



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

Position Paper of the Australian Infant, Child, Adolescent
and Family Mental Health Association Ltd (AICAFMHA)

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Foreword

The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) has been advocating for a greater focus on the mental health needs of Australian infants, children, young people and their families for over a decade. This Position Paper describes the beliefs of AICAFMHA with regard to the promotion of mental health and associated services for children and families and summarises the international and national literature that supports the principles underpinning delivery of mental health services.

The mental health of infants, children and adolescents has a significant impact on their future health and wellbeing. Evidence demonstrates that early childhood is of critical importance in establishing positive and resilient patterns to support children through youth and into adulthood. Infancy and childhood is when relationships, patterns of behaviour, emotional responses and social abilities are founded.

During the last decade, there has been a gradual, but continual recognition that services need to better address mental health in the early years, however this has not necessarily been supported with appropriate mental health programs and funding. AICAFMHA is encouraged by the greater focus in recent years on adolescent mental health, but believes that there is still more to be achieved. The Australian Government has produced a number of excellent documents that accurately reflect the issues that are pertinent in the infant, child, adolescent and family mental health area, and alternate funding models are needed to fully implement the actions recommended in them.

Through the publication of this Position Paper, AICAFMHA extends its commitment to advocating for the development and implementation of appropriate prevention, promotion and early intervention mental health programs and services for Australia's infants, children, young people and their families. I commend this document to you and encourage all agencies, policy makers, funders and programs with an interest in mental health services for children and families in the early years to make good use of it.

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Chair, AICAFMHA Board of Directors

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A. Position Statement

Recent evidence compiled by the World Health Organization (WHO) indicates that ‘by the year 2020, childhood neuropsychiatric disorders will rise by over 50% internationally to become one of the five most common causes of morbidity, mortality and disability among children’ (National Institute for Mental Health 2002, p.1).

In Australia surveys indicate that between 14% and 18% of children and young people aged 4-16 years experience mental health problems of clinical significance. This figure equates to in excess of 500 000 individuals nationally and is comparable with findings internationally.

Hence the prevalence of mental health problems and disorders in children and young people in Australia is significant and represents a large public health problem. The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) strongly supports the recent funding boost to services that provide intervention for the needs of young people in Australia. However, greater focus and investment is particularly required for infants, children and their families within the mental health system.

Treatment for infants, children and young people should be within a developmental framework that addresses their unique needs. AICAFMHA believes that service arrangements for this population should be consistent with mainstream health service provision. These services broadly provide medical, hospital and community services for infants, children and young people aged 0-18 years, that is appropriate to the age of the child and is according to age criteria recognised around the country and the world. Accordingly, mental health services should deliver treatment via methodologies and in settings that are appropriate to the age and developmental level of the child or young person.

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 advocates further investment in the development of targeted early intervention programs for infants and children in the 0-12-year age range.

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.

Although there has been a great deal of focus on adolescent mental health in recent years, AICAFMHA believes a lack of coordination remains between recent Commonwealth initiatives such as *headspace* and the traditional state-run child and adolescent mental health services.

While the focus on adolescent mental health has been welcomed, significant opportunities remain to further develop services and strategies for early intervention from the antenatal period through the early years of childhood.

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

AICAFMHA considers 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 ought to be designed specifically for children and young people that work within this framework and addresses their specific needs, their development and the families with whom they live.

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, reduced alcohol and other drug use, wellbeing, and productivity and social inclusion in adult life. Investment within a PPEI framework is critical. Moreover, it should span the period prior to conception and include 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 wellbeing of infants, children and young people, more than any other age group, are dependent on relationships with caregivers, other significant adults and their peers. Their wellbeing is influenced by systems that include the education, welfare, juvenile justice, housing, 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 local community-based services. Child and adolescent mental health services provide more specialised secondary and tertiary services that may include family and community interventions delivered in a range of settings. Relatively few 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.

This infrastructure can be further developed in association and collaboration with other key local stakeholders and within a capacity-building framework. Capacity building within communities increases the likelihood of sustainable practice partnerships that are responsive to local needs and actively involves the private sector, including non-government organisations (NGOs).

Supporting Statements

Prevalence

Community-population-based research has reported that between 14% and 18% of children and young people (under 18 years) experience mental health problems of clinical significance. The burden of mental health problems in children and young people is far greater if at-risk groups are considered. These groups include infants, children and adolescents with developmental disabilities and learning problems, and those who have experienced maltreatment, are in foster care, have co-morbid substance abuse or 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. Nevertheless, the funding allocated to child and adolescent mental health does not currently reflect the proportion of the population comprising children and young people. Significant socioeconomic inequalities are apparent in infant, child and adolescent mental health, including inequities in resourcing and 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 from those for the adult population. Environments and systems play an important role in children and young people's mental health. These mainly comprise schools, childcare settings, childhood services and child protection agencies as well as youth services, including drug and alcohol services and 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; for example, children of parents with a mental illness, or who misuse alcohol and other drugs, maltreated children, Indigenous young people and refugees.

Accountability and Research

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

Sustainability, Dissemination and Duplication

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

Needs of Rural and Remote Communities

The mental health service needs of rural and remote communities are greater than in metropolitan areas, and this discrepancy needs to be addressed in service delivery.

