainability and Duplication

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”.

The gap in Australia and internationally between research and practice has been identified as a contributing factor in the 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 framework.

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 following several years of development, 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:

- successful negotiation with TheMHS to hold a joint AICAFMHA/TheMHS 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
- success in securing Australian Government funds for an extension of the Children of Parents with a Mental Illness National Initiative and the exploration of the potential to develop a national Youth Participation in Mental Health Strategy
- launch 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
- continued distribution of hard copies of the Children of Parents Affected by a Mental Illness Scoping Project Report around Australia and the world
- in conjunction with the RANZCP and Melbourne Convention Centre, successfully bidding to host the 2006 IACAPAP congress
- maintenance and expansion of the information available via the AICAFMHA website including a links database with over 200 links to relevant information
- continuation of the popular fortnightly News In Brief e-letter with subscriber numbers in excess of 2100.

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

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