Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia

Commissioner for Children and Young People
Western Australia

April 2011

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Hon. Barry House MLC
President, Legislative Council

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Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia

In accordance with section 49 of the *Commissioner for Children and Young People Act 2006*, I hereby submit to Parliament for information the Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia.

MICHELLE SCOTT
Commissioner for Children and Young People Western Australia

29 APRIL 2011

COMMISSIONER'S FOREWORD

For children and young people, mental health is critically important – not only because it is the key to a rich enjoyment of childhood and adolescence, but also because it provides the foundation for a resilient and mentally healthy adulthood.

I undertook this Inquiry – my first as Commissioner for Children and Young People – after hearing consistently from communities across Western Australia about their concerns for the mental health of their children and young people, from infants through to young adults.

Organisations, individuals and families, together with children and young people themselves, told me of their struggles to locate and obtain mental health services and the long-term detrimental impact this was having on the quality of life of children and young people.

The issues were the same in all areas of Western Australia, although they were particularly acute in regional and remote areas and for Aboriginal children and young people.

In addition to drawing on the experience of children and young people and their families and those organisations that work with them, this Inquiry has relied on the best available research and evidence.

Despite the strength of the concerns raised with me, it appears as a community that we have not paid sufficient attention to the existence of mental health problems and illnesses affecting infants, children and young people.

The facts are that the largest single burden of disease affecting the 0 to 14 year age group, 23 per cent of all disease burdens, is from mental disorders. One in six children and young people between the ages of four and 17 years in Western Australia experiences a mental health problem. Even children in their infancy, children younger than two years of age, can and do suffer from mental illness.

The reasons for this lack of focus on, and understanding of, the extent of children and young people's mental illness are unclear. The pervasive stigma attached to mental illness which inhibits the seeking of help by those in need may be contributing to an avoidance of discussion of this important issue. While there is increasing awareness in the community about mental illness in adults, we seem too readily to be dismissive of problems among infants, children and young people by saying they are "just going through a stage".

It is clear from my Inquiry that services to promote strong mental health among children and young people, to prevent problems and disorders from arising and to treat those who are in need in Western Australia are seriously inadequate. Acknowledging the burden of disease attributed to mental illness, the Inquiry found that not only is the share of the health budget allocated to mental health too low, but the share of the mental health budget allocated to children and young people is insufficient to meet the extent of the problem.

It makes no sense not to intervene early with children and young people experiencing mental illness (which includes depression, anxiety, conduct disorders, substance use disorders, eating disorders, as well as psychosis). All of the research shows that intervention at the earliest possible stage, which may even be before the child turns two, will have the most beneficial impact.

In fact the research shows that the longer we leave our intervention the more difficult it is to make a positive difference.

COMMISSIONER'S FOREWORD

Failure to intervene imposes a severe burden of suffering on the individual child or young person and their families – not only in the present, but also in the future should problems extend into adulthood. The latter is of particular concern when it is understood that up to 30 per cent of adult mental health problems are related to adverse experiences in early childhood and up to half of lifetime mental health problems start by the age of 14.

The Inquiry also found many examples of services and programs that are working well and could be strengthened. The dedication and skill of those working to enhance the mental health and wellbeing of children and young people in the health system, in schools, in non-government and community agencies and in specialist services must be recognised.

Acknowledgement, too, must be given to the role of the Mental Health Commission, charged now with an important leadership position. It is critical that the Commission be better resourced to meet the challenges of a system that currently focuses mainly on adults and crisis intervention.

The establishment of the Mental Health Commission presents a valuable opportunity to build a leading mental health system in Western Australia that meets the needs of our future by meeting the needs of children and young people.

At the same time, there must be acknowledgement that 'mental health' cannot possibly be the sole responsibility of clinical services for mental illness, nor can it be managed entirely by the health sector. It involves a broad range of government and non-government agencies, the private sector and the community all working in partnership together with children and young people and their families. This Report sets out further steps that must be taken to refocus our efforts in this important area.

This Report is the culmination of seven months of intensive research and analysis of evidence. It provides a comprehensive picture of the current state of children and young people's mental health and wellbeing, as well as providing direction about the way forward. It is intended to be a 'road map' for the broad community, governments and the non-government sector to guide action immediately and over the next decade.

MICHELLE SCOTT
Commissioner for Children and Young People Western Australia

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ABBREVIATIONS AND ACRONYMS

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACIT	Assertive Community Intervention Team
Act	*Commissioner for Children and Young People Act 2006* (WA)
ADHD	Attention Deficit Hyperactivity Disorder
AEDI	Australian Early Development Index
AFHS	Adolescent Forensic Health Services
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
AISWA	Association of Independent Schools
APS	Australian Psychological Society
ARACY	Australian Research Alliance for Children and Youth
BAU	Bentley Adolescent Unit
CACHS	Child and Adolescent Community Health Service
CAHDS	Complex Attention and Hyperactivity Disorder Services
CAHS	Child and Adolescent Health Service
CaLD	Culturally and linguistically diverse
CAMDH	Centre for Aboriginal Medical and Dental Health
CAMHS	Child and Adolescent Mental Health Services (now ICAYMHS)
CAPS	ICAYMHS in Primary Schools Pilot
CDS	Child Development Service
CEO	Chief Executive Officer
CERT	Community Emergency Response Teams
CHPRC	Child Health Promotion Research Centre
CIT	Community Integration Team
CLMIA Act	*Criminal Law (Mentally Impaired Accused) Act 1996* (WA)
COAG	Council of Australian Governments
Committee	Education and Health Standing Committee
Commissioner	Commissioner for Children and Young People WA
COPMI	Children of parents with mental illness
CSU	Charles Sturt University
CUCRH	Combined Universities Centre for Rural Health
DCP	Department for Child Protection
DET	Department of Education and Training
DEEWR	Department of Education, Employment and Workplace Relations
DfC	Department for Communities
DoH	Department of Health
DSC	Disability Services Commission
DSSG	Diverse sexuality, sex and/or gender
DSR	Department of Sport and Recreation
EAC	Economic Audit Committee
ED	Eating Disorder
EDAC	Ethnic Disability Advocacy Centre
EDNOS	Eating disorder not otherwise specified
EPDS	Edinburgh Post Natal Depression Scale

ABBREVIATIONS AND ACRONYMS

FAHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
GP	General Practitioner
GST	Goods and Services Tax
ICAMHS	Infant, Child, Adolescent Mental Health Services (now ICAYMHS)
ICAYMH	Infant, Child, Adolescent and Youth Mental Health
ICAYMHS	Infant, Child, Adolescent and Youth Mental Health Services
ICT	Information and communication technology
IEC	Intensive English Centre
Inquiry	The Commissioner for Children and Young People WA's Inquiry into the mental health and wellbeing of children and young people in WA
ISC	Intensive Services Centre
KEMH	King Edward Memorial Hospital
LEAF	Linking Education and Families
Mental Health Act	*Mental Health Act 1996* (WA)
MHERL	Mental Health Emergency Response Line
MHC	Mental Health Commission
MOU	Memorandum of Understanding
NACMH	National Advisory Council on Mental Health
National Plan	*Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*
NGO	Non-government organisations
NIFTeY	National Investment for the Early Years
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
OMI	Office of Multicultural Interests
OYH-CP	Orygen Youth Health Clinical Program
PATHS	Promoting Alternative Thinking Strategies
PBC	Primary Behaviour Centre
PECN	People with Exceptionally Complex Needs
PLNS	Psychiatric Liaison Nursing Service
PMH	Princess Margaret Hospital
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RAWA	Relationships Australia WA
RDA	Regional Development Australia
Report	The Report of the Commissioner for Children and Young People WA's Inquiry into the mental health and wellbeing of children and young people in WA
SCSEP	Statewide Clinical and Service Enhancement Program
SFL	Swim for Life
SSAMHS	Statewide Specialist Aboriginal Mental Health Service

ABBREVIATIONS AND ACRONYMS

SSTUWA	State School Teachers' Union of Western Australia
TAFE	Technical and Further Education institutions
TICHR	Telethon Institute for Child Health Research
WA	Western Australia
WACHS	WA Country Health Service
WAPOL	Western Australia Police
WHO	World Health Organisation
WMF	Wellbeing Monitoring Framework
YACWA	Youth Affairs Council of Western Australia

ACKNOWLEDGEMENTS

The report that stems from this Inquiry reflects the contributions of many individuals and organisations. Among them are the children and young people who willingly and frankly offered their views and shared their experiences. They did so either by providing a submission or by contributing in one of the consultation processes. As always, their views were clear, their experiences poignant, their compassion moving and their advice insightful. I thank them in particular for their courage in sharing their personal stories.

I would also like to thank the 141 organisations and individuals who made a submission to the Inquiry. The high number of submissions reflects the level of interest and concern in the community about improving the mental health and wellbeing of children and young people. The submissions provided a thorough and extensive information base for the Inquiry.

The members of the Reference Group who provided guidance and advice throughout the Inquiry process have been invaluable. The members were:

- Mr Eddie Bartnik — Mental Health Commissioner
- Dr Caroline Goossens — Infant, Child and Adolescent Psychiatrist / Chair, Western Australia Faculty of Child Psychiatry
- Mr Aram Hosie — Director, Research and Policy, Inspire Foundation
- Prof Helen Milroy — Child Psychiatrist / Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia
- Ms Tricia Murray — Chief Executive Officer, Wanslea Family Services
- Prof Stephen Zubrick — University of Western Australia, Centre for Child Health Research / Head, Division of Population Science, Telethon Institute for Child Health Research

I was fortunate to have such expertise available and I thank the members for their commitment and for offering their time and assistance to help with this important work.

I would also like to acknowledge Mr Julian Gardner, the Inquiry's Independent Reviewer, who led the Inquiry process and provided considerable assistance to me in undertaking the Inquiry.

I wish to acknowledge the staff of my office, all of whom have contributed to the Inquiry in some way. In particular, I would like to thank the Inquiry Project Team – Caron Irwin, Amy Tait and Leanne Pech – for their significant contribution in producing this comprehensive Inquiry Report.

Finally, I would like to thank the government agencies and, in particular, the Mental Health Commission Western Australia for their willingness to support the Inquiry by providing extensive information in response to my requests.

MICHELLE SCOTT
Commissioner for Children and Young People Western Australia

EXECUTIVE SUMMARY

The Commissioner for Children and Young People's Inquiry into the mental health and wellbeing of children and young people in Western Australia commenced in July 2010 pursuant to section 19(f) of the *Commissioner for Children and Young People Act 2006* (WA).

The decision to hold the Inquiry resulted from mental health concerns being raised with the Commissioner in her consultations with government and non-government agencies, as well as children and young people and their families in communities across the State. The announcement of the Inquiry was broadly welcomed by all of these groups.

The Inquiry was established with comprehensive Terms of Reference to allow a wide assessment of all the factors that should be considered in the mental health of children and young people – from the strategies that help develop mentally healthy children and young people, through to the provision of services and programs for children and young people who are unwell.

The Inquiry also explored the range of complex interactions between a child or young person and their family, their community and their social, physical, cultural and economic environments, being cognisant that all these interactions impact on mental health and wellbeing in some way.

The extent of concern about the mental health and wellbeing of children and young people was evidenced by the wide range of individuals and organisations that provided 141 written submissions.

Consultations were also held with children and young people to ensure their views about mental health and wellbeing were included in the Inquiry's consideration.

The Inquiry included a comprehensive literature review, drawing on international, national and local research to inform the direction and evidence base of the report.

The overwhelming evidence to the Inquiry was that the mental health needs of children and young people have not been afforded sufficient priority and there is an urgent need for reform in terms of both investment and focus.

The Inquiry found there is a general lack of understanding in the community that children (including infants and young children) and young people can experience mental health problems and disorders. There appeared to be limited awareness that even very young children can suffer from conditions such as anxiety and depression, and that their experiences with those conditions are as real and debilitating as adults' experiences.

Children and young people with mental health problems can experience the impacts of poor social skills, low educational attainment, poor physical health, high levels of distress and a diminished ability to cope with life's challenges. This has obvious adverse effects on a child or young person's quality of life and emotional wellbeing as well as their capacity to engage in school, community, sports and cultural activities.

In addition to affecting their lives in the present, poor mental health in childhood or adolescence can set a negative trajectory for ongoing mental health issues in adulthood. Many of the mental disorders which manifest in adulthood can be traced back to experiences in childhood and adolescence.

Increasingly, research is beginning to tell a clearer story about the prevalence of mental illness among children and young people. Western Australian studies have shown that more than 11 per cent of children aged two years and 20 per cent of children aged five years have clinically significant behavioural problems. They have also found that more than one in six children aged four to 17 in Western Australia have a mental health problem.

EXECUTIVE SUMMARY

A recent national report has estimated the economic impact of youth mental health (aged 12 to 25 years) at $10.6 billion with the value of lost wellbeing (disability and premature death) costing a further $20.5 billion.

The full cost of mental health problems and disorders in children and young people extends far beyond the cost of specialist mental health services and includes:

- the emotional and psychological costs to the child or young person and to their families, friends and carers;
- the costs to schools, in general health system, drug and alcohol sector, child protection system, and police and justice systems; and
- where the problems and disorders extend into adulthood, the loss of productive capacity and the cost to the social security system.

The provision of a range of interventions early in a child's life has been shown to not only reduce individual suffering but also produce long-term cost savings to the government and the community.

Unfortunately, despite the increasing evidence of the toll that mental illness is taking on children and young people, the Inquiry found there has been significant underfunding of mental health services for children and young people relative to the funding received by adult mental health services as well as relative to need.

The lack of investment has compromised the integrity and effectiveness of the whole mental health system for children and young people. The promotion of mental health and the prevention of mental health problems are just as important as early intervention and treatment for mental illness. All aspects of this continuum are interconnected.

The Inquiry found that although there are strong, evidence-based mental health promotion programs in existence in Western Australia, they are not available to all children and young people or they are so underfunded that their delivery is limited.

Evidence to the Inquiry revealed that there are very few services for children and young people experiencing mild to moderate mental health problems. The Inquiry heard many disturbing cases of children and young people being forced to wait until their mental illness had become severe before they were able to access a service.

Further, the primary public service which offers treatment for serious mental disorders (the Infant, Child, Adolescent and Youth Mental Health Service (ICAYMHS)) is so under-resourced that the Inquiry found it is no longer able to serve its client group adequately. This has resulted in lengthy waitlists and a focus on 'crisis' responses rather than comprehensive early intervention and treatment.

All of these challenges are even more acute in regional and remote areas, with some children and young people simply unable to receive any service at any stage of their illness' progression.

The ongoing disadvantage faced by Aboriginal children and young people makes them particularly at risk of experiencing mental health problems and yet there remain very few services that are culturally safe, appropriate and targeted specifically to their needs.

Notwithstanding these findings, the Inquiry considers that Western Australia is now in a unique and well-situated position for change.

The establishment of the new Mental Health Commission is one of the most significant structural reforms ever undertaken in the Western Australia mental health area and the opportunities it presents are considerable. With mental health being coordinated by a single and separate agency, a ring-fenced budget, and with strong, strategic leadership there is a real possibility that Western Australia could become a leader in mental health service and policy provision.

The Mental Health Commission must be appropriately resourced to undertake this important role and enable it to shift its focus to areas beyond the adult mental health system.

However, the Inquiry acknowledges that effective change cannot occur with the Mental Health Commission acting alone and that rebalancing the agenda for children and young people is a responsibility which stretches far beyond the Commission's remit.

The range of agencies, programs and services that have a role to play in strengthening the mental health and wellbeing of children and young people is broad, as mental health is affected by many different kinds of policies and interventions. Further, the interlinked nature of physical and mental health means that many interventions targeted at other elements of health and wellbeing, such as sport and recreation activities, can have positive impacts on mental health.

To facilitate the strategic approach necessary, the Inquiry has recommended that the Mental Health Commission become the lead coordinating body for the improvement of service delivery for children and young people's mental health – by developing a comprehensive and strategic plan for the mental health and wellbeing of children and young people and leading a whole-of-government implementation process.

This Report has taken the first steps in this process and is intended as a 'road map' for short, medium and long-term action. It is hoped it will inform a statewide plan, assisting to guide priorities for children and young people's mental health over the next 10 years.

The Report is structured along the developmental trajectory of a child and young person. It reflects on the developmental stages of childhood and adolescence and examines the critical role of the key places and people that the child or young person comes into contact with over this period.

Any future plan for the delivery of mental health programs and services for children and young people should adopt a similar approach, as the programs and services required to support and strengthen mental health for children and young people are as different as the developmental stages themselves.

Recognition of the varied needs of children and young people is required. An acknowledgement that they are not a homogenous group and that service delivery must be flexible and adaptable is crucial to any success.

To this end, the Inquiry has also called for the involvement of children and young people in any mental health reform agenda. As the direct recipients of these mental health services, children and young people are well placed to advise on how their needs can be met and how delivery can be improved. As citizens, children and young people should be given the opportunity to be involved in decision-making that affects their lives, to enrich decision-making processes and share their perspectives.

A comprehensive, statewide plan for the mental health and wellbeing of children and young people is urgently required, but can still only go so far. Without a substantial boost to the provision of mental health services, the best that can be hoped for is an improvement in coordination and collaboration – a necessary change but inadequate on its own to improve the current situation for children and young people.

The Inquiry heard strong and persuasive evidence that substantial investment is required across promotion, prevention, early intervention and treatment services to enable the entire mental health system to work at a more functional level, with referral and transition operating smoothly across the continuum as required.

In recognition of this, and of the chronic underfunding of mental health services, the Inquiry has strongly recommended that funding to ICAYMHS be increased so it is able to provide for comprehensive early intervention and treatment services for children and young people, including meeting the needs of children and young people with mild, moderate and severe mental illnesses.

The Inquiry has also made various recommendations about ways to improve the approach to the promotion of mental health and the prevention of mental illness. One of the primary recommendations is a call for a formal across-government mechanism to coordinate, collaborate on and deliver effective parenting programs across Western Australia for parents of children and young people.

In recognition of the importance of schools as a setting where children and young people spend a vast majority of their time, the Inquiry has recommended the establishment of several pilots for the implementation of 'integrated services' on school sites.