Workforce Development

The training needs of the mental health workforce, accessibility to adequate numbers of workers and workforce planning are major issues in child and adolescent mental health, as is the training and support of the primary care workforce to optimise their role in early intervention and prevention.

E-mental Health Initiatives

Young people utilise the internet regularly to access information about mental health and mental illness. Clinical evidence suggests that some mental health problems can be treated through programs accessed on the internet. The utilisation of e-mental health initiatives can enable young people who may not have access to face-to-face services to acquire information and treatment. It can assist practitioners to expand the options for interventions that they can provide to children, young people and their families.

B. Background to the 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 ought to be designed specifically for children and young people that work within this framework and addresses their specific needs, their development and the families with whom they live.

Children's mental health needs to be understood in a somewhat different context from adult mental health. In fact, 'children's mental health is even more closely related to the concepts of healthy social and emotional development than adult mental health' (Miles et al. 2010, p.21).

Some characteristics of the infant, child and adolescent population groups are unique and require services that are responsive to these characteristics. Aynsley-Green et al. (2000, p.229) argue 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-focused 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. Their life course is fundamentally influenced by this development: creating stable attachment patterns and relationships, and mastering the regulation of emotions, behaviours, impulses and relationships. Furthermore, 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.

Raphael (2000), in the document *Promoting the mental health and wellbeing of children and young people*, notes:

Underlying this paper is the belief that, in the area of mental health, as in their general health needs, children and young people require specific programmes to address their problems that are different to those for adults. Programmes for children and young people need to reflect the many complex factors that influence their mental health and development- including family, school, genetics, and socio-economic and cultural environments. (Raphael 2000, p.3)

In addition, Professor 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. (Aynsley-Green et al. 2000, pp.229-32)

The US Department of Health and Human Services' (1999) *Mental Health: A Report of the Surgeon General* notes:

[A]dult 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 an adult. (U.S. Department of Health and Human Services 1999, p.123)

In recognition of the special needs of children, the United States 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* (Satcher 2001).

In the United Kingdom, the Audit Commission (1999) completed a national report titled *Children in mind - child and adolescent mental health services*. 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 services. (NHS Modernisation Board Annual Report 2003, p.63)

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 recognising 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 Commonwealth's third National Mental Health Plan 2003-2008 and now current *Fourth National Mental Health Plan 2009-2014*.

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, to maximise the coping skills and resiliency of the individual and to 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 differ 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.

Treatment for adolescents can often be based on studies of adults. As highlighted by Cooper and Aranti (2009), these studies do not take into account the fact that the

aetiological and maintaining factors for adolescent health are likely to differ from adults due to biological differences, co-morbidities, stigma, different social networks and life events. Therefore it is not helpful, as is often the case, to consider adolescents in a way that is as simple as viewing them as young adults. (Cooper & Aranti 2009, p.1725)

Information regarding the treatment of depression in children and adolescents illustrates the dangers of responding to young people as though they were adults. A combination of the relative unavailability of Child and Adolescent Mental Health Services (CAMHS), lack of access to skilled providers of psychological interventions, aggressive promotion by the pharmaceutical industry, and a belief that SSRIs (selective serotonin reuptake inhibitors) were safe, led to a striking increase in SSRI prescribing in under 18-year-olds in the decade leading to 2004, especially by general practitioners. Since then, reviews of the published and unpublished literature have established that some SSRIs have been insufficiently researched to demonstrate their effectiveness or otherwise in young people under 18. 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 and 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 in order to provide high level advice on the unique needs of this population.

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, reduced alcohol and other drug use, wellbeing, and productivity and social inclusion in adult life. Investment within a PPEI framework is critical. Moreover, it should span the period prior to conception and include childhood and adolescence.

The Australian Government Department of Health, Mental Health and Wellbeing website (2010) states that

mental health problems in childhood and adolescence can have far reaching effects on the physical well-being, educational, psychological and social development of individuals. Children who are mentally healthy are better able to:

- learn
- experience stronger relationships with teachers, family members and peers
- negotiate challenges including the transition into adolescence and then adulthood
- achieve long-term education and career goals
- enjoy a better quality of life
- participate in the workforce.

When early signs of difficulty are not addressed, mental health problems can potentially become more serious and possibly extend into mental disorders. (<http://www.mentalhealth.gov.au/internet/mentalhealth/publishing.nsf/Content/early-intervention-1>)

The *Change for Children Initiative (2010)*, instigated by the Australian Research Alliance for Children and Youth (ARACY) and its members, highlights that there is a positive belief in the community that children must be supported in their development. In addition, children's current and future wellbeing requires a coordinated approach from the whole community that draws on a health promotion / prevention framework.

The Australian Government has recently released a range of documents from different departments advocating an early intervention approach to supporting and addressing the needs of families - in particular, vulnerable families. Children and young people in such family situations are more at risk of developing mental health problems. The documents include the Council of Australian Governments' (COAG) *National action plan on mental health (2006-2011)*; *Protecting children is everyone's business: national framework for protecting Australia's children 2009-2014*; *Investing in the early years: a national childhood development strategy 2009*; *National partnership agreement on closing the gap on Indigenous health outcomes 2010*; *Fourth national mental health plan 2009-2014*; and *National action plan on mental health 2006-2011*.