The Inquiry has also called for an immediate investment in a specialised 24/7 emergency service for children and young people experiencing a mental health crisis. Without such a service, the emergency department of Princess Margaret Hospital or the Western Australia Police become the default admission point for children and young people in need of emergency mental health assistance.

For children and young people who have particularly complex needs, and who require the assistance of a range of agencies and service providers, the Inquiry has recommended that a new collaborative service be established as a demonstration project. It has looked to models of collaboration both in Western Australia and overseas as guides as to how this project could be established.

As a result of this Inquiry, 54 recommendations for future action have been made and are grouped under relevant headings for ease of reference. The recommendations are interlinked and should not be read in isolation from one another.

It is the Commissioner for Children and Young People's intention to provide updates on the progress of the Inquiry's recommendations in her Annual Report to the Western Australian Parliament.

SUMMARY OF RECOMMENDATIONS

The Inquiry's recommendations are grouped under relevant headings for ease of reference. The recommendations are interlinked and should not be read in isolation from one another.

Acknowledging the mental health needs of children and young people

Recommendation 1: The Council of Australian Governments' mental health reform make children and young people a priority group and include planning for mental health promotion and prevention, early intervention and treatment services and programs. (Page 54)

Recommendation 8: Increased priority be given to the mental health and wellbeing of children and young people by the Mental Health Commission. (Page 62)

A comprehensive approach to the mental health and wellbeing of children and young people

Recommendation 9: A strategic and comprehensive plan for the mental health and wellbeing of children and young people across Western Australia be developed by the Mental Health Commission. This plan provide for the implementation and funding of promotion, prevention, early intervention and treatment services and programs. (Page 63)

Recommendation 17: As part of the strategic and comprehensive plan for the mental health and wellbeing of children and young people across Western Australia, the Mental Health Commission identify the unique and specific requirements for:

- Aboriginal children and young people; and
- children and young people who are vulnerable or disadvantaged for any reason. (Page 72)

Recommendation 14: Funding to the State's Infant, Child, Adolescent and Youth Mental Health Service be increased so it is able to provide comprehensive early intervention and treatment services for children and young people across Western Australia, including meeting the needs of those with mild, moderate and severe mental illnesses. (Page 67)

Governance

Recommendation 2: The Commonwealth and State Governments work collaboratively to ensure the mental health and wellbeing needs of children and young people are addressed. (Page 54)

Recommendation 10: A whole-of-government collaboration to improve the mental health and wellbeing of children and young people across the State be led by the Mental Health Commission. (Page 63)

Recommendation 13: The Mental Health Commission monitor the operational transfer of the Infant, Child, Adolescent and Youth Mental Health Service into the Child and Adolescent Health Service to ensure there are improved outcomes for the mental health and wellbeing of children and young people. (Page 67)

Recommendation 15: The *Mental Health Act 1996* (WA) and the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) be reviewed to ensure the rights and needs of children and young people are adequately recognised. (Page 69)

Recommendation 44: A community education campaign about the importance of children and young people's mental health be led by the Mental Health Commission. (Page 142)

Recommendation 32: A central Office of Early Childhood be established and a statewide plan for early childhood be prepared. (Page 108)

Recommendation 33: Pending the establishment of an Office of Early Childhood, the Directors General of the Departments of Health, Education and Communities establish a working party mechanism to ensure collaboration and coordination in the important area of early childhood services. (Page 108)

Recommendation 30: The Department for Communities establish a mechanism across government agencies – including the Departments of Education, Health and Child Protection – to coordinate, collaborate on and deliver effective parenting programs across Western Australia for parents of children and young people of all ages. (Page 107)

Involving children and young people

Recommendation 7: The Mental Health Commission ensure that the views of children and young people are heard in the work of the Mental Health Advisory Council and in the development of mental health policy, program and service design. (Page 61)

Recommendation 51: The planning and design of the mental health facilities in the new Children's Hospital occur with the direct involvement of children and young people. (Page 153)

Innovative service models

Recommendation 3: A new collaborative service to address the needs of children and young people who have complex needs be established as a demonstration project. The development of this service should consider the models of Wraparound Milwaukee and the People with Exceptionally Complex Needs. (Page 56)

Recommendation 4: Integrated early childhood services on school sites be implemented as soon as possible. This must include those services that provide mental health promotion, prevention, early intervention and treatment programs. (Page 57)

Recommendation 39: The model of integrated services on school sites be established as pilots in a number of primary and secondary schools in Western Australia. These integrated services to include comprehensive mental health services. (Page 131)

Recommendation 40: A specialised, statewide, 24-hour emergency service be developed for children and young people experiencing a mental health crisis. (Page 133)

Gaps in services – promotion and prevention

Promotion programs promote positive mental health in children and young people and maximise their wellbeing. Prevention programs aim to maintain positive mental health in children and young people by decreasing risk and increasing protective factors (see Chapter 2).

Recommendation 29: The number of community child health nurses be increased to provide a comprehensive, universal health service to parents and children across Western Australia. (Page 103)

Recommendation 31: Significant funding be provided to increase the delivery of evidence-based parenting programs for parents of children and young people. Programs must be universal and targeted, accessible across the State, with some tailored to children and young people who have particular needs. (Page 107)

Recommendation 34: Consideration be given to rolling out *KidsMatter Early Childhood* to all early childhood services across Western Australia. (Page 109)

Recommendation 37: Funding be provided to *KidsMatter* and all primary schools in Western Australia to enable the implementation of social and emotional learning programs within the *KidsMatter* framework. (Page 121)

Recommendation 43: Funding be provided to *MindMatters* and all secondary schools in Western Australia to enable the implementation of social and emotional learning programs within the *MindMatters* framework. (Page 140)

Recommendation 46: The Department of Sport and Recreation, the Department of Culture and the Arts and the Mental Health Commission work to increase arts, cultural, sport and recreation opportunities for children and young people – particularly in regional and remote areas. (Page 146)

Recommendation 38: The current focus on bullying be maintained and enhanced by the continued development and implementation of evidence-based anti-bullying programs involving the Commonwealth and State Governments, non-government agencies, community, parents and children and young people. (Page 124)

Gaps in services – early intervention and treatment

Early intervention involves identifying early symptoms of mental health problems in children and young people and providing services to prevent their progression and reduce the impact of problems and disorders. Early intervention can occur at any time – in infancy, early childhood, childhood and adolescence. Treatment is intended to cure the illness or reduce the symptoms or effects of mental health problems in children and young people (see Chapter 2).

Recommendation 35: The State Child Development Services receive significant investment to increase service to an appropriate level and reduce waiting times. (Page 112)

Recommendation 36: A comprehensive, specialist infant mental health service be developed that can provide early intervention and treatment services for very young children and their parents. (Page 114)

Recommendation 42: The Department of Education increase the numbers of school psychologists to enable the expansion of the services and programs they currently provide for children and young people with mild to moderate mental health problems and to promote mental health and wellbeing. (Page 139)

Recommendation 47: The Mental Health Commission coordinate the establishment of co-located 'youth service centres' across the State. (Page 148)

Recommendation 45: Information and communication technology be an integral part of any comprehensive mental health plan for children and young people. (Page 143)

Recommendation 48: Confidentiality, wherever possible, should be a critical consideration in the design and operation of services and programs, to encourage young people to seek help with issues concerning their mental health and wellbeing. (Page 149)

Recommendation 49: As a matter of urgency, the Bentley Adolescent Unit be upgraded to provide a more therapeutic service for children and young people. (Page 153)

Recommendation 50: Planning for the new Children's Hospital should include comprehensive therapeutic services for children and young people with mental illness, and be able to accommodate and support young people up to 25 years of age where developmentally and clinically appropriate. (Page 153)

Recommendation 52: A short-term residential facility for young people being discharged from acute in-patient care be made available, as a 'step-down' from hospital care when appropriate. (Page 155)

Recommendation 53: The previous reports by the Western Australian Coroner, Deputy Coroner, Telethon Institute for Child Health Research and the Senate Community Affairs Reference Committee be taken into account by the Mental Health Commission to inform a comprehensive approach to suicide and suicide prevention in Western Australia. (Page 156)

Recommendation 54: Transition strategies for young people moving into adult services be developed and implemented between services to ensure the individual is supported and continuity of care is maintained. (Page 160)

Vulnerable children and young people

Recommendation 19: Children and young people appearing before the Children's Court of Western Australia have access to appropriate, comprehensive mental health assessment, referral and treatment services. (Page 80)

Recommendation 20: A dedicated forensic mental health unit for children and young people be established. (Page 83)

Recommendation 21: The Rapid Response framework identify and respond to the mental health requirements of individual children and young people in care and that this be monitored on a regular basis by the Department for Child Protection. (Page 85)

Recommendation 22: To meet the mental health needs of children and young people of parents with a mental illness, the Mental Health Commission in partnership with relevant agencies identify and support a strategic and coordinated approach to services and programs. (Page 87)

Recommendation 23: Agencies providing services for adults in the areas of domestic violence, mental or chronic illness, disability, alcohol or drug abuse or prison recognise that children and young people in these families are a vulnerable group with specific mental health needs, and incorporate a child-centred approach to the services they deliver. (Page 88)

Recommendation 25: The Disability Services Commission work with the Mental Health Commission to identify the services required to address the unique needs and risk factors of children and young people with disabilities in a coordinated and seamless manner. (Page 95)

Recommendation 18: The allocation of funding from the Royalties for Regions program be considered for the provision of mental health services for children and young people living in regional and remote communities. (Page 78)

Recommendation 24: The Integrated Services Centres at Parkwood and Koondoola be maintained and consideration be given to expanding this model on additional school sites. (Page 91)

Building the capacity of the non-government sector

Recommendation 5: Arrangements for long-term funding be included in new contracts between government and non-government organisations for the provision of mental health services for children and young people. (Page 59)

Recommendation 6: The Mental Health Commission build the capacity of the non-government sector so it is equipped to deliver mental health promotion, prevention, early intervention and treatment services for children and young people. (Page 60)

Building the capacity of the workforce

Recommendation 16: A comprehensive mental health workforce strategy be developed by the Mental Health Commission in collaboration with the Commonwealth Government. This strategy to include cultural competency training and specific planning for the recruitment, training and retention of Aboriginal mental health professionals. (Page 71)

Recommendation 26: The Commonwealth Government provide for additional training to general practitioners and health professionals to assist in the early identification and treatment of mental health problems in pregnant women and children and young people. (Page 99)

Recommendation 27: The Commonwealth Government support incentives to ensure general practitioners have longer consultations with pregnant women, explaining mental health issues and supports. (Page 99)

Recommendation 41: Additional resourcing be provided to schools so appropriate mental health training can be provided to school staff with pastoral care roles. (Page 138)

Recommendation 28: Training be provided at university and TAFE as a part of relevant undergraduate and certificate courses (for example: general practitioners, teachers, allied health professionals, youth workers and child care workers) to improve the understanding of the mental health needs of children and young people. (Page 99)

Data collection and monitoring

Recommendation 11: The Mental Health Commission improve and maintain comprehensive data collection on the mental health of children and young people in Western Australia, including expenditure and mental health and wellbeing outcomes. (Page 65)

Recommendation 12: The State Government provide funding for the regular conduct of the Telethon Institute for Child Health Research's Child Health Survey and for this survey to be conducted in Western Australia every three years. (Page 65)

1.1 Role of the Commissioner for Children and Young People

Michelle Scott was appointed as Western Australia's inaugural Commissioner for Children and Young People (the Commissioner) in December 2007 pursuant to the *Commissioner for Children and Young People Act 2006* (the Act).

Under the Act, the Commissioner has responsibility for advocating for all Western Australian citizens under the age of 18 and for promoting legislation, policies, services and programs that enhance the wellbeing of children and young people. For the purposes of this Inquiry, discussion may include people up to 25 years of age.

One of the guiding principles of the Act is the recognition that parents, families and communities have the primary role in safeguarding and promoting the wellbeing of their children and young people and should be supported in that role.

In performing all functions under the Act, the Commissioner is required to have regard to the United Nations' *Convention on the Rights of the Child*[1] and the best interests of children and young people must be the paramount consideration.

The Commissioner must also give priority to, and have special regard to, the interests and needs of Aboriginal and Torres Strait Islander children and young people, and to children and young people who are vulnerable or disadvantaged for any reason.

The Commissioner is an independent statutory officer who reports directly to the Western Australian Parliament.

1.2 Background to the Inquiry

Since the Commissioner was appointed, she has travelled extensively across Western Australia and consulted widely with government and non-government agencies, as well as with children and young people, their families and communities.

On an ongoing basis, this consultation has informed the Commissioner's priorities, research and policy focus and application of resources.

One issue that has been consistently raised by communities across Western Australia is concern about the mental health and wellbeing of children and young people, and the gaps in services to strengthen and promote their mental health and wellbeing.

There is a large amount of research and evidence demonstrating that the mental health of Western Australia's children and young people requires attention, with one in six children and young people between four and 17 years of age experiencing a mental health problem.[2] Mental illness is also known to affect very young children, with a 2009 study showing 11.5 per cent of children aged two years and 20 per cent of children aged five years had clinically significant behavioural problems; and more than six per cent of the children having clinically significant mental health problems at both ages.[3]

1 Office of the United Nations High Commissioner on Human Rights [website], Convention on the Rights of the Child, viewed 16 March 2011, http://www2.ohchr.org/english/law/crc.htm.
2 Zubrick, S et al 1995, The Western Australian Child Health Survey: Developing Health and Well-being in the Nineties, Australian Bureau of Statistics and the Institute for Child Health Research, Perth, p. 35.
3 Robinson, et al, 'Pre- and postnatal influences on preschool mental health: a large-scale cohort study', The Journal of Child Psychology and Psychiatry, 2008, 49 (10), pp. 1118-28.

Acknowledging the concerns of communities about the mental health and wellbeing of children and young people, and being cognisant of the evidence supporting those concerns, the Commissioner initiated the Inquiry into the mental health and wellbeing of children and young people in Western Australia (the Inquiry) under section 19(f) of the Act.[4]

This is the first Inquiry undertaken by the Commissioner for Children and Young People.

1.3 Purpose of the Inquiry

The purpose of the Inquiry was to report on the mental health and wellbeing of children and young people in Western Australia and to make recommendations that strengthen and enhance the mental health and wellbeing of children and young people.

The Inquiry has assessed available evidence to promote an increased level of understanding of the mental health and wellbeing of children and young people through all sections of the community. In addition the Inquiry provided a unique opportunity for the views and experiences of children and young people, their families and professionals to be heard.

The Inquiry has had a broad focus, examining the range of interventions that may be required from birth through to adulthood to promote positive mental health and wellbeing, as well as prevent and treat mental health problems and disorders.

In identifying the range of interventions available, the Inquiry wanted to highlight those interventions or programs and services that are working well in Western Australia and elsewhere, and those that may need to be strengthened and enhanced.

1.4 Terms of Reference

The Inquiry's Terms of Reference were to examine and report on:

1. The mental health and wellbeing of children and young people in Western Australia.

2. The experiences of children and young people and their families in relation to the mental health and wellbeing of children and young people.

3. Agencies that have a critical role to play in strengthening the mental health and wellbeing of children and young people.

4. Models and interventions that strengthen the mental health and wellbeing of children and young people in Western Australia, including those that reduce the risk or prevent mental health problems or disorders.

5. Opportunities for coordination and collaboration within the government sector and between government, non-government and private sectors to assist in the promotion of the mental health and wellbeing of children and young people.

6. Positive approaches and partnerships that are evidenced-based and are proving effective in strengthening the mental health and wellbeing of children and young people (in Western Australia or elsewhere and which would be relevant to Western Australia).

4 Commissioner for Children and Young People Act 2006 (WA), section 19(f) of the Act provides that a function of the Commissioner is: 'to initiate and conduct inquiries into any matter, including any written law or any practice, procedure or service, affecting the wellbeing of children and young people'.

7. Recommendations to inform future directions that will strengthen the mental health and wellbeing of children and young people, including interventions aimed at reducing the risk or preventing mental health problems and disorders and effective treatment.

Considerations

In particular, the Inquiry was to:

- have regard to the best interests of children and young people as the paramount consideration in accordance with section 3 of the Act;
- consider the interests of all children and young people in Western Australia, but, in accordance with section 20 of the Act, give priority to, and have special regard to, the interests and needs of:
  - Aboriginal children and young people and Torres Strait Islander children and young people
  - children and young people who are vulnerable or disadvantaged for any reason; and
- ensure that the views and experiences of children and young people, their families, service providers and others with an interest are taken into account.

Exclusions

The Inquiry was not about resolving individual cases (although the experience of individuals could be referred to as an example), nor about issues that are outside the jurisdiction of the Commissioner or the scope of the Terms of Reference.

1.5 Governance of the Inquiry

Independent Reviewer

The Commissioner conducted the Inquiry with the assistance of an Independent Reviewer: Mr Julian Gardner.

Mr Gardner has been involved for more than 30 years with legal and social policy reform and the delivery of human services. He has held a number of independent statutory positions with both the Commonwealth and State Governments.

In his role as the Inquiry's Independent Reviewer, Mr Gardner was supported by staff of the Commissioner and assisted by the Reference Group established for the Inquiry.

Inquiry Project Team

Caron Irwin
Amy Tait
Leanne Pech

Reference Group

The expert Reference Group assisted the Commissioner by providing advice, comment and information as the Inquiry into mental health and wellbeing of children and young people progressed. Members also provided comment on the Inquiry's Terms of Reference during the commencement phase.

The Reference Group comprised the following members:

- Ms Michelle Scott — Commissioner for Children and Young People Western Australia
- Mr Julian Gardner — Independent Reviewer
- Mr Eddie Bartnik — Mental Health Commissioner
- Dr Caroline Goossens — Infant, Child and Adolescent Psychiatrist / Chair, Western Australia Faculty of Child Psychiatry
- Mr Aram Hosie — Director, Research and Policy, Inspire Foundation
- Prof Helen Milroy — Child Psychiatrist / Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia
- Ms Tricia Murray — Chief Executive Officer, Wanslea Family Services
- Prof Stephen Zubrick — University of Western Australia, Centre for Child Health Research / Head, Division of Population Science, Telethon Institute for Child Health Research

Mr Neil Guard participated at the first Reference Group meeting in his capacity as then Acting Mental Health Commissioner.

1.6 Conduct of the Inquiry

Submissions

The Commissioner sought information and advice on the mental health and wellbeing of children and young people by inviting written submissions from government agencies, non-government organisations, communities, children and young people and their families.

The Inquiry was advertised widely. A mail-out was conducted, advising more than 500 stakeholders about the Inquiry's commencement, and information about the Inquiry was included in the Commissioner's newsletter which was distributed to over 1,000 recipients. In addition, print media in each region of the State ran advertisements about the Inquiry information sessions, with several also publishing an article about the Inquiry. A new section of the Commissioner's website was published to house information about all aspects of the Inquiry.

The submission process was made as accessible as possible, with two Submission Information Packs (one for adults and one for children and young people) that included questions based on the Terms of Reference available on the Commissioner's website. Copies of the Submission Information Pack are at Appendices 1 and 2.

The Inquiry received 141 submissions. The list of the individuals and organisations who prepared a submission is at Appendix 6.

Requests for information from government agencies

Under section 22(2) of the Act, the Commissioner may ask a government agency or service provider to disclose to the Commissioner relevant information. Section 22(3) of the Act requires the government agency to provide the information requested unless such disclosure contravenes a prescribed written enactment relating to secrecy or confidentiality.

Under these sections, the Commissioner wrote to several government agencies requesting specific information (listed at Appendix 4). A whole-of-government response to these requests was collated by the Mental Health Commission and provided to the Commissioner. A further request was made to some of the government agencies to seek clarification or further details on the information that was provided.

The Commissioner also wrote to some Commonwealth Government departments, non-government agencies, independent agencies and professional associations requesting their assistance in providing information.

Information sessions

To ensure submissions were received from across the State, and from wide-ranging perspectives, the Commissioner conducted a series of information sessions about the Inquiry in metropolitan and regional areas of Western Australia.

The primary purpose of the information sessions was to provide details about the scope of the Inquiry and the submission process. The sessions were a useful opportunity to explain the role of the Commissioner and to encourage individuals and organisations to lodge a submission. They also allowed for broad discussion of mental health issues particular to specific regions.

Between August and September 2010, the Inquiry's Independent Reviewer and/or staff from the Commissioner's office visited the following areas to hold information sessions:

- Northam
- Broome
- Bunbury
- Geraldton
- Port Hedland
- Kalgoorlie
- Albany

Three information sessions were also held in Perth, one for Aboriginal organisations and two general sessions.

In addition, the Inquiry's Independent Reviewer presented an information session on the Westlink Network which broadcasts across Western Australia to 130 regional network centres, all TAFE campuses, 30 selected schools and eight hospitals.

Consultations with children and young people

In accordance with her statutory responsibility, the Commissioner was committed to ensuring children and young people's views and experiences informed the Inquiry and were integrated in the Inquiry's report.[5]

The Commissioner undertook the following consultation strategies as part of the Inquiry:

- consultation with the Commissioner's two 2010 Advisory Committees.
- direct staff contact with key organisations working with children and young people to make sure they were aware of the Inquiry and encouraged them to prepare a submission including the views of children and young people.
- communications to organisations and professionals to encourage them to include the views of children and young people in their submissions, or encourage children and young people they have contact with to make their own submissions; and
- funding of a special consultation project.

5 Commissioner for Children and Young People Act 2006 (WA), section 19(n).

A small amount of funding (up to $2,000) was made available to specific organisations to undertake consultations with children and young people. The organisations prepared submissions documenting the views of children and young people.

Having regard to section 20 of the Act, the majority of organisations that received the funding were approached because of their work with vulnerable groups of children and young people who would otherwise be unlikely to be heard.

The organisations which participated in this part of the Inquiry are listed at Appendix 5.

Literature review

A broad review of research, studies and strategies was undertaken as part of the Inquiry. The literature review aimed to identify critical references in the area of mental health as well as those with a particular focus on children and young people and the Western Australian context. A full reference list from the literature review can be found at Appendix 8.

2.1 Mental health and wellbeing

Positive mental health and wellbeing are important for people of all ages to maintain physical health, constructive relationships, participation in the community, enjoyment of life and productivity.

Individuals with positive mental health and wellbeing are better equipped with resilience and coping skills which enable them to respond appropriately to stressors or adverse circumstances experienced in life.[6]

At a societal level, citizens with strong mental health build the foundations of a cohesive and prosperous community.[7] Individuals with positive mental health and wellbeing help to create family units with strong relationships, communities that are socially and culturally enriched and workforces underpinned by confidence.

It is widely accepted that mental health is not merely the absence of mental illness. Positive mental health and wellbeing can be experienced by those with a mental illness and, conversely, people without a mental illness can experience poor mental health.[8]

The World Health Organisation defines mental health as:

> *A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*[9]

The Commissioner for Children and Young People's (the Commissioner) Inquiry includes the term 'wellbeing' in its scope, so as to capture a broad definition of mental health in Western Australia. The intention was to ensure mental wellbeing was central to an understanding of the mental health of children and young people, and allow a wide assessment of all the factors that should be considered – from the development of mentally healthy children and young people through to the provision of services and programs for children and young people who are unwell.

Importantly, the Inquiry recognises that Aboriginal people have a holistic view of mental health – a view which incorporates the physical, social, emotional and cultural wellbeing of individuals and their communities.[10]

The Commissioner acknowledges the unique contribution of Aboriginal people's culture and heritage to Western Australian society and Aboriginal people's whole-of-life view of mental health that incorporates the importance of connection to the land, culture, spirituality, ancestry, family and community.[11]

The Inquiry acknowledges that this recognition and identity is fundamental to Aboriginal people's social and emotional wellbeing and that mutual resolve, respect and responsibility are required to close the gap on Aboriginal disadvantage and to improve mental health and wellbeing.

6 Friedli, L 2009, Mental Health, Resilience and Inequalities, World Health Organisation, Europe, p. 3.
7 Centre on the Developing Child 2010, The Foundations of Lifelong Health Are Built in Early Childhood, Harvard University, Massachusetts, p. 2.
8 Department of Mental Health, Health Division (England) 2010, New Horizons: Confident communities brighter futures a framework for developing wellbeing, England, p. 12.
9 World Health Organisation Australia 2009 [website], Mental health strengthening our response, Fact sheet 220, viewed 1 February 2011 http://www.who.int/mediacentre/factsheets/fs220/en/
10 Purdie, N et al 2010, Working Together: Aboriginal and Torres Strait Islander Mental Wellbeing Principles and Practice, Australian Council for Educational Research, the Kulunga Research Network, and Telethon Institute for Child Health Research, Perth, p.xxvi.
11 Australian Health Ministers Advisory Council 2004, Social and emotional wellbeing framework: a national strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional well being: 2004 – 2009, Australian Government Department of Health and Ageing, Canberra, p. 8.

The importance of mental health and wellbeing for children and young people

For children and young people, mental health is profound in its importance – not only because it is the key to a rich enjoyment of childhood and adolescence, but also because it provides the foundation for a resilient and mentally healthy adulthood. Healthy children tend to grow into healthy adults.[12]

> *Mental health is an essential component of wellbeing: good mental health means that young people are more likely to have fulfilling relationships, adapt to change and cope with adversity.*[13]

Conversely, children and young people with mental health problems can experience behavioural issues, a negative sense of self-worth and a diminished ability to cope with life's challenges. This has obvious adverse effects on a child or young person's quality of life and emotional wellbeing as well as their capacity to engage in school, community, sports and cultural activities.

> *Poor mental health and wellbeing in childhood and adolescence is associated with many poor childhood outcomes such as lower educational attainment, increased likelihood of smoking, alcohol and drug use, poorer social skills and poorer physical health.*[14]

The Telethon Institute for Child Health Research's comprehensive studies found that large proportions of children identified as having mental health problems had their daily lives significantly affected by these problems – including home, friendships, learning, leisure, relationships, level of distress (for example, eating and sleeping problems) and their ability to do the normal things expected of children their age.[15] [16]

Likewise, in the *National Survey of Mental Health and Well-being*, substantially worse self-esteem and greater limitations in school and peer activities were identified in children with more emotional and behavioural problems than for children with fewer problems.[17]

Additionally, poor mental health in childhood or adolescence can set a negative trajectory for ongoing mental health issues in adulthood, and is associated with a broad range of poor adult health outcomes.[18] Up to 30 per cent of adult mental health problems are related to adverse experiences in early childhood[19] and up to half of lifetime mental health problems start by the age of 14.[20]

> *Many childhood disorders – once thought to resolve with age – are now known to cast long shadows over later development. Equally importantly, many adult disorders are now recognised as having roots in childhood vulnerabilities, traceable in some instances to the very earliest stages of development.*[21]

12 Council of Australian Governments 2009, Investing in the Early Years: A National Early Childhood Development Strategy, Commonwealth of Australia, p. 6.
13 Australian Research Alliance for Children and Youth 2008, The Wellbeing of Young Australians: Report Card, p. 4.
14 Department of Health, Mental Health Division (England) 2010, New horizons: confident communities brighter futures a framework for developing wellbeing, England, p. 26.
15 Zubrick, S, et al 1995, The Western Australian Child Health Survey: Developing health and well-being in the nineties, Australian Bureau of Statistics and the Institute for Child Health Research, Perth, p. 37.
16 Zubrick, S, et al 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, Vol 2 pp. 26, 551.
17 Sawyer, M, et al 2000, Mental Health of Young People in Australia: Child and Adolescent Component of the National Survey of Mental Health and Well-Being, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra p. 16.
18 Department of Health, Mental Health Division (England) 2010, New horizons: confident communities brighter futures: a framework for developing wellbeing, England, p. 26.
19 The Royal Australian and New Zealand College of Psychiatrists 2010, Infants and children urgently in need of mental health services [website], viewed 22 July 2010, www.ranzcp.org/media/infants-and-children-urgently-in-need-of-mental-health-services.html
20 World Health Organisation 2010, Fact file: 10 facts on mental health, fact 1-10 [website], viewed 22 September 2010, http://www.ho.int/features/factfiles/mental_health/mental_health_facts/en/index.html
21 Maughan, B, & Kim-Cohen, J. 2005, 'Continuities between childhood and adult life', British Journal of Psychiatry, vol. 187, pp. 310-303 [website], viewed 1 February 2011, http://bjp.rcpsych.org/cgi/reprint/187/4/301.

Therefore there is a strong case for implementing strategies for children and young people's mental health and wellbeing as an important part of reducing the long-term impact of mental illness.[22] [23] Estimates suggest that between one-quarter to one-half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence.[24]

Not only do children and young people experience mental health problems that continue into their adult lives, but many of the disorders that manifest in adulthood can be traced back to experiences in childhood and adolescence.[25] [26] For example, research has shown that of those who will experience an anxiety or affective disorder, two thirds will have had their first episode by the time they are 21 years of age.[27]

> *Interventions early in life can address risk factors more effectively, reduce symptoms more easily, to improve outcomes for children and reduce adverse impact on development, especially for conduct and anxiety disorders.*[28]

2.2 Age, wellbeing and intervention

There is a range of complex interactions between a child or young person, their family, their community and their social, physical, cultural and economic environments that all impact on wellbeing. Individuals, families, communities and agencies – government and non-government – have important roles to play in the mental health and wellbeing of children and young people.

> *Mental health for each person is affected by individual factors and experiences, social interaction, societal structures and resources and cultural values. It is influenced by experiences in everyday life, in families and schools, on streets and at work…*[29]

Consequently, the scope of the Commissioner's Inquiry was deliberately broad and considered the mental health and wellbeing of children and young people across three continuums:

- Age: Age covers the developmental stages of a child and young person and considers what needs to occur to ensure optimum mental wellbeing. A 'healthy' trajectory was examined and opportunities for intervention were explored.
- Wellbeing: Wellbeing examines the continuum of mental health – from mental health to mental illness – and the Inquiry explored the supports and programs that are being provided for children and young people at each stage.
- Intervention: Intervention examines the various programs and services that are in place in terms of their function – whether they promote mental health and wellbeing, prevent mental health problems and disorders, intervene early in mental health problems and disorders, or provide treatment.

By undertaking this review and examining the results, the Inquiry was able to paint a substantial picture of the services, issues and gaps in Western Australia and assess what is required in the future to ensure the optimum mental health and wellbeing of children and young people.

22 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 6.
23 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, National Academies Press, Washington D.C. pp. 49-50.
24 Kim-Cohen, J. et al 2003, cited in Department of Health, Mental Health Division (England) 2010, New horizons: confident communities, brighter futures: a framework for developing wellbeing, England, p. 26.
25 Maughan, B, & Kim-Cohen, J. 2005, 'Continuities between childhood and adult life', British Journal of Psychiatry, vol. 187, pp. 310-303, viewed 1 February 2011, http://bjp.rcpsych.org/cgi/reprint/187/4/301
26 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, National Academies Press, Washington D.C., p. 55.
27 Commonwealth of Australia 2009, Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014, ACT, p. 17.
28 The Children's Mental Health Coalition 2010, Our children, our future [website], viewed 1 February 2011, http://www.ranzcp.org/images/stories/ranzcpattachments/Home/Our_children_our_future_final.pdf p. 2
29 Lahtinen et al 1999, cited in World Health Organisation, Victorian Health Promotion Foundation, & University of Melbourne 2005, Promoting mental health; concepts, emerging evidence, practice, WHO Press, Geneva, p. 4.

2.2.1 Age

Under the Act, the Commissioner for Children and Young People has responsibility for advocating for citizens less than 18 years of age. However, for the purposes of this Inquiry discussion may include people up to 25 years of age.

The programs and services required to support and strengthen mental health across the age continuum of minus nine months to 25 years are as different as the stages themselves. Obviously, an infant's development is profoundly different to that of a preadolescent, and that in turn differs greatly to that of a late adolescent.

Acknowledging this, the Inquiry examined the trajectory of healthy development and explored the possible places for intervention.

The developmental stages examined by the Inquiry were:

- pregnancy, infancy and early childhood (-9 months to 3 years);
- childhood (4 to 12 years);
- adolescence (13 to 17 years); and
- transition to adulthood (16 to 25 years).

The Inquiry considered the key intervention points throughout a child's development where mental health promotion, mental illness prevention and early intervention programs would be of greatest benefit. It also examined the services available for the specialist treatment of mental illness in children and young people.

Pregnancy, infancy and early childhood (-9 months to 3 years)

It is now known that some predictors of mental health for a child are present even before birth, with the mother's health and experiences during pregnancy recognised as critical factors in mental health outcomes for young children.[30]

Extensive research in neurobiological and social sciences has provided a strong and well recognised evidence base for understanding how children's development is influenced by the very earliest years of their lives. This research confirms that early life experiences have a major impact on the development of the brain, social and emotional skills and play a central role in favourable or unfavourable health and development outcomes for children.[31] Early childhood is also a critical time for the development of 'school readiness,' a set of skills that helps to equip a child for school success and subsequent life outcomes.[32]

Childhood (4 to 12 years)

Children in this age group begin to move out of the relatively narrow contextual experiences of infancy and early childhood and into broader experiences, such as formal schooling (in most instances) and wider community involvement in sports, clubs and other social and recreational activities.

When in primary school, children are developing social and emotional skills, learning to interact with their peers and beginning to test their independence from family. Children will experience their first taste of academic success or failure in these years, and the school environment plays an important role in supporting children.

Adolescence (13 to 17 years)

Adolescence is characterised by the growth of the child towards cognitive and physical maturity.[33] Throughout the adolescent years, the brain is still in the process of developing and this affects how young people think, feel, behave and respond to environmental influences.[34]

30 Robinson, M, Oddy, W, Li, J, et al 2008, 'Pre- and postnatal influences on preschool mental health: a large-scale cohort study', Journal of Child Psychology, vol. 49, no 10.
31 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth, p. 3.
32 Clark, K, et al 2006, Early Years Services: Rationale and Design Considerations, Telethon Institute for Child Health Research, Perth, p. 16.
33 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 12.
34 Australian Research Alliance for Children and Youth, Youth Violence in Australia [website], viewed 1 March 2011, http://www.aracy.org.au/cmsdocuments/Preventing_Youth_Violence_Rationale_180809.pdf

This period of physical, social and emotional growth can be a difficult time – presenting challenges for both the young person and their families or carers.[35] Adolescence is also a time when engaging in risky behaviours is more prevalent, increasing the young person's vulnerability and exposure to risk factors.[36]

Transition to adulthood (16 to 25 years)

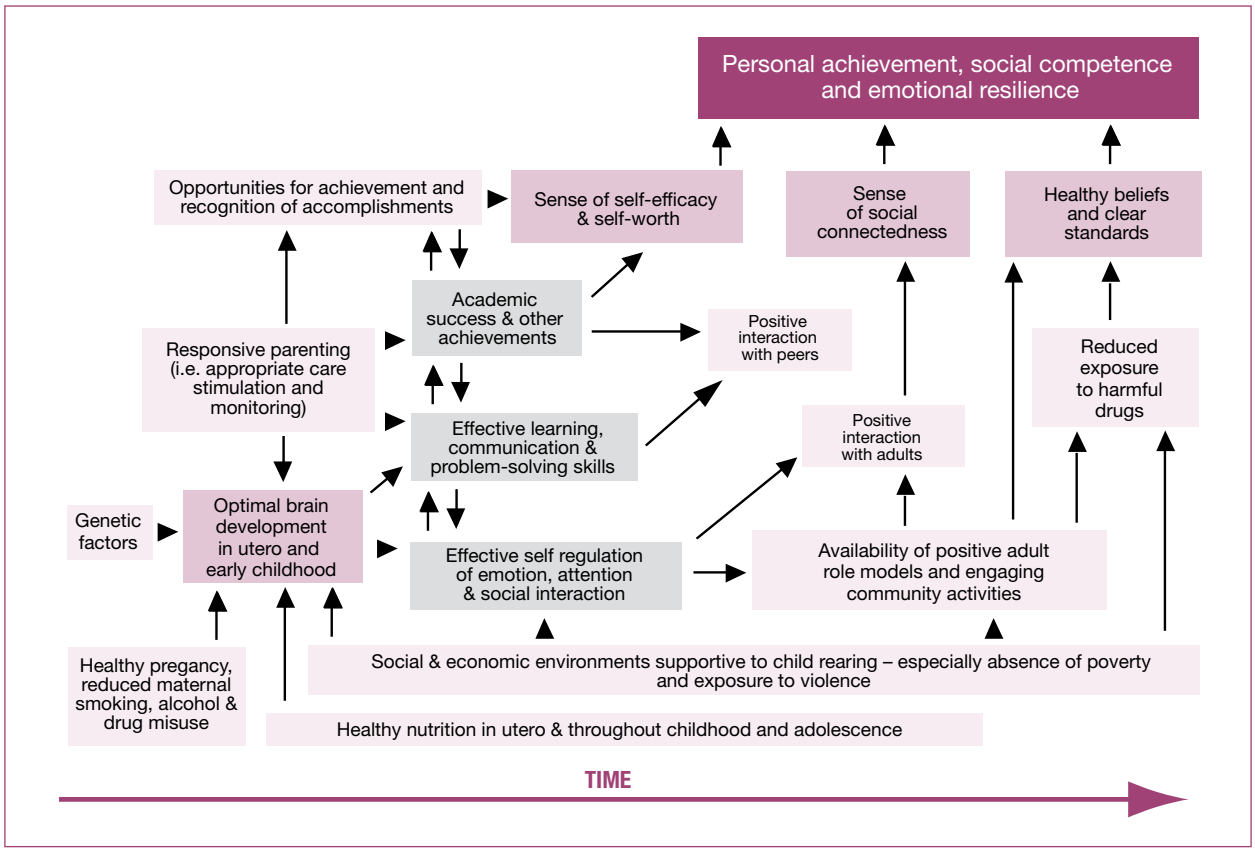
Transitioning from adolescence to adulthood, and all the social and emotional adjustments that this requires, is neither a fast nor an easy process. Evidence suggests that this transition period is long and varies between individuals depending on their own developmental trajectory.