In order to achieve effective promotion, prevention and early intervention COAG's *National action plan on mental health 2006-2011* recommends that specific policy directions are necessary in the area of

building resilience and the coping skills of children, young people and families; raising community awareness; improving capacity for early identification and referral to appropriate services and improving treatment services to better respond to the early onset of mental illness, particularly for children and young people. (COAG 2006, p.2)

The *Fourth national mental health plan 2009-2014* recommends implementing 'targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations' (Commonwealth 2009, p.32). It also recommends expanding the level of support for families and carers of people with a mental illness and mental health problems, including children of parents experiencing mental illness.

The *Fourth national mental health plan 2009-2014* also promotes a partnership approach where different sectors of the service system across all areas of government and the community work together to ensure intervention strategies that are 'early in life, early in illness and early in episode' (Commonwealth 2009, p.64).

A recent report by Miles et al. (2010) highlights that there is significant evidence that health promotion, prevention and intervention in the earliest years, beginning with a future mother's health, pregnancy and early

childhood, can have lifelong consequences and lay the groundwork for both physical and mental wellbeing of children.

All of the above reports recognise the importance of intervening early not only to enhance protective factors but also to diminish risk factors that contribute to poor social, emotional and developmental outcomes for children. The reports recognise the long-term consequences of not intervening early in childhood, as problems that begin in infancy and childhood can have long-lasting effects into adolescence and adulthood.

AICAFMHA believes that early intervention in mental health should occur across all health, welfare and education sectors and begins early in the lives of infants and children. Miles et al. (2010), at the Centre for Human Development, note, however, that the issue of early intervention may be used in different contexts within government departments. In the 'field of mental health, early intervention refers to clinical or preventative services for a person of any age that begin prior to or in the early stages of a mental health problem' (Miles et al. 2010, p.26). This is a different approach from the areas of social welfare and education where early intervention is encouraged from the early years in life.

It is noted that in the current mental health plans, however, that there has been significant funding for targeted early intervention programs for young people - aged from 12 to 25 - with mental health problems and also a particular emphasis on detecting early psychosis, dealing with the onset of serious mental illness that is prevalent in 1% of the population.

AICAFMHA advocates that targeted early intervention strategies be available for mental health problems with higher prevalence rates that often develop in childhood such as conduct disorder (4-7%), anxiety (5-10%) and depression (3-5%) (Sawyer 2000; US Department of Health and Human Services 1999), and also continue into the adult population. Evidence shows that targeted early intervention in children as young as '5 years can reduce the long-term consequence associated with conduct disorder in later life' (Friedl & Parsonage 2009, p.30). This approach would be congruent with other Australian Government plans and policies that have been developed to address the needs of vulnerable children, young people and their families.

It is well recognised that many mental illnesses have their origin in adolescence or earlier. The Report of the Committee on the Prevention of Mental Disorders and Substance Abuse on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* (2009) identifies that three-quarters (75%) of adult disorders had onset by age 24; half (50%) by age 14, with initial symptoms occurring up to 4 years earlier.

The Australian Government requires reliable information on the costs and health outcomes of current practice and of options for change in developing policy and allocating resources for mental health services. The ACE (Assessing Cost-Effectiveness)-Prevention Report (Vos et al. 2010) reveals that there is enough evidence for preventative interventions to be funded by the Australian Government. Through analysis of current interventions, a number of cost-effective preventive interventions for mental disorders were identified. These include 'screening for childhood depression and anxiety; problem-solving after a suicide attempt; and early psychosis intervention' (2010, p.9) and 'parenting intervention for the prevention of childhood anxiety disorders' (2010, p.34).

AICAFMHA supports the Council of Australian Governments' 'New Early Intervention Services (NEIS) for Parents, Children and Young People' measure as part of the *National action plan on mental health 2006-2011* (COAG 2006). The measure aims to support mental health promotion, prevention and early intervention for all children through universal evidence-based school and early childhood programs as well as through targeted programs such as parenting programs and the Children of Parents with a Mental Illness (COPMI) national initiative. These programs are aimed at children who are at highest risk of developing mental health problems or who have early signs, symptoms or diagnosis of mental health problems. These programs do not adequately address gaps in specific targeted early intervention for children 0 to 12 years of age.

AICAFMHA congratulates the Australian Government on its commitment within the *Fourth national mental health plan* to provide 'early intervention services' to particular age groups.

AICAFMHA believes that there is a lack of accessible targeted early intervention services for young and school aged children and urges the Australian Government to consider the funding of mental health services within the community for young and school age children (2 to 12 years old).

AICAFMHA encourages further 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.

Current national mental health strategies advocate that consumer and carer input is important for quality service delivery. Actively involving consumers and carers in CAMHS services can be complex because of the developmental range of children and youth who are referred for support.

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) notes:

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, p.1)

Aynsley-Green et al. (2000, p.229) support this in their list of proposed strategies for improving the status of children and adolescents. They state that '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'.

Young people experience considerable barriers to accessing care and are often resistant to seeking help. Involving young people in service planning and delivery provides an opportunity to increase access for young people that would not otherwise utilise services (National Youth Participation Strategy Scoping Project Report 2008, p.15).

AICAFMHA has developed a youth participation strategy for mental health projects, which can be found at: http://www.aicafmha.net.au/youth_participation/index.html.