These factors have implications for the design of appropriate service delivery for young people in this age range and run counter to the existing model where a 16th or 18th birthday dictates which mental health service a young person is eligible to access.

The 'Pathways to resilience' diagram shown in Figure 1 outlines some of the key developmental stages on this age continuum that help to lead a child and young person to personal achievement, social competence and emotional resilience.

Figure 1: Pathways to resilience[37]

(Sliburn, 2003)



35 Raphael, B 2000, Promoting the Mental Health and Wellbeing of Children and Young People. Discussion Paper: Key Principles and Directions, National Mental Health Working Group, Commonwealth Department of Health and Aged Care, Canberra, p. 22; Submission No. 69 from Headspace National, p. 5.

36 Bennet, D. 2007, Adolescent Development & Risk-taking, Youth Action and Policy Association NSW, [website], viewed 1 March 2011, http://www.yapa.org.au/youth/facts/devrisk.php

37 Submission No. 125 from Telethon Institute for Child Health Research. p. 38.

2.2.2 Wellbeing

As outlined previously, the Inquiry took a broad perspective of wellbeing and assessed the full continuum of mental health through to mental illness – from wellness to mild problems, early signs of disorder, episodes of acute illness or severe disorder. This holistic view aims to prevent mental illness from being seen as a separate and isolated issue to mental health and wellbeing.

The following terms and definitions are used throughout this Report when referring to children and young people's mental health and wellbeing. They are derived from widely accepted Australian and international research and policy documents, relevant in the Western Australian context.

Mental health

> *Mental health for children and young people has a strong inter-relationship with normal growth and development. Mental health for children and young people means the capacity to enjoy and benefit from a satisfying family life and relationships and educational opportunities, and to contribute to society in a number of age-appropriate ways. It also includes freedom from problems with emotions, behaviours or social relationships that are sufficiently marked or prolonged to lead to suffering or risk to optimal development in the child or to distress or disturbance in the family.*[38]

Mental health problem

> *A mental health problem interferes with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental disorder. Mental health problems are more common and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental disorders, but may develop into a mental disorder. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of severity and duration of the symptoms.*[39]

Mental disorder

A mental disorder is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Mental disorders are of different types and degrees of severity and are diagnosed by standardised criteria.[40] [41] Examples of mental disorders affecting children and young people are depression, anxiety, conduct disorders, substance use disorders, eating disorders and psychosis.

Mental illness

The term mental illness is considered to be synonymous with mental disorder.[42] Throughout this Report the term 'mental illness' is used for ease of reading to cover mental health problems and mental disorders when both are being referred to.

38 Raphael, B 2000, Promoting the Mental Health and Wellbeing of Children and Young People. Discussion Paper: Key Principles and Directions, National Mental Health Working Group and National Community Child Health Council, Commonwealth Department of Health and Aged Care, Canberra, p. 5

39 Mental Health and Special Programs Branch 2000, National action plan for promotion, prevention and early intervention for mental health 2000: a joint Commonwealth, State and Territory initiative under the second national mental health plan, Commonwealth Department of Health and Aged Care, Canberra, p. 5.

40 Mental disorders are diagnosed by standardised criteria, such as those contained in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (American Psychiatric Association, 1994) and the International Classification of Diseases, 10th Edition (ICD-10) (WHO, 1992).

41 Mental Health and Special Programs Branch 2000, National action plan for promotion, prevention and early intervention for mental health 2000: a joint Commonwealth, State and Territory initiative under the second national mental health plan, Commonwealth Department of Health and Aged Care, Canberra, p. 5.

42 Ibid.

2.2.3 Intervention

As a framework for examining what is required to strengthen the mental health and wellbeing of children and young people in Western Australia, the widely accepted continuum of mental health interventions was adopted by the Inquiry.[43] Programs and services were considered which:

- promote mental health and wellbeing;
- prevent mental health problems and disorders;
- intervene early with mental health problems and disorders; and
- treat mental health problems and disorders.

The definitions of mental health interventions used by the Inquiry are provided below and, as with previous definitions, are derived from widely accepted research and policy documents. It should be noted that because interventions are on a continuum, terms can overlap.

Promotion

> *Promotion strategies refer to any action taken aimed at promoting positive mental health and maximising wellbeing among populations and individuals. Mental health promotion includes efforts to enhance an individual's ability to achieve developmentally appropriate tasks (developmental competence) and a positive sense of self esteem, mastery, wellbeing and social inclusion and strengthen their ability to cope with adversity.*[44]

Prevention

> *Prevention strategies aim to maintain positive mental health through pre-emptively addressing factors which may lead to mental health problems or illnesses. These strategies can be aimed at increasing protective factors, decreasing risk factors or both, as long as the ultimate goal is to maintain or enhance mental health and wellbeing.*[45]

Prevention programs for children and young people may be 'universal', in that they are offered to the whole population (for example, a school-wide program). They may be 'selective', provided to groups at heightened risk of developing mental health problems (for example, children in care, in the justice system or who have parents with a mental illness). Prevention programs may also be 'indicated', targeted for children or young people who have minimal but detectable signs or symptoms of mental health problems (for example, depression or anxiety).[46]

Early intervention[47]

> *Early intervention strategies refer to the identification of early manifestations of mental illnesses, and the subsequent delivery of a prompt response aimed at preventing progression and reducing impact.*[48]

43 Mental Health and Special Programs Branch 2000, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Health and Aged Care, Canberra. p. 28.
44 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 4.
45 Ibid, p. 5.
46 Ibid, p. 5.
47 Note that early intervention can sometimes refer to early intervention in the treatment of psychosis. It can also refer to early intervention in the life course. This report specifies when it uses these definitions.
48 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 5

Treatment[49]

> *[Treatment] interventions [are] targeted to individuals who are identified as currently suffering from a diagnosable disorder and are intended to cure the disorder or reduce the symptoms or effects of the disorder, including the prevention of disability, relapse, and/or comorbidity.*[50]

This intervention continuum underpins an effective mental health system. If mental wellbeing describes a continuum from mental health to illness, then the nature of interventions required will vary not only as a response to the age of the person but also to their point on that wellbeing continuum.

In conceptualising the intervention continuum, it is useful to draw comparisons with physical health issues, where integrated health systems that include promotion, prevention, early intervention and treatment reduce health burdens in a substantial and cost-effective way.[51]

A critical point to note is that age has no bearing on the type of mental health intervention required. It is a common and erroneous assumption that young children need mental health promotion and prevention services while adolescents need early intervention and treatment services. In fact, the full range of interventions need to be available for all children and young people, as children and young people of any age can be positioned anywhere along the wellbeing continuum.

For example, a four-year-old child may have a diagnosed mental illness and require specialist treatment. Another four-year-old may be exhibiting the initial signs of a mental health problem (for example, withdrawn or aggressive behaviour) and may require early intervention to assist them to move back on to a healthy developmental trajectory. The rest of their four-year-old kindergarten class mates may benefit from a universal promotion or prevention program to develop their emotional and social skills and resilience.

Ideally, and with all stages of the intervention continuum operating at optimal levels, a child or young person could move seamlessly across each stage as required, with collaboration, communication and referrals across the continuum occurring smoothly.

If, however, there is a service gap at any stage, the integrity and effectiveness of the whole continuum (and therefore mental health system) is compromised. For example, by solely resourcing treatment services without also adequately resourcing promotion, prevention or early intervention services, the system becomes heavily skewed to treating severe mental health disorders. The consequence of this is that there is no opportunity to reduce the prevalence or severity of mental health problems and disorders so the demand on treatment services continues to grow, eventually becoming excessive and unmanageable.

> *Treatment services have the capacity to resolve some acute problems as well as to tackle the most difficult chronic conditions and can make a difference… However, these services are not without their problems. Because they are only available to those who meet specified criteria, they are unable to respond to the emerging needs and problems, and so miss opportunities to reduce the numbers needing intensive help. Furthermore, by the time children and families become eligible for treatment services, the problems are often so severely entrenched that they are difficult to shift.*[52]

49 The Inquiry considers mental health problems (not just mental health disorders) to be included in the scope of this definition of treatment.

50 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., pp. xxix, 65-67.

51 Geelhoed, et al 2005, cited in Centre for Community Child Health 2006, Policy Brief 5: Childhood mental health: promotion, prevention and early intervention, Royal Children's Hospital Melbourne.

52 Tolan & Dodge; Fonagy, cited in Centre for Community Child Health 2006, Policy Brief 4: Services for young children and families: an integrated approach, The Royal Children's Hospital Melbourne, p. 2.

As another example, a gap in early intervention services and treatment for mild to moderate mental illnesses means that a child or young person is forced to wait until their condition becomes severe and complex before they can access a service. This is not best practice in terms of treatment and causes high levels of distress for the child or young person and their family.

A balanced approach across the whole intervention continuum is required for optimum outcomes for children and young people.

Interventions offered to children and young people must also be age-appropriate. Children and young people's mental health needs are unique and distinct from adult requirements – children are not 'mini-adults' with 'mini-adult illnesses'.

> *Unfortunately, when individuals assume that children are "little adults," they also mistakenly assume that treatments for adults and children must also be the same… [such assumption] leads them to think that children simply aren't as developed as adults and so cannot have such [mental health] experiences.*[53]

Interventions for children and young people, from promotion through to treatment, must therefore be designed and delivered accordingly by people trained with the appropriate and specific skills.

This Inquiry considered the evidence it received in light of the intervention continuum and examined how effectively it is being implemented in practice. Service gaps and their consequences for children and young people and their families were described to the Inquiry in many submissions and are included throughout the report.

2.3 Risk and protective factors

The factors influencing mental health are broad and varied. The *Western Australian Aboriginal Child Health Survey* found the three major facilitators of optimal social and emotional wellbeing in children and young people are:

- intellectual flexibility coupled with an outgoing, easy temperament;
- good language development; and
- emotional support, especially in the face of challenge.

In addition, the survey identified four constraints on optimal social and emotional wellbeing in children and young people:

- stress that accumulates and overwhelms;
- chaos;
- social exclusion; and
- social inequality.[54]

In a great deal of mental health literature, these and other facilitators and constraints are described as 'risk factors' and 'protective factors':

- risk factors are associated with an increased probability of onset, greater severity and longer duration of major health problems; and
- protective factors refer to conditions that improve people's resistance to risk factors and the development of mental illness.[55]

Risk and protective factors can be individual, family or community related, social, environmental or economic. High quality mental health promotion and prevention activities target these risk and protective factors as they are proven to have a connection to the onset of mental illness.[56]

53 Davey, L 2010, How to Talk About Children's Mental Health: A FrameWorks Message Memo, FrameWorks Institute, Washington D.C., pp. 5-6.

54 Zubrick, S, et al 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, pp. 557-558.

55 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options – summary report, World Health Organisation, Geneva, p. 20.

56 Ibid.

Tables 1 and 2 outline some examples of commonly identified factors.

Table 1: Protective factors potentially influencing the development of mental illnesses (particularly children)[57]

Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
• Easy temperament • Adequate nutrition • Attachment to family • Above-average intelligence • School achievement • Problem-solving skills • Internal locus of control • Social competence • Social skills • Good coping style • Optimism • Moral beliefs • Values • Positive self-regulated cognitions	• Supportive caring parents • Family harmony • Secure and stable family • Small family size • More than two years between siblings • Responsibility within the family (for child or adult) • Supportive relationship with other adult (for child or adult) • Strong family norms and morality	• Sense of belonging • Positive school climate • Pro-social peer group • Required responsibility and helpfulness • Opportunities for some success and recognition of achievement • School norms against violence	• Involvement with significant other person (partner/ mentor) • Availability of opportunities at critical turning points or major life transitions • Economic security • Good physical health	• Sense of connectedness • Attachment to and networks within the community • Participation in church or other community group • Strong cultural identity and ethnic pride • Access to support services • Community/cultural norms against violence

57 Mental Health and Special Programs Branch 2000, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Health and Aged Care, Canberra, p. 15.

Table 2: Risk factors potentially influencing the development of mental illnesses (particularly children)[58]

Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
• Prenatal brain damage • Prematurity • Birth injury • Low birth weight, birth complications • Physical and intellectual disability • Poor health in infancy • Insecure attachment in infant/child • Low intelligence • Difficult temperament • Chronic illness • Poor social skills • Low self-esteem • Alienation • Impulsivity	• Having a teenage mother • Having a single parent • Absence of father in childhood • Large family size • Antisocial role models in childhood • Family violence and disharmony • Marital discord in parents • Poor supervision and monitoring of child • Low parental involvement in child's activities • Neglect in childhood • Long-term parental unemployment • Criminality in parent • Parental substance misuse • Parental mental illness • Harsh or inconsistent discipline style • Social isolation • Experiencing rejection • Lack of warmth and affection	• Bullying • Peer rejection • Poor attachment to school • Inadequate behaviour management • Deviant peer group • School failure	• Physical, sexual and emotional abuse • School transitions • Divorce and family breakup • Death of a family member • Physical illness/ impairment • Unemployment, homelessness • Incarceration • Poverty/economic insecurity • Unsatisfactory workplace relationships • Workplace accident/injury • Caring for someone with an illness/disability • War or natural disasters	• Socioeconomic disadvantage • Social or cultural discrimination • Isolation • Neighbourhood violence and crime • Population density and housing conditions • Lack of support services including transport, shopping, recreational facilities

58 Ibid, p. 16.

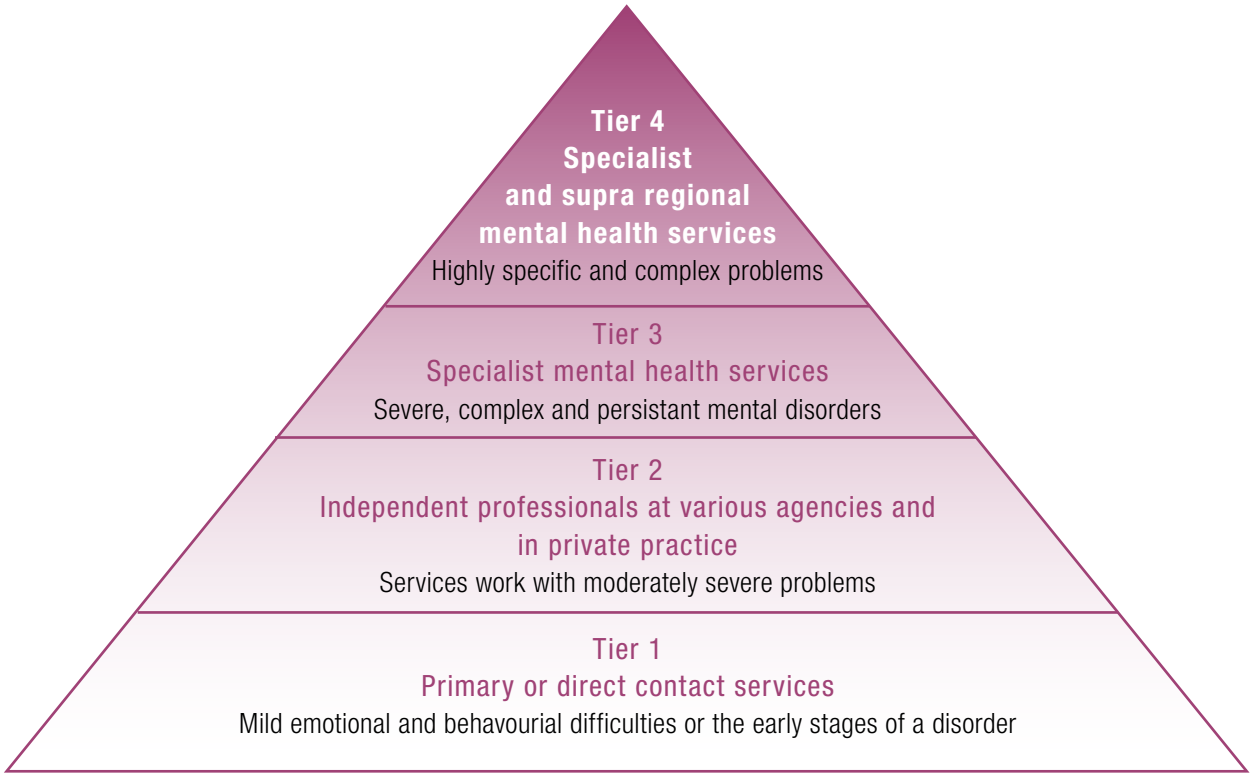
2.4 Mental health services in Western Australia

Mental health services in Western Australia are delivered by a range of public services, non-government agencies and private practitioners.