Macdonald et al. (2007) state that

consumer participation in mental health services for children and young people must be conceptualized differently from that in adult services. Existing participation frameworks that focus on adult consumer participation or youth participation fail to recognise the complexity of service delivery where young consumers with mental health problems are seen predominantly in the context of their families. (Macdonald et al. 2007, p.504)

The authors advocate for a developmental framework of consumer and carer participation where the role of parents as consumers of services is determined by the age of the child who has been referred to CAMHS. For younger children, services are family focused; and for young people, treatment may be youth focused.

AICAFMHA is committed to advocating for the 'voice of children, young people and their families' to be heard in the development of mental health policy, services, interventions and programs that affect them.

Children, Young People and Their Local Ecology

The health and wellbeing of infants, children and young people, more than any other age group are dependent on relationships with caregivers, other significant adults and their peers. Their wellbeing is influenced by systems that include the education, welfare, juvenile justice, housing, 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 as well as the development across portfolio areas of joint planning in respect to infant, child and adolescent mental health.

Sawyer et al. (2000) note in *The mental health of young people in Australia*:

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, p.xii)

The field of child protection is one domain that has long been linked with mental health and within CAMHS; 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, p.6)

Child maltreatment remains a major public health and social welfare problem in high-income countries. As noted by Gilbert et al:

Child maltreatment substantially contributes to child mortality and morbidity and has long-lasting effects on mental health, drug and alcohol misuse (especially in girls), risky sexual behaviour, obesity, and criminal behaviour, which persist into adulthood. Neglect is at least as damaging as physical or sexual abuse in the long term but has received the least scientific and public attention. The high burden and serious and long-term consequences of child maltreatment warrant increased investment in preventive and therapeutic strategies from early childhood. (Gilbert et al. 2009, p.68)

MacMillan et al. (2009) highlight that early intervention strategies can prevent exposure and re-exposure to child maltreatment and minimise the adverse outcomes of being exposed to physical, sexual, emotional abuse, neglect and domestic violence.

Homelessness, particularly among young people, is a significant community concern. Links between homelessness and mental health have been made regularly 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* (Commonwealth Advisory Committee on Homelessness 2004, p.95) 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' (Commonwealth Advisory Committee on Homelessness 2004, p.95).

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

AICAFMHA strongly recommends that joint planning and policy development occur across sectors relevant to infant child and adolescent mental health. This planning process should commence with a dedicated Infant, Child, Adolescent and Family Mental Health Policy, which should be developed through leadership from an Expert Reference 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 local community-based services. Child and adolescent mental health services provide more specialised secondary and tertiary services that may include family and community interventions working in a range of settings. Relatively few infants, children and young people require hospitalisation or access to hospital emergency departments for mental health problems.

The recent Child and Adolescent Mental Health Services (CAMHS) review in the UK (2009) indicated that while there had been notable improvements in services,

provision was not yet consistent and some children found it difficult to access the help they needed. Not getting help at the first sign of a problem can lead to emotional and behavioural disturbances and antisocial behaviour, at great cost to the young person, their families and society. (New Horizons; A Shared Vision for Mental Health 2009, p.23)

In Australia, the state- and territory-run CAMHS provide a comprehensive range of clinical services, including individual and family interventions. These services are staffed by dedicated multidisciplinary professionals, and future planning should ensure that these services are appropriately staffed to handle the service demand.

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, p.4)

The majority of child and adolescent mental health problems can be treated effectively in community settings, including clinic-based and more intensive outreach models. Considerable debate continues 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 offered to match these developmental levels. There is currently an emphasis for funding for mental health services to focus on young people and adults aged

12 to 25 years. AICAFMHA believes that a developmental approach for children 0 to 12 years needs to be considered in future funding plans.

In recognition of 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 CAMHS, 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* (2002, p.79) made the following key recommendations:

[Y]oung people aged under 16 years should not be admitted to adult psychiatric wards, and those aged 16 or 17 years can be considered for admission to adult psychiatric wards only when:

- no suitable specialist adolescent psychiatric bed is available
- they have severe mental illness
- acceptable standards of care are met
- child and adolescent psychiatric consultation and advice is available throughout the admission.

Health commissioners need to develop appropriate services (and should recognise that) 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 better 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 a child- and adolescent-focused 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.

A recent study in the UK (Singh et al. 2010) found that only 4% of young people who were transferred from CAMHS to adult mental health services (AMHS) reported the process to be satisfactory. For the majority of young people, the transition was 'poorly planned, poorly executed and poorly experienced. Transition processes appeared to accentuate all the pre-existing barriers between CAMHS and AMHS'. (Singh et al. 2010, p.310)

Specific services for young adults in the 18-25 age range that take 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 state/territory run community CAMHS where the majority of infants, children, adolescents and their families are treated. 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. The focus of the inpatient stay should be treating the patient both to minimise the duration of their stay in hospital and to develop discharge plans that 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, particularly the case for young people in the 16-19 year age range, is inappropriate for transitioning between child and adolescent and adult services. Flexibility needs to be built into services to enable appropriate transitions. Young people in this upper age group sometimes need access to resources that are not available in adult mental health services. 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 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.

This infrastructure can be further developed in association and collaboration with other key local stakeholders and within a capacity-building framework. Capacity building within communities increases the likelihood of sustainable practice partnerships that are responsive to local needs and actively involves the private sector, including NGOs.

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' (Commonwealth Department of Health & Aged Care 2000, p.26). 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 (cited in Baum 1995, p.3.)