In Western Australia, services for children and young people with a mental illness are described by the Department of Health and the Mental Health Commission as being delivered in a tiered system (see Figure 2). This structure comprises four tiers and:

> *…recognises that children and young people presenting with mental health problems and disorders will require different types and levels of support… [The four tiers] are not intended as rigid prescriptions of service design but serve to identify the styles and levels of specialisation of work involved in offering comprehensive coordinated mental health services for children and young people.*[59]

Figure 2: The mental health tiered system of care[60] [61]



59 Mental Health Division, Department of Health 2001, Infancy to Young Adulthood: A Mental Health Policy for Western Australia, Government of Western Australia, p. 8.
60 Mental Health Commission 2010, WA Mental Health towards 2020: Consultation Paper, Government of Western Australia, Perth, p. 109.
61 Mental Health Division, Department of Health 2001, Infancy to Young Adulthood: A Mental Health Policy for Western Australia, Government of Western Australia.

A basic overview of the tiered structure and the services within each level, as stated by the Mental Health Commission and the Department of Health,[62] [63] is provided below.

Tier 1 – Primary or direct contact services

These services work with infants, children and adolescents who manifest mild emotional and behavioural difficulties or the early stages of a disorder. These services offer promotion and prevention services and are able to identify when additional support is required. Services at this level are provided by generalist health workers (not mental health specialists) including: general practitioners, youth workers, child care, schools, community child health nurses, community health workers.

Tier 2 – Independent professionals at various agencies and in private practice

These services work with infants, children and adolescents who have moderately severe mental health problems that will need attention by professionals trained in children's mental health. Personnel require skills to identify mental health problems and disorders in children who are presenting with problems and can provide assessment for cases that are not complicated by comorbidity or severe risk factors. Services at this level are provided by professionals including school psychologists, youth justice staff, Child Development Services staff and paediatricians.

Tier 3 – Specialist mental health services

These services work with infants, children and adolescents with more severe, complex and persistent mental disorders. Assessment and treatment are informed by a number of specialist mental health clinicians from complementary professions with different expertise working collaboratively. Infant, Child, Adolescent and Youth Mental Health Services (ICAYMHS[64]) are Tier 3 providers. ICAYMHS offers community-based outpatient care with specialist assessment and treatment for infants, children, adolescents, young people and their families experiencing severe emotional, psychological, behavioural, social, and/or mental health problems. Interventions may include individual, group and family counselling, parental education, psychiatric intervention, referral to an inpatient facility or specialist programs and integration with other agencies.

Tier 4 – Specialist and supra-regional mental health services

Tier 4 services are often provided in particular settings such as inpatient units or specialist outpatient clinics for children who have unusual, very severe, complex or persistent disorders almost always complicated by risk factors. This tier also includes tertiary services that are supra regional as not all regions can expect to offer this level of service. Services include the Bentley Adolescent Unit (BAU), Princess Margaret Hospital (PMH), YouthLink, YouthReach South, Multi-Systemic Therapy.

This tier system presents an approach skewed towards the management of moderate to severe mental health problems and disorders.

The Inquiry considers that the tier system addresses only part of the intervention continuum – the early intervention and treatment stages. As previously described, a comprehensive mental health system requires a focus that commences earlier than at the first sign of a disorder. It must also include promotion of mental health and the prevention of mental illness and must be balanced across all stages of the intervention continuum. Without this balance, the integrity and effectiveness of the mental health system is compromised.

62 Ibid, p. 8.
63 Western Australian Mental Health Commission 2010, WA Mental Health towards 2020: Consultation Paper, Government of Western Australia, Perth, pp. 109-111.
64 ICAYMHS used to be known as the Child and Adolescent Mental Health Service (CAMHS). Many still refer to it using this name so throughout the Inquiry Report CAMHS, CAYMHS or ICAMHS all refer to ICAYMHS.

Figure 3 below illustrates how the age, wellness and intervention continuums should be interwoven to create a comprehensive mental health system for children and young people. The diagram is representational and is in no way inclusive of all services or programs, but is intended to demonstrate how planning can ensure programs and services are provided comprehensively across all continuums.

Interventions for children and young people's mental health should be developed with an understanding of age-related changes (milestones and developmental tasks), risk and protective factors, as well as within a place-based context, recognising the various settings where a child will spend time and therefore where interventions would be most effective.[65]

65 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington DC. pp. 71-72.

Figure 3: Examples of programs and services across the age and intervention continuums

	-9 months to 3 years	4 to 12 years	13+ years
Treatment > Early intervention >	Specialist infant mental health services providing early intervention and treatment services for infants and young children and their families. For example, Joining Together Program, Fremantle ICAYMHS Early intervention at signs of disorder. For example, play therapy through Relationships Australia Identifying developmental delays. For example, Child Development Centres	Community-based emergency response to an acute mental illness. For example, Community Emergency Response Teams and Mental Health Emergency response Line(adults) Coordinated interagency service for children and young people with complex needs. For example, Wraparound Milwaukee and People with Exceptionally Complex Needs (PECN) models Specialist treatment programs. For example, Family Pathways Community-based early intervention and treatment. For example, integrated services on schools sites	Specialist treatment programs. For example, PMH Eating Disorders Program Comprehensive assessment, referral and treatment services for children and young people appearing before the Children's Court. For example, Adolescent Forensic Health Service (Victoria) One-stop shop for coordinated early intervention and treatment services. For example, Orygen Youth Health Clinical Program (Victoria) Early intervention and treatment programs in schools, youth centres. For example, Youth Focus
Prevention > Promotion	Universal child health services. For example, community child health nurses Parenting programs. For example, Hey Dad WA (Ngala) Supported opportunities for social and emotional learning. For example, child care and playgroups Antenatal care. For example, general practitioners	Parenting programs. For example, Triple P Social and emotional skills programs implemented in schools. For example, Aussie Optimism Sport and recreation programs	Online and telephone counselling. For example, ReachOut.com Anti-bullying programs. For example, Solid Kids – Solid Schools – Solid Families Parenting services. For example, Parenting WA Line Sport and recreation programs. For example, Swim for Life
	-9 months to 3 years	4 to 12 years	13+ years

2.5 Agencies involved in mental health

Figure 3 also gives a sense of the range of agencies and sectors involved in the effective delivery of mental health programs and services to children and young people and their families. Child care, schools, general practitioners, the justice system and many others have an important role to play in supporting the mental health of children and young people.

Submissions to the Inquiry made the point that many agencies and factors need to be taken into account in addressing the mental health and wellbeing of children and young people. For example, Ngala submitted that it is wise to consider child development from an 'ecological view', acknowledging that development occurs in the nested contexts of family, school, neighbourhood and the larger culture.[66] [67] Risk and protective factors occur across family, school and community settings, and effective mental health interventions must therefore do the same.

It is clear, then that *'no single agency is in a position to effectively manage these problems and tackle their root causes'.*[68] The mental health of children and young people cannot be managed entirely by the health sector nor be the sole responsibility of treatment services for mental illness.

This was also a conclusion of the *National Mental Health Strategy* published in 2000, which stated:

> *Of major significance for the development of interventions to improve mental health is the realisation that most of the protective and risk factors for mental health lie* outside *the main ambit of mental health services, in socioeconomic and sociocultural conditions. Of equal importance is recognition that effective interventions related to these risk and protective factors have positive outcomes* beyond *the mental health domain.*[69]

The range of agencies, programs and services that have a role to play in mitigating risk factors and strengthening protective factors is broad, as mental health is affected by many different kinds of policies and interventions. Further, the interlinked nature of physical and mental health means that many interventions targeted at other elements of health, such as sport and recreation activities, can have positive impacts on mental health.[70]

Some of the sectors, other than the health sector, with a role in addressing the mental health needs of children and young people are listed in Box 1.

66 Ibid, p. 73.
67 Submission No. 117 from Ngala.
68 Zubrick, S, et al 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, p. 565.
69 Mental Health and Special Programs Branch 2000, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Health and Aged Care, Canberra, p. 17.
70 Lahtinen et al. 1999, cited in World Health Organisation, Victorian Health Promotion Foundation, & University of Melbourne 2005, Promoting mental health; concepts, emerging evidence, practice, WHO Press, Geneva, p. 12.

Box 1: Sectors other than health involved in addressing the mental health needs of children and young people[71]

- the early childhood sector, including child health services, parenting programs, play groups, child care and preschools, child and family services;
- the education sector, including teachers, school psychologists and chaplains;
- sport and recreation services;
- the welfare sector, including welfare and social workers, crisis workers in street-based outreach services;
- the juvenile justice sector, including police, youth workers, the courts and detention/remand centre staff;
- child protection services;
- drug and alcohol services;
- accident and emergency services, including ambulance officers and police;
- community support services, including home help services, recreational program workers, phone help lines;
- volunteer services, including home visiting and parent support programs;
- migrant and refugee services;
- youth services;
- religious organisations, including clergy, youth and outreach workers;
- housing services, including youth housing, shelters, supported accommodation staff;
- cultural programs; and
- local government.[72]

71 Raphael, B 2000, Promoting the Mental Health and Wellbeing of Children and Young People. Discussion Paper: Key Principles and Directions, National Mental Health Working Group, Commonwealth Department of Health and Aged Care, Canberra, p. 43.

72 Submission No. 58 from City of Cockburn, p. 1; Submission No. 33 from Western Australian Local Government Authority, p. 1.

3.1 Children and young people in Western Australia

Children and young people under 18 represent 23.5 per cent of the Western Australian population. The Australian Bureau of Statistics (ABS) estimates that at 30 June 2010 there were 538,963 people aged 0 to 17 years in the State.[73]

Aboriginal children and young people aged 0 to 17 represent 5.7 per cent (or more than 30,000) of all children and young people in Western Australia.[74] Forty-four per cent of the entire Western Australian Aboriginal population is aged under 18 years of age.[75]

Western Australia's population continues to grow faster than that of any other Australian State or Territory, increasing by 2.3 per cent in 2009–10.[76] The number of children and young people in Western Australia aged 0 to 14 years grew in that year by an even faster rate of 2.5 per cent.[77]

Infants and young children

The ABS estimates that in 2010, Western Australia was home to 125,096 children aged 0 to three. They represent approximately 23.2 per cent of the State's population of children and young people.[78]

Over the past decade the number of births per year in Western Australia has steadily increased by 24 per cent and for the past few years the number of babies born in Western Australia has been over 30,000 per year (see Figure 4).[79]

Births to Aboriginal women made up approximately eight per cent of total births in Western Australia in 2009, with the fertility rate for Aboriginal women being higher than that for the total female population of the State.[80] In 2004, an estimated 11 per cent of Aboriginal children in Western Australia were born to mothers aged 17 years or under compared with two per cent of children in the total population.[81]

73 Australian Bureau of Statistics 2010, Population by Age and Sex, Australian States and Territories, June 2010, 'Table 5. Estimated Resident Population by Single Year of Age, Western Australia, datacube: Excel Spreadsheet, cat. no. 3201.0 [website], viewed 10 February 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3201.0Jun/202010/OpenDocument

74 Commissioner for Children and Young People WA calculations based on Australian Bureau of Statistics 2010, National Aboriginal and Torres Strait Islander Social Survey, 2008, 'Tables 3, 5, and 9, datacubes: Excel Spreadsheet, cat. no. 4714.0 [website], viewed 10 February 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02008/OpenDocument

75 Ibid.

76 Australian Bureau of Statistics 2010, Australian Demographic Statistics June 2010, cat 3101.0 [website], viewed 8 February 2011, http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0

77 Australian Bureau of Statistics 2010, Population by Age and Sex, Australian States and Territories, June 2010, cat. 3201.0 [website], viewed 8 February 2011, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3201.0Main+Features1Jun%20 2010?OpenDocument

78 Australian Bureau of Statistics 2010, Population by Age and Sex, Australian States and Territories, Jun 2010, cat 3201.0 [website], viewed 10 March 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3201.0Jun%202010?OpenDocument

79 Australian Bureau of Statistics 2010, Births, Australia, 2009 [website], viewed 8 February 2011, http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/3301.0

80 Australian Bureau of Statistics 2010, WA Statistical Indicators 2010, 'Table 1.5 Births, Summary statistics for Western Australia, datacube: Excel spreadsheet, cat. no. 1367.5 [website], viewed 8 February 2011, http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/861A1F351DF2D978CA2577CF000DF18E/$File/33010do001_2009.xls#TopOfTable_Table_5

81 Department of Health WA 2007, WA Aboriginal Primary Care Action Plan, Western Australia.

Figure 4: Number of births in Western Australia per year since 2000[82]

Children

Children aged between four to 12 years comprise almost 50 per cent of all Western Australian children and young people under 18 years.[83] From 2006 to 2010 the estimated population of this age group increased by more than five per cent.[84]

Adolescents

Young people aged 13 to 17 years constitute 35 per cent of all children and young people less than 18 years of age in Western Australia. For Aboriginal young people the equivalent figure is 32 per cent of the total Aboriginal 0 to 17 year population.[85]

3.2 Service demand

The rise in the number of births and the steadily growing population has brought with it an increasing demand for services for children and young people in Western Australia. Many submissions to the Inquiry made the point that without additional funding, many mental health programs and services have become stretched and neglected, with stringent eligibility criteria in place to keep demand manageable – thereby excluding many children and young people in need of assistance.[86] This has been particularly evident for the Infant, Child, Adolescent and Youth Mental Health Service (ICAYMHS), an issue which is described in more detail throughout the Report.

Planning for mental health programs and services – across the intervention continuum – must take into account Western Australia's population growth.

82 The figure for 2010 is the figure provided by the Registry of Births, Deaths and Marriages WA. All other figures are based on: Australian Bureau of Statistics 2009, Births, Australia, Table 1: Births, Summary, States and territories—1999 to 2009', datacube: Excel Spreadsheet, cat. no. 3301.0 [website], viewed 8 February 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3301.0 2009?OpenDocument

83 Australian Bureau of Statistics 2010, Population by Age and Sex, Australian States & Territories, cat. No. 3201.0, Table 5, Estimated Resident Population by Single Year of Age, Western Australia [website], viewed 8 February, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3201.0Jun%202010?OpenDocument

84 Ibid.

85 Australian Bureau of Statistics 2006, Census of Population and Housing, Cat. No. 2068.0: Age by Indigenous Status by Sex; and Australian Bureau of Statistics 2006 Census of Population and Housing Cat. No. 2068.0, Age (Full Classification List) by Sex – Place of Usual Residence [website], viewed 8 February, http://www.abs.gov.au/websitedbs/d3310114.nsf/89a5f3d8684682b6ca256de4002c809b/074b029ae7f4f3c7ca25721300145003!OpenDocument

86 Submission No. 20 from Catholic Education Office; Submission No. 23 from Western Australian Secondary School Executives Association; Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch (Submission No. 9, 12, 15, 31, 35, 39, 64, 65, 67, 75, 91, 93, 94, 98, 109, 126, 138 also referenced).

3.3 Prevalence of mental health problems among children and young people

Recently, and particularly since the appointment of Professor Patrick McGorry[87] as Australian of the Year (2010), there has been increased publicity about the prevalence of mental illness among young people. Professor McGorry has emphasised the under-diagnosis and under-treatment of young people who are dealing with mental health problems and disorders, and made the comment that there has been a tendency to overlook issues as just 'part of growing up'.[88]

Additionally, several Australian studies conducted over the past decade have provided evidence of the prevalence of mental health issues, not just in young people but also in infants and children. Major findings from these studies are listed below. However, these studies have not resulted in adequate policy and resourcing responses.

Certain groups of children and young people, such as children in care, children in juvenile detention and children of parents with a mental illness have higher rates of mental health problems, or are at higher risk of experiencing mental health problems.[89] Information about these particularly vulnerable children and young people is highlighted in Chapter 5 and throughout the Report.

Prevalence: Australia

- In 2007, the Australian Institute of Health and Welfare reported that, of the total burden of disease and injury experienced by children and young people aged 0 to 14 years, 23 per cent was due to mental disorders – the largest burden of disease for this age group.[90]

- The most recent population survey conducted in Australia found that 14 per cent of children and adolescents aged four to 17 years have mental health problems.[91] [92]

- Access Economics reports almost a quarter (24.3 per cent) of Australian young people aged 12 to 25 years have anxiety, affective or substance use disorders and a variety of other mental illnesses.[93]

- The *National Survey of Mental Health and Wellbeing 2007* found that more than one in four young people aged 16 to 24 years experienced a mental disorder in the previous 12 months. This is a higher prevalence than in any other age group.[94]

- The Australian Research Alliance for Children and Youth's *2008 Report Card* ranked Australian young people (aged 15 to 24 years) 13th out of 23 Organisation for Economic Co-operation and Development countries, and Aboriginal young people 23rd of 24 countries in the area of mental health.[95]

87 Professor McGorry is an internationally renowned expert in adolescent mental health, Executive Director of Orygen Youth Health (OYH) and a founding board member of headspace, the National Youth Mental Health Foundation.
88 Australian Broadcasting Corporation 2010, Interview with Professor Patrick McGorry, ABC Sunday Profile [website], viewed 15 October 2010, http://www.abc.net.au/sundayprofile/stories/2800855.htm
89 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioural Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington DC, p. 236.
90 Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L, Lopez, AD 2007, The burden of disease and injury in Australia 2003, PHE 82. Australian Institute of Health and Welfare, Canberra, p. 48, viewed, 28 February 2011, http://www.aihw.gov.au/publications/hwe/bodaiia03/bodaiia03.pdf
91 Sawyer, M, et al. 2000, Mental Health of Young People in Australia: Child and Adolescent Component of the National Survey of Mental Health and Well-Being, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. xi-xii.
92 In this report, children and adolescents were considered to have a mental health problem if the number of emotional and behavioural problems they were experiencing was in the range typically reported for children and adolescents attending mental health clinics.
93 Access Economics Pty Ltd. 2009, The economic impact of youth mental illness and the cost effectiveness of early intervention, p. 11.
94 Slade, T, et al. 2009, The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing, Department of Health and Ageing, Canberra, p. xii.
95 Australian Research Alliance for Children and Youth 2008, The Wellbeing of Young Australians: Report Card, Canberra, p. 4.

- Across the country, children and young people are concerned about mental health issues. In its 2010 national youth survey, Mission Australia identified that just over 20 per cent of 11 to 14 year olds were concerned about coping with stress, as were 32 per cent of 15 to 19 year olds.[96]

Prevalence: Western Australia

- The most comprehensive research on the mental health and wellbeing of the half a million young citizens in Western Australia is the Telethon Institute for Child Health Research's *Western Australian Child Health Survey* in 1995 and the *Western Australian Aboriginal Child Health Survey* in 2005. These surveys found that more than one in six children aged four to 17 years had a mental health problem[97] and 24 per cent of Aboriginal children aged four to 17 years were at high risk of clinically significant emotional or behavioural difficulties.[98]

- Other Western Australian data has been obtained from the Raine Study[99] which, in 2008, reported that 11.5 per cent of children aged two years and 20 per cent of children aged five years had clinically significant behavioural problems, with more than six per cent of the children having clinically significant mental health problems at both ages.[100]

- The 2009 results of the Department of Health's annual health and wellbeing survey found that 8.5 per cent of parents with children aged one to four years, 29.5 per cent with children aged five to nine years and 28.7 per cent with children aged 10 to 15 years believed their child needed special help for emotional or behavioural challenges.[101]

- In 2009 the Commissioner for Children and Young People commissioned a research project to ask a broad range of children and young people across Western Australia about their views on what is important to their wellbeing. Almost 1,000 children and young people participated. More than one-third of the children responding to the online survey agreed with the statement "I have too much stress or worry in my life".[102]

- Since 2005, there has been a steady increase in the proportion of children and young people presenting to Kids Helpline counsellors with a mental health issue.[103] In 2005, only 27 per cent of Western Australia counselling contacts involved a mental health issue whereas in 2009 this figure rose to 53.1 per cent, almost double the rate of five years ago and proportionally 18 per cent higher than the rest of Australia.[104]

96 Mission Australia 2010, National Survey of Young Australians 2010: key and emerging issues, Mission Australia, p. 12.
97 Zubrick, S, et al 1995, Western Australian Child Health Survey: Developing Health and Well-being in the Nineties, Australian Bureau of Statistics and the Institute for Child Health Research, Perth, p. 35.
98 Zubrick, S, et al 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, p. 25.
99 The Western Australian Pregnancy Cohort (Raine) Study is a longitudinal study that began in 1989 and has allowed research to be conducted in a number of areas including mental health.
100 Robinson, et al, 'Pre- and postnatal influences on preschool mental health: a large-scale cohort study', The Journal of Child Psychology and Psychiatry, 2008, 49 (10), pp. 1118-28.
101 Daly, A, & Joyce, S 2010, The Health and Wellbeing of Children in Western Australia in 2009, Overview and Trends, Department of Health, Western Australia, p. 47.
102 Commissioner for Children and Young People 2010, Speaking out about wellbeing, Western Australia, p. 22.
103 Kids Helpline uses a broad definition of mental health, incorporating: A mental illness or symptoms of mental illness; emotional distress or concern about how they respond to others and situations; continued disordered eating behaviours such as symptoms of anorexia or bulimia; habitual or problematic use of drugs and/or alcohol; experiencing suicidal thoughts; engaging in self-injurious behaviours (without suicidal intent). Kids Helpline 2009, Kids Helpline 2009 Overview, p. 23. [website], viewed, 1 March 2011,http://www.kidshelp.com.au/upload/22862.pdf
104 Submission No. 82 from BoysTown, p. 6.

3.4 Expenditure on mental health in Western Australia

3.4.1 The cost of mental health problems

In its report, *The economic impact of youth mental illness and the cost effectiveness of early intervention*, Access Economics reported that Australia faces *'substantial costs arising from mental illness in young people'*. It found that, in 2009, the national financial cost of mental illness in people aged 12 to 25 years was $10.6 billion with the value of lost wellbeing (disability and premature death) costing a further $20.5 billion.[105] These figures highlight the economic impact of mental illness.

The Inquiry was unable to source a published figure for the costs of mental illness for those less than 18 years of age in Western Australia.

The full costs of mental illness in children and young people extends far beyond the clinical costs of specialist mental health services. It includes, for example, the emotional and psychological costs to the individual, as well as to their family, friends and carers. It also includes the cost to schools, the general health system, the drug and alcohol sector and the child protection and juvenile justice systems. Finally, and where childhood mental illness extends into adulthood, the total cost includes the loss of productive capacity and the cost to the social security system.[106] [107]

Any economic modelling that looks purely at the cost of providing services for diagnosed mental illness, and does not take into account the other contexts where the costs of mental health problems are substantial, will most certainly be markedly lower than the actual cost.

3.4.2 The cost benefits of early intervention

A recent study published by the RAND Corporation has linked the absence of intervention in mental health problems and disorders in children and young people with ongoing costs to society through aspects such as lost productivity and welfare payments. It also concludes the converse is true, with effective mental health treatments proving cost effective in the longer term:

> *… [R]esearch indicates that effective treatments targeted at children that lower the risk of experiencing these psychological conditions or that mitigate their adult psychological and economic consequences are likely to have long lasting payoffs and to be very cost effective. Treating children effectively will also benefit their parents, siblings, classmates and neighbours.*[108]

What is known is the proven economic advantage of early intervention – early in the life course as well as in the course of illness. Early intervention in both contexts results in financial savings and social benefits later on. Obviously, prevention of mental illness is one of the most effective ways to reduce the burden.[109] [110]

105 Access Economics Pty Ltd 2009, The economic impact of youth mental illness and the cost effectiveness of early intervention, p. ii.
106 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioural Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., p. 17.
107 Australian Research Alliance for Children and Youth 2006, The impact of drug and alcohol misuse on children and families, Edith Cowan University, Western Australia, p. 16.
108 Smith, JP, Smith, GC 2010, Long term economic costs of psychological problems during childhood, Social Science & Medicine Vol 71, No 1, p. 110-115. Cited in Rand Labour and Population Fact Sheet, What are the long term economic costs of psychological problems during childhood?
109 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options – summary report, World Health Organisation, Geneva, p. 3.
110 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional and Behavioural Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academic Press, Washington D.C., p. 260.

> *On any reckoning the costs of mental ill-health – and hence the potential benefits of prevention – are extremely high partly because of the widespread occurrence, partly because of its typically early manifestation and persistence throughout the life span and partly because of the multi-dimensional nature of its consequences.*[111]

The World Health Organisation (WHO) describes prevention of mental illness as a 'public health priority' and outlines the significant progress in prevention research which has changed scepticism about the possibility of preventing mental disorders:

> *Scientific knowledge has increased about the role of malleable risk and protective factors in the development of mental and behavioural disorders across the lifespan. Many studies have shown that preventive interventions can be successful in reducing risk factors and strengthening protective factors, and are beginning to show reductions in the onset and recurrence of serious mental health problems and mental disorders in populations at risk.*[112]

Cost benefits of intervening early in the life course

Investing in early childhood development makes sound financial sense. From a purely economic perspective, investment in very young children – across health, care and education – saves money in the longer term. A large body of evidence shows that social policies that intervene in the early years have a very high rate of return, higher than social policies which intervene at later ages in the life course.[113]

> *When we do not make wise investments in the earliest years, we will all pay the considerable costs of greater numbers of school-aged children who need special education and more adults who are under-employable, unemployable, or incarcerated.*[114]

Professor James Heckman, Nobel Laureate of Economic Sciences, has been a vocal advocate of investing in young children, arguing that:

> *The returns to human capital investments are greatest for the young for two reasons: (a) skill begets skill and (b) younger persons have a longer horizon over which to recoup the fruits of their investments… At current levels of investment, cost-effective returns are highest for the young.*[115]

Box 2: Savings from early intervention

The Western Australian Education and Health Standing Committee found that adequate child health services in the community would avoid a substantial number of hospital admissions (for children and adults) that could be costing the State's health service up to $60.6 million per year.[116]

111 Friedli, L, Parsonage, M 2007, Mental Health Promotion: Building an Economic Case, Northern Ireland Association for Mental Health, p. 5.

112 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options – summary report, World Health Organisation, Geneva, pp. 14, 19.

113 Heckman, JJ 2000, Invest in the very young, Ounce of Prevention Fund and the University of Chicago Harris School of Public Policy Studies, Chicago, p. 5. [website] viewed 1 March 2011, http://www.ounceofprevention.org/includes/tiny_mce/plugins/filemanager/files/Heckman%20Invest%20in%20the%20Very%20Young%20Final%20PDF.pdf

114 National Scientific Council, Center on the Developing Child at Harvard University 2007, The Science of Early Childhood development: Closing the gap on what we know and what we do, p. 3. [website] viewed 1 March 2011, http://www.developingchild.net

115 Heckman, JJ 2000, Invest in the very young, Ounce of Prevention Fund and the University of Chicago Harris School of Public Policy Studies, Chicago, p. 5. [website] viewed, 1 March 2011, http://www.ounceofprevention.org/includes/tiny_mce/plugins/filemanager/files/Heckman%20Invest%20in%20the%20Very%20Young%20Final%20PDF.pdf.

116 Education and Health Standing Committee, 2010, Invest now or pay later: Securing the future of Western Australia's children, Legislative Assembly, Western Australian Parliament, Perth, p. xii.

The WHO concurs that there is ample evidence proving early intervention programs are a powerful prevention strategy – the most successful being those which address risk and protective factors early in life and are targeted at child populations at risk, especially from families with low income and education levels.[117]

The WHO cites programs such as home-based interventions during pregnancy and infancy, parenting and preschool programs as among those that are the most successful.[118]

Cost benefits of intervening early in the course of illness

In addition to early interventions in the lifespan to counteract risk factors and strengthen protective factors, there is increasing evidence for early intervention in the course of illness in order to reduce incidence, prevalence and recurrence of symptoms.[119]

The Inquiry acknowledges an increased commitment for investment in early intervention in psychosis at a national level, with the additional Commonwealth budget for *'expanding the successful Early Psychosis Prevention and Intervention Centre model beyond Victoria'*.[120]

Additionally, the Inquiry notes the Western Australian Minister for Mental Health's focus on *'targeting early intervention with some of our young people from the age of 15 to 24 who are most vulnerable to early onset psychosis'*.[121]

While this additional investment and focus on early intervention in psychosis is welcome, much more is needed to overcome an historical under-allocation of resources addressing the broader mental health needs (along the full intervention continuum) of all children and young people. The recent increases in funding have largely been directed at the adolescent and young adult age group and the needs of younger children remain relatively ignored.

Currently, many children and young people have to wait until symptoms are severe before they are able to access services – a situation that is not only counter-intuitive, but also contrary to the evidence on achieving optimum outcomes.

This point was summarised powerfully by a young woman in a consultation for the Inquiry:

> *"Telling someone who has an eating disorder [ED] that they have not yet lost enough weight to be seen by an ED clinic is BAAAAAAAD!" (Female, 18)*[122]

The Inquiry recognises there is increased competition for resources within the health care sector and that it is challenging for prevention and early intervention strategies to be prioritised over specialist treatment services.

However, there is a need for an increased focus on prevention in order to curb the ever-increasing costs of treating acute mental illness. This requires efforts and leadership from across a wide range of government agencies, not

117 Brown & Sturgeon, cited in World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options – summary report, World Health Organisation, Geneva, p. 28.

118 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options – summary report, World Health Organisation, Geneva, p. 28.

119 Mrazek & Haggerty, 1994. cited in World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options – summary report, World Health Organisation, Geneva, pp. 17-18.

120 Australian Government 2010, Australian Government 2009-2010 Health and Ageing Portfolio Budget Statements, Outcome 11 Mental Health, Australian Government, Canberra, p. 316. [website], viewed 1 March, http://www.health.gov.au/internet/budget/publishing.nsf/Content/2010-11_Health_PBS_sup2/$File/Outcome%2011%20-%20Mental%20Health.pdf

121 Morton, H 2011, The next step towards mental health reform, Ministerial Media Statements, [website] viewed 1 March 2011, http://www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=136261&

122 Submission No. 114 from WA AIDS Council's Freedom Centre, p. 12.

just the health or mental health system, to maximise mental health promotion, prevention and early intervention opportunities and reduce the financial burden of mental illness in Western Australia.

3.4.3 Mental health expenditure in Western Australia

In 2007–08, child and adolescent mental health services in Western Australia received 11 per cent of the total expenditure on publicly funded, specialised mental health services. Preliminary estimates for 2009–10 indicate this percentage was the same (11 per cent, or $45.8 million).[123]

The Mental Health Commission (MHC), in providing the Inquiry with these figures, stated that:

> *…the data needs to be assessed in consideration of the geography of Western Australia and the impact of this on the cost of service delivery in rural and remote areas. Even if Western Australia increased its proportion to the 14% expended by Victoria, the Mental Health Commission believes that this would still be insufficient to meet all service gaps. Additionally, the child and adolescent population (0-17 years) in Western Australia is 23% of the total population.*[124]

The MHC's consultation paper *WA Mental Health Towards 2020: Consultation Paper*, released in 2010, found this insufficient funding is resulting in an inability for child and adolescent mental health services to meet the needs of their client group:

> *Consultations revealed that child and adolescent mental health services were unable to meet the needs of their target population. For example there were very long waiting lists (in some areas 6-8 months for non-urgent referrals and several months for priority referrals). There was also limited staff to undertake early intervention, adopt speciality programs or develop collaborative relationships with key areas. Regional areas were also signalled as being significantly underresourced…*[125]

In 2010, the Children's Mental Health Coalition (the Coalition) – comprising the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society Ltd, National Investment for the Early Years, the Australian Infant, Child, Adolescent and Family Mental Health Association, Australian Affiliate of the World Association for Infant Mental Health, and the Australian Child and Adolescent Trauma, Loss and Grief Network – launched a blueprint for children's mental health services in Australia.

The blueprint argues that funding for mental health should be reflective of the burden of disease attributable to mental health. The Coalition proposes that 15 per cent of the total mental health budget should be directed to children's services (aged 0 to 12 years).[126]

The Inquiry considers this to be a conservative proposal, given that 23 per cent of the burden of disease and injury experienced by children and young people aged 0 to 14 years was due to mental disorders.[127]

The Inquiry made several attempts to source more specific expenditure figures for children and young people's mental health services and programs in Western Australia. Ultimately, it was unsuccessful in collating a full and comprehensive picture of expenditure as the data was either not collected, not available and/or not applicable to the 0 to 18 years age range (many datasets applied to the 16 to 24 age group).

123 Information provided to the Commissioner for Children and Young People from the Mental Health Commission, 2 March 2011.
124 Ibid.
125 Mental Health Commission, 2010, WA Mental Health Towards 2020: Consultation Paper, p. 111.
126 The Children's Mental Health Coalition 2010, Our Children, Our Future [website], viewed 1 March 2011, http://www.ranzcp.org/images/stories/ranzcp-attachments/Home/Our_children_our_future_final.pdf
127 Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L, Lopez, AD 2007, The burden of disease and injury in Australia 2003, PHE 82. Australian Institute of Health and Welfare, Canberra, p. 48 [website], viewed, 28 February 2011, http://www.aihw.gov.au/publications/hwe/bodaiia03/bodaiia03.pdf

However, the Inquiry was able to determine the following specific issues regarding funding:

- Clinical mental health services for children and young people in Western Australia are under-funded and under-resourced. The 2007 Review of the Child and Adolescent Mental Health Services (CAMHS) in Western Australia found *'the failure to resource CAMHS adequately means that the staffing of individual CAMHS clinics is usually too sparse for the tasks that they are expected to address.'*[128]
- Since the 2007 Review there has been no significant investment to ICAYMHS. It is therefore likely the Review's findings remain current and applicable.
- The ICAYMHS Executive Group estimates that ICAYMHS is currently only funded adequately to provide a service to one per cent of the population of children and young people, although five per cent require its expertise (for treatment of mental health disorders).[129]

128 Nurcombe, B 2007, A Review of Child and Adolescent Mental Health Services in Western Australia, [unpublished], p. 22.
129 Infant Child and Youth Mental Health Executive Group 2009, New Strategic Directions for Child and Adolescent Mental Health Services 2010-2020 [unpublished].

4.1 Introduction

There are several recent significant structural reforms and policy changes in Western Australia that have the potential for a positive impact on the delivery of mental health services.

This chapter outlines and explores some of the key opportunities arising, at both Commonwealth and State level, for improving the mental health and wellbeing of all Western Australian children and young people. It also identifies some of the critical areas for action that require priority status.

4.2 National reform agenda

The National Advisory Council on Mental Health (NACMH) was established by the Commonwealth Government in June 2008. The NACMH provides a formal mechanism for the Australian Government to gain independent advice from a group of experts to inform national mental health reform.

In November 2009 the NACMH published a discussion paper *A Mentally Healthy Future for all Australians*.[130] The discussion paper highlighted the importance of a mentally healthy Australia to the sustainability of the nation. It welcomed the National Health and Hospital Reform Commission's Final Report *A Healthier Future for All Australians,*[131] which identified mental health reform, Aboriginal health and dental health as areas requiring urgent action.

The NACMH noted:

> *Our governments' investment in mental health need to evolve significantly beyond the dominant focus on acute and sub-acute health care to include a more balanced emphasis on community care, a clear focus on managing the risk factors that can give rise to mental illness and a strengthening of the protective factors that prevent mental illness and promote mental health.*[132]

At present, the guiding strategy applicable for the planning and delivery of mental health services is the *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–2014* (the National Plan).[133]

The National Plan includes a series of outcomes and actions which have been agreed to by all governments and encompass areas of Commonwealth and State/Territory areas of responsibility.

Although the National Plan includes several action areas that relate to children and young people, it does not address the needs of children and young people in a comprehensive way, across the intervention continuum.