The report of the Committee on the Prevention of Mental Disorders and Substance Abuse (2009), *Preventing mental, emotional, and behavioural disorders among young people: progress and possibilities*, recommends that states and communities should develop networked systems to apply resources to the promotion of mental health and prevention of mental health problems among children and young people. These systems should involve

individuals, families, schools, justice systems, health care systems and relevant community-based systems. Such approaches would build on available evidence-based programs and involve local evaluators to assess the implementation process of individual programs or policies and to measure community-wide outcomes. (National Research Council and Institute of Medicine 2009, p.22)

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

C. Background to the Supporting Statements

Prevalence

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

In the United States, the document *Blueprint for change: research on child and adolescent mental health* (National Institute for Mental Health 2002, p.1) notes:

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 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% and 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 current findings nationally and internationally.

The Medical Research Council, UK reports that nearly 10% of children in the UK have a diagnosable mental health problem. It estimates that 5% of all children in the UK have been diagnosed with a conduct disorder and that these children 'go on to commit 30% of crime' in later years (Medical Research Council 2010, p.9).

The American Academy of Pediatrics highlights that there is also another larger group of children who require support and services. These are children who do not meet DSM-IV criteria for a disorder but who have clinically significant impairment that is 'estimated to be equal to twice the prevalence of children with severe emotional disorders' (AAP 2010, p.411).

The Mission Australia *National survey of young Australians* (2009) reports that a significant number of young people identified mental health as a priority issue for them. Areas of concern included depression and coping with stress (16% of 11- 14-year-olds and 21% of 15- 19-year-olds). Other issues of concern were suicide, family conflict, personal safety, bullying and emotional abuse.

Raphael (2000) defines the term '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 that 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 affect children's and young people's social, academic and emotional development and can create instability in their families (Rutgers University 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 Council of Australian Governments' (2006) *National action plan on mental health, 2006 - 2011* outlines the 'reduction of the prevalence and severity of mental illness in Australia' and the 'reduction in the prevalence of risk factors that contribute to the onset of mental illness and longer term recovery' as key outcomes. A focus on

reducing the prevalence of mental health problems and disorders in children and young people will have long term positive outcomes for the Australian population (COAG 2006, p.1).

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 that 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. Nevertheless, the funding allocated to child and adolescent mental health does not currently reflect the proportion of the population comprising children and young people. Significant socioeconomic inequalities are apparent in infant, child and adolescent mental health, including inequities in resourcing and in accessing services.

There is a growing practice nationally and internationally for governments to ‘calculate’ the return on investment to taxpayers from evidence-based prevention and intervention programs and policies (Mayfield & Lee 2009). The Australian Government has commissioned studies to gain reliable information on the costs and health outcomes of current practice and of options for change in mental health intervention.

The ACE-Prevention Report (2010) has provided evidence that there are a number of preventative interventions that could be implemented with infants, children, adolescents and their families that are cost-effective and would decrease the impact of mental health disorders in Australia. In particular, the evidence supports introduction of interventions for screening childhood depression and anxiety; problem-solving after a suicide attempt; and early psychosis intervention.

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.

Professor Albert Aynsley-Green (2000) argues strongly for the cost-effectiveness of early in life interventions. This view is shared by many researchers and applies across a range of diagnoses.

Childhood and adolescence are key life stages in the development of mental illness.

Adolescence is a key stage in relation to schizophrenia and depression while earlier life is important for conduct disorder and hyperactivity. Many childhood disorders persist into adulthood and they are associated with poor educational attainment and crime. (Medical Research Council 2010, p.18)

Recent findings from a long-term study in the USA revealed that adults who reported childhood psychological problems such as depression and substance abuse experiences, were 10 to 20 times more likely to experience diminished vocational opportunities, educational outcomes and success in relationships (Smith & Smith 2010).

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

The potential to reduce future adverse outcomes is a significant characteristic of the younger consumers of mental health services. A paper from the United States reports on the consequences of inadequate care for children and youth with mental health problems. It notes that those with severe disturbances who 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).

Children who have learning, behavioural or emotional problems are more likely to have negative impacts on the quality of their lives 'and in turn, the lives of their children. These problems accrue to the whole society in the form of increased social inequality, reduced productivity and high costs associated with entrenched intergenerational disadvantage' (COAG 2009b).

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 early intervention and service development within Australia.

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 from those for the adult population. Environments and systems play an important role in children and young people's mental health. These mainly comprise schools, childcare settings, childhood services and child protection agencies as well as youth services, including drug and alcohol services, and 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.

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, a more positive outcome for the family as a whole has resulted. There is an established need for broad intersectoral partnerships, including services outside those traditionally used by adult mental health services. These include preschools, kindergartens, the education system, paediatricians, the justice system, childcare and child protection.

The Council of Australian Governments has recently produced frameworks, plans and strategies that promote partnerships and better coordination, planning and implementation of services. These comprise services across all systems and jurisdictions to support vulnerable families and children (*National framework for protecting Australia's children* COAG 2009c; *National early childhood development strategy* COAG 2009b; *Fourth national mental health plan* Commonwealth of Australia 2009).

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. (US Dept of Health and Human Services 1999)

Primary care workers who are interested in enhancing mental health services for children and families within their community form partnerships through developing an understanding of the diverse work cultures of workers from different agencies. The process of working together 'opens primary care clinicians, families, and their community partners to new opportunities for mutual support and new solutions to common problems' (American Academy of Pediatrics 2010, p.93). In this context, primary health care providers require specialist support from CAMHS.