As the NACMH found, early intervention, treatment and follow up for children and young people must be a priority.[134]

In the Council of Australian Government's (COAG) communiqué of 13 February 2011, Heads of Government signed up to further reforms in mental health over the next three years.[135] In response, the Mental Health Council of Australia has indicated that a substantial investment, similar to the $20 billion COAG Health Agreement, is required in mental health.[136]

130 National Advisory Council on Mental Health 2009, A Mentally Healthy Future for all Australians: A Discussion Paper, Canberra.
131 National Health and Hospital Reform Commission 2009, A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission, ACT.
132 National Advisory Council on Mental Health 2009, A Mentally Healthy Future for all Australians: A Discussion Paper, Canberra, p. 4.
133 Commonwealth of Australia 2009, Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014, ACT.
134 National Advisory Council on Mental Health 2009, A Mentally Healthy Future for all Australians: A Discussion Paper, Canberra, p. 17.
135 Council of Australian Governments 2011, Communique Attachment A - Heads of Agreement – National Health Reform [website], viewed 28 February, http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/docs/communique_attachmentA-heads_of_agreement-national_health_reform_signatures.pdf, p. 10.
136 The Mental Health Council of Australia 2011, COAG paves way for mental health reform, Media Release, ACT [website], viewed 2 March 2011, http://www.mhca.org.au/MediaReleases/2011/CoAG%20paves%20way%20for%20reform.pdf

The Inquiry notes and supports the recent COAG commitment to reform in mental health. Given that children and young people have not been afforded sufficient priority by the Commonwealth Government there is an urgent need for reform both in terms of investment and focus.

What is required is a comprehensive mental health and wellbeing strategy for children and young people specifically. Children and young people need to be a priority group in future planning across mental health promotion, prevention, early intervention and treatment programs and services.

Recommendation 1: The Council of Australian Governments' mental health reform make children and young people a priority group and include planning for mental health promotion and prevention, early intervention and treatment services and programs.

Recommendation 2: The Commonwealth and State Governments work collaboratively to ensure the mental health and wellbeing of children and young people are addressed.

4.3 State reform agenda

4.3.1 Economic Audit Committee

In October 2008, the Western Australian Government announced the *'establishment of an economic audit group to conduct a wide-ranging review of the operational and financial performance of the Western Australian public sector'.*[137]

In October 2009, the Economic Audit Committee (EAC) released its report *Putting the Public First: Partnering with the Community and Business to Deliver Outcomes*[138] which set out a reform agenda directed toward achieving the vision of a more collaborative and innovative public sector. The EAC report identified key strategies for improving outcomes for all Western Australians. The ambition of the EAC is summed up in the following comment:

> *Above all, in five to ten years the Western Australian public sector will achieve outcomes for Western Australians, including for the most disadvantaged, that are among the best in the nation and are continually improving. This report provides a road map for the public sector and the Government to drive to this destination.*[139]

In addition to outlining far reaching reform across the public sector, the EAC report identified mental health in particular as an area where reform could achieve better outcomes for the people of Western Australia. The Government has stated that the establishment of the Mental Health Commission (MHC) is a key step in implementing the EAC's reform agenda.[140]

This outcome from the EAC report provides a unique opportunity to reform not only the mental health sector in Western Australia but to influence the involvement of other agencies that impact on the mental health and wellbeing of the State's 500,000 youngest citizens.

Implementation of the EAC reform agenda has the potential to position Western Australia to become a leader in the nation in terms of its focus on improving the mental health and wellbeing of children and young people.

137 Department of Treasury and Finance [website], viewed 2 March 2011, http://www.dtf.wa.gov.au/cms/content.aspx?id=2163
138 Economic Audit Committee 2009, Putting the Public First - Partnering with the Community and Business to Deliver Outcomes, Department of Premier and Cabinet, Government of Western Australia.
139 Ibid, p. ii.
140 Barnett, C & Jacobs, G 2010, Mental health services revolutionised with Australia-first initiative, Ministerial Media Statements [website], viewed 4 February 2011, http://www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=133084&minister=Barnett&admin=Barnett&page=2

4.3.2 Collaboration and integration

An important finding of the EAC pertaining to mental health is the call for improved outcomes for citizens through effective collaboration, across government agencies as well as with other sectors:

> *The need for collaboration is not restricted to interagency collaboration. CEOs should ensure that collaborative approaches are used to break down silos within agencies as well as between agencies, and their partners in the community and private sectors.*[141]

The findings of this Inquiry concur with the EAC on this point. Several submissions to this Inquiry raised the importance of collaboration in the delivery of mental health programs and services for children and young people.[142]

> *It would be good to see better collaboration between the government sector and non-government sector. As was mentioned earlier the community sector is able to build solid relationships with young people, this should be embraced, build on these foundations… This relationship is often formed through the worker helping the young person in a number of practical ways that in most cases counsellors/psychologists are not able to do.*[143]

Other submissions noted that the practice is less forthcoming than the theory:

> *The notion of 'joined-up' services has been discussed for a long time but progress appears to have been limited…*[144]

The submission from Children's Court Magistrates Potter and Horrigan, noting they frequently deal with children who are suffering from mental illness, stated:

> *It is our view that there should be a coordinated, holistic support provided to families in all regions of Western Australia, at the earliest possible stage. This is not occurring.*[145]

A large body of evidence to the Inquiry was received regarding the lack of a coordinated response to the mental health and wellbeing of children and young people. This was particularly so for those who have complex needs – effective, coordinated services are almost non-existent for this group. These children and young people would greatly benefit from the EAC's commitment that *'collaboration will be a standard approach to problem solving'*[146] and its view that the public sector needs to *'have the flexibility to respond to the complex and changing needs of citizens'*.[147]

The Inquiry considered best practice examples of collaboration in Western Australia and other jurisdictions. One example is the People with Exceptionally Complex Needs (PECN) model. The PECN model in WA involves senior officers from seven public sector agencies working together on an Interagency Executive Committee in order to manage adults (over 18 years) who are identified as having complex needs and are known to multiple agencies.[148] PECN has been evaluated and shown to deliver positive outcomes.

141 Economic Audit Committee 2009, Putting the Public First – Partnering with the Community and Business to Deliver Outcomes, Department of Premier and Cabinet, Government of Western Australia, p. 37.
142 Submission No. 20 from Catholic Education Office; Submission No. 35 from Discover Me Occupational Therapy (Submission No. 55, 57, 68, 83, 100, and 133 also referenced).
143 Submission No. 70 from Swan and Surrounding Suburbs Youth Network, p. 4.
144 Submission No. 20 from Catholic Education Office, pp. 2-3.
145 Submission No. 29 from Children's Court of Western Australia, p. 1.
146 Economic Audit Committee 2009, Putting the Public First – Partnering with the Community and Business to Deliver Outcomes, Department of Premier and Cabinet, Government of Western Australia, p. i.
147 Ibid, p. 4.
148 Submission No. 141 from Mental Health Commission, p. 71.

A similar model for children and young people operates in Milwaukee: the Wraparound Milwaukee project (see Box 3).

Box 3: Wraparound Milwaukee

Wraparound Milwaukee is a unique type of managed care program operated by the Milwaukee County Behavioural Health Division that is designed to provide comprehensive, individualised and cost-effective care to children with complex mental health and emotional needs.

Wraparound Milwaukee services families who have a child who has serious emotional or mental health needs, who is referred through the Child Welfare or Juvenile Justice System and is at immediate risk of placement in a residential treatment centre, juvenile facility or psychiatric hospital.

Wraparound Milwaukee contracts with nine community agencies for the approximately 72 care coordinators who facilitate the delivery of services and other supports to families using a strength-based, highly individualised wraparound approach.

Wraparound Milwaukee has also organised an extensive provider network of 204 agency and individual providers that can offer an array of over 80 services to families. A Wraparound Milwaukee operated Mobile Urgent Treatment Team ensures families have access to crisis intervention services.[149]

In Western Australia there is currently no service similar to either the PECN model or Wraparound Milwaukee for children and young people with complex needs, yet the Inquiry found the need is urgent.

Children and young people with complex needs may have a mental health problem or disorder and/or be in contact with the criminal justice system and child protection (and others), and yet there is currently little to no across-agency collaboration to governance, resources or outcomes for the individual child.

The Inquiry therefore recommends a model of collaboration be implemented in order to provide a system of care for children and young people who have complex needs.

Recommendation 3: A new collaborative service to address the needs of children and young people who have complex needs be established as a demonstration project. The development of this service should consider the models of Wraparound Milwaukee and the People with Exceptionally Complex Needs.

4.3.3 Community hubs

The importance of collaboration for effective service delivery does not only apply to complex situations. The EAC recognised that a key element of improving services for citizens more broadly involves breaking down government 'silos' and improving partnerships with other sectors:

> *To achieve [improved collaboration], the public sector will need to function collaboratively to deliver across organisational (i.e. break down the silos within government) and sectoral boundaries (i.e. partner with local government, community sector service providers and the private sector).*[150]

149 Wraparound Milwaukee [website], viewed 2 March 2011, http://county.milwaukee.gov/WraparoundMilwaukee.htm
150 Economic Audit Committee 2009, Putting the Public First - Partnering with the Community and Business to Deliver Outcomes, Department of Premier and Cabinet, Government of Western Australia, p. 6.

The EAC identified 'community hubs' incorporating co-location, information sharing and shared corporate services as a way to achieve the goal of establishing and servicing citizens' priority needs.[151] The report found:

> *Community hubs can offer citizens seamless support, based on the simple but fundamental principle that there should be 'no wrong door' for a person in their search for support or accessing services provided by government. This involves place-based collaboration between human service providers at all levels of government and across the community sector. The concept holds the greatest potential for those with multiple service needs.*[152]

This model was supported by submissions to the Inquiry. Relationships Australia, for example, wrote that it had achieved success from developing integrated services:

> *It is our experience that integrated service models work well in the community. By collaborating with other organisations we can provide a holistic service that is resource efficient, is seamless for the client and responsive to identified needs.*[153]

On 15 December 2010 the Western Australian Premier, Hon Colin Barnett MLA, announced that schools would be receiving increases in resources to enable them to become one-stop-shops for a range of early childhood services including child care, playgroups, kindergarten for three-year-olds, child health services, health services for young mothers and parenting services.[154]

In his opening statement to Parliament on 15 February 2011 the Premier outlined the Government's commitment to this important initiative:

> *Early intervention to ensure that children start school healthy and ready and able to learn is not just an option; it is a moral imperative.*[155]

The benefits of early childhood 'hubs' on school sites have already been demonstrated in several schools in Western Australia.[156] With appropriate planning and by using best practice processes,[157] hubs can provide a range of benefits and opportunities for children and their families.

> *[The Association of Independent Schools of Western Australia] would like to see the State Government focus on providing centres that offer holistic support for families from pre-birth to school-age, where families can access one centre for various services such as psychology, paediatric, occupational therapy, speech therapy etc.*[158]

The Inquiry notes that co-location on school sites is just one model and others could include location with family centres, community houses and neighbourhood centres.

Recommendation 4: Integrated early childhood services on school sites be implemented as soon as possible. This must include those services that provide mental health promotion, prevention, early intervention and treatment programs.

151 Ibid, p. 61.
152 Economic Audit Committee 2009, Putting the Public First: Partnering with the Community and Business to Deliver Outcomes, Summary Report, Department of Premier and Cabinet, Government of Western Australia.
153 Submission No. 104 from Relationships Australia, p. 2.
154 Harvey, B 2010, 'Children the winners in State's mining boom', The West Australian, Wednesday 15 December, p. 1.
155 Hon Colin Barnett, Premier, Legislative Assembly, Tuesday 15 February 2011, Hansard – Daily Transcript, p. 161.
156 For example at Challis Primary School and Balga Primary School – see Economic Audit Committee 2009, Putting the Public First - Partnering with the Community and Business to Deliver Outcomes, Department of Premier and Cabinet, Government of Western Australia, p. 60.
157 Department of Education and Early Childhood Development 2008, Evaluation of Victorian children's centre: Literature review, Victoria, Melbourne, p. 60.
158 Submission No. 118 from Association of Independent Schools of Western Australia, p. 3.

4.3.4 Government and non-government funding and contractual arrangements

The EAC report identified the need for improved and genuine partnerships between the public service and the community organisation sector[159] in the delivery of human services. This requires the public service to move away from direct service provision and increasingly act as a facilitator of services.[160] There was recognition that, to enable this, changes must occur in the contractual and financial arrangements for the outsourcing of services by the community sector:

> *The outsourced delivery of human services by community organisations must be freed from unnecessarily prescriptive processes and controls, and the burden of multi-layered reporting obligations. With less emphasis on contractual compliance and more prudent risk management, social innovation can flourish.*[161]

The findings of this Inquiry concur with those of the EAC. Several submissions to this Inquiry identified the challenges of establishing and maintaining successful programs on short-term contracts or pilot funding.[162]

Non-government organisations (NGOs) reported they were hindered by having to spend disproportionate amounts of time on funding applications rather than program development, and described the challenges faced by non-recurrent funding.[163]

> *The obvious constraint that non-recurrent funding creates is the precarious position this places on ongoing service delivery. However, the lack of continuous funding sources also constrains capacities to expand or replicate services and programs that have been demonstrated to be effective. In addition, the opportunity to convert successful pilot programs into ongoing viable and larger scale services is dependent on the availability of significant government funding.*[164]

Some NGOs also noted the current funding arrangements create competition rather than collaboration (for example, through no linkage between State and Commonwealth funded programs).[165] They also spoke of their frustrations at requirements that every program had to be new, saying this prevented expansion on existing, successful programs and forcing organisations to try and 'invent' new ways of delivering the old, successful outcomes. The requirement that funded pilot projects should grow to become 'self-sustainable' was also perceived as being unrealistic.

> *…establishing a new service sounds pro-active, but in fact in the long run is a waste of resources as every time there is a change the 'wheel is reinvented'.*[166]

> *Despite the existence of worthwhile, evidence-based programs, programs are often fragmented and threatened by sustainability issues (including staff turnover and short-term funding).*[167]

Agencies consistently identified the need for long-term effective programs (for example, five to 10 years or for a generation).[168] Mission Australia submitted that effective programs have a long-term focus:

159 The EAC report defined 'Community sector organisations' as those which are voluntary and community-based non-government groups that are driven by a set of values and have social, environmental or cultural objectives. This Inquiry uses the term non-government organisation (NGO) to include this definition.
160 Economic Audit Committee 2009, Putting the Public First: Partnering with the Community and Business to Deliver Outcomes, Summary Report, Department of Premier and Cabinet, Government of Western Australia, p. 26.
161 Ibid.
162 Submission No. 36 from Bentley Family Clinic, Submission No. 67 from South Metropolitan Mental Health Advisory Group (SuMMat), Submission No. 81 from Mission Australia (Submission No. 13, 58, 96, 133 also referenced).
163 Submission No. 96 from City of Swan, p. 4.
164 Submission No. 81 from Mission Australia, pp. 13-14.
165 Submission No. 69 from headspace National, p. 8.
166 Submission No. 36 Confidential, p. 2.
167 Submission No. 133 from Australian Research Alliance for Children and Youth, p. 20.
168 Submission No. 12 from Princess Margaret Hospital.

> *…achieving strong and sustainable outcomes related to well-being and mental health require an intensive, long-term approach. Services and programs that remain in operation and are available to clients over long timeframes facilitate sustained outcomes. Longevity also enables programs and services to learn, evolve and grow to better meet community and client needs.*[169]

The need for a long-term focus is particularly crucial in order to address intergenerational disadvantage. Services must be able to work with children and their families over a long timeframe, sometimes into the next generation.

The disparity between government sector salaries and those offered in the non-government sector was another issue raised. The difference is such that it means NGOs struggle to be competitive in the labour market as well as having great difficulty recruiting senior and experienced staff.[170]

To this end, the findings of the EAC provide a timely opportunity for government to reassess its contractual and funding processes in order to facilitate longer-term successes in the delivery of human services for children and young people.

Recommendation 5: Arrangements for long-term funding be included in new contracts between the government and non-government organisations for the provision of mental health services for children and young people.

4.3.5 Building the capacity of the non-government sector

The EAC emphasised an approach that transfers service delivery from the public sector to the community sector. This move, which is currently being explored,[171] relies on the existence of capable, adequately funded and experienced NGOs to be effective. In terms of the provision of mental health services for children and young people, it is important to note there are currently only a small number of Western Australian NGOs with the expertise to provide early intervention or treatment services for children and young people experiencing a mental illness.

> *[TICHR's] experience has been that community based services tend to struggle to develop and deliver programs that are of consistently high quality and are well targeted to meet the needs of families and young children. Reasons oft cited include a chronic shortfall in funding, the short term nature of contracts and performance management regimes that focus more on outputs than outcomes. There are of course notable exceptions, but on the whole it is reasonable to argue that the services and programs available fall well short of what is needed to strengthen the mental health and wellbeing and reduce the risk or prevent mental health problems or disorders for children and young people across the WA population.*[172]

The challenges for this area, therefore, lie beyond restructuring funding arrangements or transferring service delivery responsibility. There is a more preliminary requirement for the capacity of this sector to be developed to an adequate level so that it may deliver the range of mental health services required by children and young people.

169 Submission No. 81 from Mission Australia.
170 Submission No. 93 from Hon Alison Xamon MLC, p. 3.
171 Economic Audit Committee 2009, Putting the Public First – Partnering with the Community and Business to Deliver Outcomes, Department of Premier and Cabinet, Government of Western Australia.
172 Submission No. 125 from Telethon Institute for Child Health Research.

Box 4 is an example of an NGO that is working in the provision of early intervention and treatment services for young people.

Box 4: Youth Focus[173]

Youth Focus is an independent charity that provides a broad range of free mental health services to young people 12 to 25 years. It is aimed at supporting young people and their families to overcome the issues associated with suicide, depression and self-harm in Western Australia. Youth Focus has offices at Burswood, Joondalup, Fremantle, Rockingham, Mandurah, Bunbury, Collie and Albany and also provides outreach via schools.

Youth Focus has grown significantly over the past 10 years with the support of Perth's corporate community.

Recommendation 6: The Mental Health Commission build the capacity of the non-government sector so it is equipped to deliver mental health promotion, prevention, early intervention and treatment services for children and young people.