In relation to children and adolescents, the *Mental health of young people in Australia* (Sawyer et al. 2000) found:

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, p.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; for example, children of parents with a mental illness, or who misuse alcohol and other drugs, maltreated children, Indigenous young people and refugees.

For infants and children, exposure to ongoing stress and experience of traumatic events such as abuse and neglect can have lifelong effects on both the structural development of a child's brain and nervous system responses to stress. This has 'consequences for a child's future learning, behaviour and physical and mental health as well as significant costs to society' (COAG 2009b).

Certain populations of children are at risk for being exposed to higher levels of stress and possible abuse. It is estimated that up to 23% of Australian families have a parent with a mental illness (Maybery et al. 2005). According to Victorian mental health attendance data cited in Maybery et al. (2009) 1.3% of Australian children have at least one parent with a severe mental illness. This figure equates to one million children in the community living with a parent with a mental illness and almost 60 000 in families where a parent has a severe mental illness. Estimates suggest that between one- and two-thirds of children of parents known to adult mental health services will experience difficulties, depending on sampling and assessment criteria (Falkov 1998).

A recent Australian study (Maybery et al. 2009) showed that children in families where parents do not have mental health problems had only a 17% chance of being assessed as being at-risk of mental health problems (this is similar to the findings of Sawyer et al. in 2000). However, children from a general community sample who had a parent with a mental illness were more than twice as likely to be in the at-risk range (40%). Finally, children whose parents attend adult mental health services - that is parents with more severe mental disability - were three times as likely to be in the elevated at-risk range (57%). Other Australian researchers (Cowling et al. 2004) report findings highlighting children of parents with a mental illness are at higher levels of risk to their mental health than their peers in the community.

This group of children and young people present a special challenge for services, as they themselves may 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* (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). The *Fourth national mental health plan* (Commonwealth of Australia 2009) recommends in 'Priority area 2: prevention and early intervention' that the level and range of support for families and carers of people with mental illness and mental health problems be expanded, including for children of parents with a mental illness.

Children who have a parent suffering with chronic, long term and debilitating physical illnesses also need information, support, respite and possibly protection. Their existence may not be known to service providers who fail to ask if the identified patient has dependent children. They may also be child carers (Wates 2010).

In 2006-07 there were 58 563 substantiated cases of child abuse and neglect in Australia - a 45% increase from 2002-03 (Australian Institute of Health and Welfare 2008). In approximately two-thirds of substantiated child protection cases, the primary problem is maltreatment through neglect or emotional abuse. Physical or sexual abuse comprise the remainder (AIHW 2008; Scott 2009). In 2007 there were 28 441 children in state care in Australia, which is almost double the number a decade ago. Moreover, during that period the rate of Indigenous children in out-of-home care was eight times that of other children (AIHW 2008). In all states of Australia, except Victoria, increases have occurred in the number of children placed in out-of-home care due to child abuse and neglect. In NSW, there was a large increase of 16% from 2006 to 2008. Based on the current system, as many as 24 000 children are predicted to be in state care by 2013-2014 in NSW (NSW Government 2009).

Children in out-of-home care are a group at significant risk who experience high rates of developmental and mental health problems. The Royal Australian and New Zealand College of Psychiatrists reports that the

children's psychopathology is complex and is currently not well understood, however research suggests that its origin lies in insecure attachments and the cumulative effects of childhood maltreatment. There is also a high prevalence of intellectual disability in this group which adds to the complexities of their mental health needs. These children warrant special attention and priority access to multi-disciplinary mental health care that is competent in meeting their complex care needs. (RANZCP 2009)

Children with disabilities and siblings of children and young people with disability or chronic illness are another hidden risk group. The Australian Early Development Index (AEDI) Report (Centre for Community Child Health and Telethon Institute for Child Health 2009) identified that there are 11 486 (4.4%) young children (4 to 5 years of age) with chronic physical, intellectual and medical needs. In Australia, there are over 200 000 people under the age of 25 years with significant special needs (disability or chronic illness). Similar numbers have mental illness. These families can experience considerable stress, evidenced by the large rate of family breakdown (some anecdotal evidence suggests from 80% to 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 2010).

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 (Advisory Council on the Misuse of Drugs 2003, p.2).

Dawe, Harnett and Frye (2008) estimate that approximately 13% of Australian children live in a household with at least one adult who is regularly binge drinking. While not all of these children will suffer from abuse and neglect, Scott (2009) notes that parental alcohol misuse

greatly increases the risk of emotional abuse, by witnessing domestic violence; neglect, from having inadequate food, clothing and medical care; physical and sexual abuse, both directly as a result of the disinhibiting effects of alcohol on the perpetrator, and indirectly due to the reduced capacity of intoxicated parents to protect children from abuse by others. (Scott 2009, p.38)

Children who are exposed to domestic violence are also at high risk. In July 2004 the Access Economics report, prepared for the Australian Government's Office of the Status of Women *Cost of Domestic Violence to the Australian Economy* refers to domestic violence costing \$8.1 billion dollars a year. Furthermore, 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. Additionally, it was found 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 October 2004).

Of particular significance relating to infant mental health is the presence and effect of domestic violence experienced by women antenatally and postnatally, increasing the mother's risk of developing postnatal depression. A mother's emotional availability and ability to respond sensitively to her infant are severely

compromised in these circumstances. Consequently, her responses are influential in limiting the infant's secure attachment impacting on the early cognitive, emotional, social and behavioural development of children (Milgrom et al. 2007).

'Aboriginal and Torres Strait Islander (ATSI) people experience disproportionately high rates of mental health and social and emotional wellbeing problems' and the 'frequency of child, youth and adult mental health disorders in the community are higher' (Commonwealth Department of Health and Ageing 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 of refugees. The Professional Alliance For The Health Of Asylum Seekers And Their Children Submission to the HREOC Inquiry (2002, p.13) 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.

Although refugee children and adolescents are at particularly high risk of mental health difficulties because of the multiple traumas experienced, children of other migrant families can also be emotionally vulnerable. Second-generation children experiencing emotional and behavioural difficulties sometimes do not have their problems adequately understood because questions are not asked about the place of their parents' birth. Issues can often arise because parenting practices from the 'home' country applied to children growing up in Australia can create much discord and stress in these families (Luntz 1998, 2000).

AICAFMHA recognises that within the infant, child and adolescent population there are particular subgroups that have special needs or who 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.

Accountability and Research

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

Worldwide evidence shows that the scale of mental health research is not proportionate to the 'burden of disease which according to the World Health Organisation accounts for 15% of the health burden in the developed world' (Medical Research Council 2010, p.6).

AICAFMHA believes that innovative pilot programs 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 programs with a research base that have never been implemented because of insufficient funding being made available to trial them. In the United States, the SAMHSA Model Program's online database provides an excellent example of recognising and sharing information about effective programs (<http://www.modelprograms.samhsa.gov/>).

In Australia, COAG's *National action plan for promotion prevention and early intervention for mental health* (2000) outlined many evidence-based programs that could be implemented across the entire lifespan. Yet over the past decade, many of these programs have still not been rolled out, in particular with young children. International evidence indicates that the 'best buys' for investment in mental health can be realised 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 published *The NIMH blueprint for change report: Research priorities in child and adolescent mental health* (Hoagwood & Olin, 2002). This targeted approach to developing a clear research agenda would be an excellent step in supporting research in the Australian context.

Limited funds are currently provided in Australia for research in the child and adolescent mental health area. In 2008, the National Health and Medical Research Council allocated fewer than 5% of the research budget to child and adolescent mental health research (Birleson & Vance 2008).

A recent study of policies related to provision of children's mental health services revealed that 90% of all states in the USA developed policies founded on evidence-based practice. Implementation of the policies was shown to be affected by limited information-sharing practices and technology and funding (Cooper & Aratani 2009).

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 CAMHS 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 programs in specific areas of its work, including children of parents with a mental illness. 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 *Fourth national mental health plan 2009 - 2014*.

AICAFMHA recognises that the *National mental health report* provides a comprehensive overview of mental health service activity in Australia, however is primarily focused on the activities of adult mental health services. CAMHS service indicators need to be specifically developed and implemented for younger children. 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, Dissemination 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* (Commonwealth Dept of Health and Aged Care 2000, p.22) states that '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' (Commonwealth Dept of Health and Aged Care 2000, p.51).

In Australia and internationally, the gap 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 owing 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.

Needs of Rural and Remote Communities and Service Responses

The mental health service needs of rural and remote communities are greater than in metropolitan areas, and this discrepancy needs to be addressed in service delivery.

The report of 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. (Burdekin 1993, p.678)

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

Workforce Development

The training needs of the mental health workforce, accessibility to adequate numbers of workers and workforce planning are major issues in child and adolescent mental health, as is the training and support of the primary care workforce to optimise their role in early intervention and prevention.

The *National Practice Standards for the Mental Health Workforce* developed in 2002 were revised in 2010. In order to meet the practice standards, it is important to ensure that infant, child and adolescent mental health staff are provided with appropriate training and development opportunities. This may include travel to major cities on a regular basis for collegial support as well as targeted training and development activities. The use of telehealth and e-learning technologies to provide online learning opportunities has been seen as an effective tool to develop knowledge and skills about supporting vulnerable families for workers in rural areas. In addition to training, 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.

The use of web-based learning to deliver professional education and training programs across Australia is increasing. Numerous national initiatives are being developed to further the knowledge and skills of mental health workers, including those who work with families and children. For example, in early 2011, MHPOD (Mental Health Professional Online Development) will become available and will provide education based on the national practice standards for mental health workers across Australia.

Over the past five years AICAFMHA, through the COPMI national initiative, has developed a comprehensive website to provide resources to the mental health workforce and other allied workers who support families where a parent experiences mental illness. The use of an e-discussion list for workers has fostered the sharing of information and resources across Australia.

In 2009, AICAFMHA launched the *Keeping Families and Children in Mind Online Education Resource* in aid of mental health workers who support families where a parent experiences mental illness. This resource can be accessed by individual learners or utilised by workforce educators for group training purposes. Over 100 workforce educators across Australia have been taught how to deliver the resource, with workshops delivered in South Australia, Victoria, Western Australia, Canberra, Queensland and New South Wales. There are plans to deliver a train-the-trainer program in 2010 to 2012.

AICAFMHA supports investment in the ongoing expansion and education of the mental health workforce, including infant, child and adolescent mental health practitioners.

E-mental Health Initiatives

Young people utilise the internet regularly to access information about mental health and mental illness. Clinical evidence suggests that some mental health problems can be treated through programs accessed on the internet. The utilisation of e-mental health initiatives can enable young people who may not have access to face-to-face services to acquire information and treatment. It can assist practitioners to expand the options for interventions that they can provide to children, young people and their families.

The *Fourth national mental health plan 2009-2014*, *Draft National Primary Health Strategy 2008* and *National E-Health Strategy 2008* all advocate for the use of e-mental health approaches as an efficient and innovative use of technology to deliver services to people who do not access current mental health services.

Of young adults, 93% go online and 33% of them look for mental health information online (Fox & Jones 2009). Given that half of mental health problems are evident before 15 years of age, e-health technologies are familiar and easily accessible to young people. These technologies may also lead to appropriate referrals to face-to-face primary and secondary mental health interventions (Christensen & Hickie 2010b). A recent study showed that 85% of young adults diagnosed with serious mental illness looked up mental health information online and 44% did this at least once a month (Gowen & Deschaine 2010).

Web-based intervention programs are currently being developed that work in partnership with primary health care workers such as general practitioners. As noted by Christensen and Hickie there is

increasing evidence that internet-delivered treatments are effective, efficient and cost effective for anxiety (social anxiety, panic disorder), depression, post traumatic stress disorder, eating disorders, and obsessive-compulsive disorder, using cognitive behaviour therapy, psycho education and /exposure techniques. (Christensen & Hickie 2010a, p.S53)

A range of successful models of e-health services are available that could be utilised to overcome barriers to accessing mental health care. From 2010 to 2012 AICAFMHA will develop and pilot test a web-based training program, associated program materials and a manual for primary mental health workers to undertake brief preventive intervention with families where a parent experiences depression or anxiety.

AICAFMHA supports the use of e-learning strategies to develop programs for providing mental health promotion, prevention strategies and treatment to families and children.

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.

Incorporated in June 2000 following several years of development, the association actively promotes the mental health and wellbeing 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, in the one organisation, professionals from a wide range of disciplines, as well as consumers and carers. AICAFMHA has developed strong cross-sectoral contacts and a strong consumer constituency.

Recent Activities of AICAFMHA

AICAFMHA's recent activities include:

- success in securing Australian Government funds for an extension of the Children of Parents with a Mental Illness National Initiative, 2010 to 2012.
- funding and coordination of the joint Inaugural World COPMI Conference and 6th National Child and Adolescent Mental Health Conference, October 27-29, 2009.
- launch of COPMI national initiative resources October 26th 2009. This included the Keeping Families and Children in Mind Online Education Resource, Piecing the Puzzle Together Booklet and the Just Being Me Resource for middle primary teachers in conjunction with Mind Matters.
- publication of a National Youth Participation in Mental Health Strategy 2008.
- provision of ongoing management for the Children of Parents with a Mental Illness National Initiative (COPMI Project), including monthly updates about progress on the website.
- continued distribution of hard copies of the Children of Parents Affected by a Mental Illness Scoping Project Report, Principles and Actions Document around Australia and the world.
- monthly e-letter (News In Brief) circulation to over 2100 subscribers covering mental health news, events, and resources.
- submission to Senate Enquiry in Mental Health 2006.
- maintenance and expansion of the information available via the AICAFMHA website, including a links database with over 200 links to relevant information.

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

Board Members

Philip Robinson (Chair), Children, Youth and Women's Health Service, SA

Dr Nicholas Kowalenko (Deputy Chair), Royal North Shore Hospital, NSW

Merrie Carling, Birdseye Psychology Practice, ACT

Dr Margaret Jones, Child and Adolescent Mental Health, WA

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E. Appendix

Current Policy Context Relating to Child, Infant, and Adolescent Family Mental Health: Australia

Assessing cost-effectiveness in prevention: ACE Report 2010

Council of Australian Governments' (COAG) National action plan on mental health (2006-2011)

Draft Implementation Strategy for 4th National mental health plan

Fourth national mental health plan 2009 - 2014

Investing in the early years: a national childhood development strategy 2009

National E-health Strategy 2008

National Family Support Program 2009

National Framework for Universal Child and Family Health Services 2010

National Health and Hospital Network Agreement 2010

National Mental Health Action Plan 2006 - 2011

National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes 2010

National Primary Health Strategy 2008

National Suicide Prevention Strategy 2008

National Survey of Mental Health and Wellbeing 2007

National Survey of Young Australians 2009

Melbourne Charter for Promoting Health and Preventing Behavioural Disorders 2009

Prevention Taskforce report NMHRC report

Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009 - 2020

Snapshot of Early Childhood Development AEDI National Report 2009

Time for Action -National Plan to Reduce Violence Against Women and Children 2009

Consistent Key Themes in 2008-2010 Policies and Reports

Aboriginal health

Accountability/reporting

Cost-effectiveness

Early intervention

E-mental health

Evidence based practice

Integration of services from all sectors

Partnerships

Population based approach

Preventative strategies

Problems in childhood leading to disorder in adulthood- long term costs

Promotion of wellbeing- good mental health

Quality services

Social determinants of health; addressing risk factors

Targeted interventions

Workforce and leadership development