4.3.6 Involving children and young people

The EAC has a strong focus on the need for an effective public sector that *'routinely collaborates across agencies and with stakeholders – particularly the community, to ensure that the desired outcomes are achieved'.*[174] It enforced the point that *'ongoing engagement with the public'*[175] is key to successful strategic management and accountability and that *'citizens will need to be empowered and their voice heard in the process of designing services'.*[176]

As citizens, children and young people should be involved in decision-making that affects their lives and that is appropriate to their age and maturity.[177] The aim of this involvement is to enable children and young people to *'…enrich decision-making processes, to share perspectives and to participate as citizens and actors of change.'*[178]

Government and non-government organisations have an important role to play in ensuring children and young people's views are heard and reflected in their policies, programs and services.

> *Including children and young people in decision making processes can benefit individuals, organisations and the community. Children and young people often have unique insights into issues, can offer creative solutions and their involvement can enrich decision-making processes and outcomes.*[179]

Importantly, involving children and young people in the development of services that are intended for them will help to ensure the services are relevant and appropriate.

> *ARACY strongly supports the principles of incorporating the views and experiences of children and young people in the development of policies and services that impact on them.*[180]

The Inquiry notes the commitment by the Government to engage with children and young people and to ensure their views influence service design.[181] A recent example is the comprehensive and ongoing consultation that has been

173 Information provided to the Commissioner for Children and Young People from Youth Focus, 10 March 2011; Youth Focus, [website] viewed 11 March 2011, http://youthfocus.com.au/
174 Economic Audit Committee 2009, Putting the Public First - Partnering with the Community and Business to Deliver Outcomes, Department of Premier and Cabinet, Government of Western Australia, p. 9.
175 Ibid, p. 10.
176 Ibid, p. 6.
177 Submission No. 134 from Youth Affairs Council of Western Australia, p. 9.
178 UNICEF, Convention on the Rights of the Child Factsheet: 'The Right to Participation', http://www.unicef.org/crc/files/Right-to-Participation.pdf, [website] viewed 2 March 2011.
179 Commissioner for Children and Young People 2010, Involving Children and Young People: Participation Guidelines, Western Australia.
180 Submission No. 133 from Australian Research Alliance for Children and Youth, p. 13.
181 Examples of recent consultation processes conducted by Government agencies include, but are not limited to, the Princess Margaret Hospital new Children's Hospital Youth Advisory Committee, Western Australian Museum xhIBIT alBANY, Clinical Senate (Department of Health) Health and the 'Facebook' Generation.

undertaken with the Youth Advisory Committee for the new Children's Hospital. Minister for Health, Hon Kim Hames MLA, has described this consultation as:

> *"…a unique opportunity to work with children and young people to build a hospital that is not only able to provide the highest quality of clinical care, but also meets the needs of patients to ensure a positive and comfortable stay… Our focus on involving young people and gaining insight into their experiences shows our desire to meeting the needs of future generations."* [182]

An opportunity for similar engagement arises with the Mental Health Advisory Council (MHAC) that was recently established to facilitate ongoing consumer input into mental health reform in Western Australia.[183] The Inquiry welcomes the establishment of the Council and considers it to be a significant opportunity to involve children and young people in this important reform.

The newly established MHAC would benefit greatly from the input of children and young people and those organisations that work with them.

Recommendation 7: The Mental Health Commission ensure that the views of children and young people are heard in the work of the Mental Health Advisory Council and in the development of mental health policy, program and service design.

4.4 Governance arrangements

4.4.1 Mental Health Commission

In March 2010, the Western Australian Government established the Mental Health Commission (MHC) – the first of its kind in Australia. The role of the MHC is to assume responsibility for mental health strategic policy, planning, procurement and performance monitoring and evaluation of services.

The functions of the MHC are to improve mental health services in the following ways:

- developing and providing mental health policy and advice to the Government;
- leading implementation of the Mental Health Strategic Plan;
- taking responsibility for articulating key outcomes and determining the range of mental health services required for defined areas and populations across the State;
- taking responsibility for specifying activity levels, standards of care and determining resourcing required;
- identifying appropriate service providers, benchmarks and the establishment of associated contracting arrangements with both government and non-government sectors;
- providing grants, transfers and service contract arrangements;
- conducting ongoing performance monitoring and evaluation of key mental health programs in Western Australia;
- ensuring effective accountability and governance systems are in place; and
- promoting social inclusion, public awareness and understanding of matters relating to the wellbeing of people with mental illness to address stigma and discrimination.[184]

The MHC is headed by a Commissioner and in its first year of operating had a dedicated budget of just over $500 million.[185] [186]

182 Barnett, C & Hames, K 2011, Planning for WA's new children's hospital begins, Ministerial Media Statements [website], viewed 28 February 2011, http://www.mediastatements.wa.gov.au/Pages/ByPortfolio.aspx?ItemId=133153&search=&admin=&minister=&portfolio=Health&region=&page=2

183 Morton, H 2010, The next step towards mental health reform, Ministerial Media Statements [website], viewed 1 March 2011, http://www.mediastatements.wa.gov.au/Pages/ByPortfolio.aspx?ItemId=133153&search=&admin=&minister=&portfolio=Health&region=&page=2

184 Submission No. 141 from Mental Health Commission supplementary information.

185 Jacobs, G 2010, Government announces State's first-ever Mental Health Commissioner, Ministerial Media Statements [website], viewed 27 July 2010, <http://www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=133799>.

186 Jacobs, G 2010, State Budget 2010-11: First ever budget for new approach to mental health, Ministerial Media Statements [website], viewed 20 May 2010, http://www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=133492

The opportunities presented by the establishment of the MHC are significant. With mental health being coordinated by a single and separate agency, a ring-fenced budget and with strong, strategic leadership there is a real possibility that Western Australia could become a leader in mental health service and policy provision.

Further, the MHC has advised it is currently involved in short and long-term planning projects for the infant, child, adolescent and youth mental health sector. This is welcomed given that there has been inadequate resourcing of the needs of children and young people for mental health services and programs, and given the evident cost benefit from the allocation of resources to early intervention – not only with adolescents, but also infants and children.

The establishment of the MHC presents the opportunity to bring about much needed reform in the area of mental health for children and young people. However, the MHC will require the appropriate level of resourcing to undertake this significant reform.

Recommendation 8: Increased priority be given to the mental health and wellbeing of children and young people by the Mental Health Commission.

State strategy and planning

The MHC has released the *WA Mental Health Towards 2020: Consultation Paper*[187] following consultation in 2009. Community feedback was sought on the paper subsequent to its release. The purpose of this feedback process was to:

> *…confirm the proposed vision, framework, principles, key reform areas, specific population groups, actions and initiatives articulated in the Consultation Paper; to identify any gaps; and to ensure that the final policy and strategic directions document captures the vision and direction needed for mental health reform in WA.*[188]

The MHC states that it will be leading implementation of the Mental Health Strategic Plan but the final policy and strategic directions had not yet been published at the time of this Report.

The large number of submissions received by this Inquiry indicates there is concern in the community about the future of mental health programs and services for children and young people, and their unique needs which require a separate and dedicated planning process to address them.

The MHC advised the Inquiry that it will be *'working in collaboration with State and interstate youth mental health experts to develop a plan for youth mental health services in Western Australia, including inpatient, early identification and treatment and forensic mental health services.'*[189] It also advised that it will be *'working in collaboration with State infant and child mental health experts to develop short and long-term initiatives, including initiatives that focus on a sustainable specialist workforce.'*[190]

While the Inquiry is supportive of a focus on youth mental health services and initiatives for infants and children, it is imperative that this work is all part of a long-term, comprehensive plan for all children and young people young in Western Australia.

This planning must also take into account the full intervention continuum, that is, what children and young people need in terms of promotion, prevention, early intervention and treatment services and how this can best be provided.

187 Western Australian Mental Health Commission 2010, WA Mental Health Towards 2020: Consultation Paper, Government of Western Australia, Perth.
188 Ibid, p. 5.
189 Submission No. 141 from Mental Health Commission, supplementary information.
190 Ibid.

Any strategic plan should be developed in close cooperation with the Commonwealth Government to ensure a strategic and collaborative approach is developed that avoids duplication of services.

Recommendation 9: A strategic and comprehensive plan for the mental health and wellbeing of children and young people across Western Australia be developed by the Mental Health Commission. This plan provide for the implementation and funding of promotion, prevention, early intervention and treatment services and programs.

Collaboration

As noted previously, collaboration across government, NGOs and the private sector is critical not only for the delivery of specific services for individuals, but also for the delivery of improved outcomes for citizens as a whole.

The NACMH identified that if we are to create a mentally healthy Australia, reform and investment must be:

> *…embedded across a whole-of-government national policy framework. This means that we need to reflect a focus on mental health across the board – in our approach to education, social services, housing employment, Indigenous affairs and so on – not just in our mental health services.*[191]

There are many government agencies involved in delivering mental health services to children and young people across the intervention continuum, but the key ones are the:

- Department of Health;
- Department of Education;
- Department for Child Protection;
- Department of Corrective Services;
- Disability Services Commission;
- Drug and Alcohol Office;
- Department for Communities; and
- Department of Sport and Recreation.

The MHC is best placed to lead these agencies (and others as required) in a 'whole-of-government' collaborative approach to identify, address and improve mental health services for children and young people across the State.

Recommendation 10: A whole-of-government collaboration to improve the mental health and wellbeing of children and young people across the State be led by the Mental Health Commission.

4.4.2 Data collection, monitoring and reporting

Integral to coordinating the provision of services to children and young people and reporting on outcomes is the collation of accurate and reliable data.

In undertaking the Inquiry, the Commissioner for Children and Young People (The Commissioner) wrote to a number of government agencies (see Appendix 4) requesting statistics and information on the prevalence and cost of mental health and wellbeing among children and young people.

While some agencies were able to provide data on particular aspects of their service, no full or comprehensive picture of the extent on, or expenditure of, delivering mental health programs and services for children and young people could be obtained. (See Chapter 3 for discussion on expenditure issues).

191 National Advisory Council on Mental Health 2009, A Mentally Healthy Future for all Australians: A Discussion Paper, Canberra, p. 4.

It is clear that comprehensive data collection is required to understand the extent of mental illness and the number of children and young people experiencing these issues. This is a point well made by NACMH.[192] Accurate data is also required for State Government, community and private sector expenditure in this area. Economic modelling on the cost of failing to address problems to the child or young person and the community would also be useful. The Inquiry notes that data collections must have the capacity to highlight comorbidity and developmental trajectories of children with additional needs.

As the lead agency for mental health in the State, and to ensure it is able to effectively meet its functions of planning services and monitoring outcomes, the MHC will need to improve and maintain comprehensive data collection on the mental health of children and young people.

In recognition of the need for comprehensive Western Australian data that monitors the wellbeing of children and young people the Commissioner has commenced the Wellbeing Monitoring Framework (WMF) project.

The WMF is designed to develop an evidence-based, repeatable data collection framework that monitors specific indicators of children and young people's wellbeing. The WMF will collect data which will be of assistance to the MHC and other agencies in monitoring the mental health and wellbeing of children and young people.

In 2007, the Western Australian Department of Health funded the Telethon Institute for Child Health Research (TICHR) to undertake preliminary work on the 2008 *Child Development Survey*. This project included the planning and development phases for a 2008 *Western Australian Child Health Survey*. TICHR submitted to the Inquiry that the survey would:

> *…examine the development of children within their spheres of influence (including families, other carers, peers, communities and schools) and apply this developmental framework to questions of current importance for children and their families, including mental health problems, childhood obesity, diet and nutrition, asthma and diabetes. The study will measure educational experiences and outcomes, psychosocial determinants including family functioning, parenting and individual self-efficacy, relationships with peers and social exclusion. The study will also explore patterns of antisocial and delinquent behaviour and connections between delinquency and child victimisation.*[193]

However, despite completing tool development, trialling and establishment of governance structures, the *Child Development Survey* was not funded. This has resulted in a chronic shortage of quality data.[194]

The availability of high quality information on the health, wellbeing and development of children and young people is critical for the appropriate development, delivery and evaluation of services for children and families. This data, together with the WMF, will be invaluable to the MHC in determining how Western Australian children and young people are faring in terms of their development.

Another valuable monitoring tool is the Australian Early Development Index (AEDI). The AEDI is a measure of young children's development based on the scores from a teacher-completed checklist in the first year of school. The AEDI checklist measures five domains of child development:

- physical health and wellbeing;
- social competence;
- emotional maturity;
- language and cognitive skills; and
- communication skills and general knowledge.[195]

192 Ibid, pp. 23-24.
193 Submission No. 125 from Telethon Institute for Child Health Research, p. 7.
194 Ibid.
195 Australian Early Development Index [website], viewed 2 March 2011, http://www.rch.org.au/aedi/index.cfm?doc_id=13051

The AEDI has been rolled out nationally with the purpose of measuring the health and development of populations of children to help communities assess how well they are doing in supporting young children and their families. The AEDI can also be used to monitor changes and provide an evidence base for actions in a community over time.

The usefulness of the AEDI in identifying areas of need and monitoring effectiveness of interventions is such that it should become a fundamental tool in policy and planning of services for children and young people.

Recommendation 11: The Mental Health Commission improve and maintain comprehensive data collection on the mental health of children and young people in Western Australia, including expenditure and mental health and wellbeing outcomes.

Recommendation 12: The State Government provide funding for the regular conduct of the Telethon Institute for Child Health Research's Child Health Survey and for this survey to be conducted in Western Australia every three years.

4.4.3 Infant, Child, Adolescent and Youth Mental Health Service (ICAYMHS)

Although the MHC has taken on responsibility for policy, planning, procurement and monitoring of mental health services, the Department of Health maintains responsibility for the operational delivery of government-run mental health services.

The primary Government mental health service for children and young people is the Infant, Child, Adolescent and Youth Mental Health Service (ICAYMHS).[196] ICAYMHS includes a range of community, inpatient and statewide services and provides Tier 3 and Tier 4 mental health services (see Chapter 2). ICAYMHS includes services in the metropolitan area as well as in regional and remote areas (through the WA Country Health Service (WACHS)).

The 2007 *Review of Child and Adolescent Mental Health Services in Western Australia* (the Nurcombe Review) found that ICAYMHS was under-resourced, unable to meet the needs of its client group and that operating procedures and structures were inconsistent between ICAYMHS clinics:

> *Developing in an uncoordinated and, often, isolated manner, CAMHS has no common set of practice standards. Different CAMHS clinics do things their own way. There are no universally accepted methods of intake, risk analysis, triage, diagnostic assessment, data gathering, diagnostic formulation, treatment planning, negotiation with the family, treatment monitoring, record keeping, or report-writing. There are no benchmarks for caseload or number of hours of face-to-face work per week.*[197]

Evidence presented to this Inquiry concurs with these findings, with many submissions expressing deep concern that the ongoing under-funding has resulted in lengthy waitlists and a focus on 'crisis' response rather than comprehensive early intervention and treatment.

> *Long waitlists exist for ICAMHS services. There are strict criteria to access these services and priority is given to problems which present as urgent (e.g. suicidality, psychosis).*[198]

196 ICAYMHS used to be known as the Child and Adolescent Mental Health Service (CAMHS). Many still refer to it using this name so throughout the Inquiry Report CAMHS, CAYMHS or ICAMHS all refer to ICAYMHS.
197 Nurcombe, B 2007, A Review of Child and Adolescent Mental Health Services in Western Australia, [unpublished], p. 22.
198 Submission No. 91 from Australian Association for Infant Mental Health WA Branch, pp. 6-7.

> *Limited CAMHS resources result in time delays in children or adolescents with high risk conditions accessing appropriate services in a timely way. This includes the high risk time between a child or adolescent's discharge from hospital and follow-up community care.*[199]

> *There are limited staff to undertake early intervention and infant mental health programs and nor is there opportunity to adopt specialty programs, including outreach programs, or to develop collaborative relationships with key agencies. Clinics instead focus on urgent referrals only and in some areas have lost standing in the broader community as a result.*[200]

> *Accessing resources BEFORE crisis point is very hard for many reasons one of the biggest being lack of resources for agencies such as CAHMS.*[201]

Submissions highlighted that these concerns are even more profound in regional and remote areas, with some children and young people unable to receive any service.

> *Mental health services for mothers and infants are at this stage non-existent in rural and remote WA…*[202]

The findings from the Inquiry on this issue support the conclusion in the MHC's *WA Mental Health Towards 2020: Consultation Paper* which stated that:

> *Consultations revealed that child and adolescent mental health services were unable to meet the needs of their target population. For example there were very long waiting lists (in some areas 6-8 months for non-urgent referrals and several months for priority referrals). There was also limited staff to undertake early intervention, adopt speciality programs or develop collaborative relationships with key areas. Regional areas were also signalled as being significantly underresourced; it was highlighted that many regional areas are without a child psychiatrist or other ICAYMH practitioners and they often relied on telepsychiatry for this role.*[203]

The impact of this situation in ICAYMHS as it applies to children and young people receiving mental health services is discussed more fully in Chapters 6 to 9.

In October 2010, the Department of Health announced that the two metropolitan ICAYMHS (currently managed by North and South Metropolitan Area Services) would be brought together as a single dedicated stream within the Child and Adolescent Health Service (CAHS). This operational transfer occurred on 28 February 2011.

The Inquiry was advised in March 2011 by the Department of Health that child and adolescent mental health clinicians in country and regional areas will continue to be line managed by the WACHS but will have close links with the ICAYMHS Executive Unit in CAHS. This unit will manage statewide operational policy development and negotiations with the MHC regarding metropolitan and regional ICAYMHS.

There will be approximately 325 full-time equivalent positions within CAHS ICAYMHS, with a budget of approximately $40 million.

The main priorities in consolidating ICAYMHS are to:

- create a child-focused, rather than disease-focused culture, by embedding child mental health services in general health services for children;
- ensure equitable access to services;

199 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch.
200 Infant, Child and Youth Mental Health Executive Group 2009, New Strategic Directions for Child and Adolescent Mental Health Services 2010-2020, [Draft], p. 20.
201 Submission No. 23 from Western Australian Secondary School Executives Association, p. 4.
202 Submission No. 15 from Dr. Prue Stone, p. 1.
203 Mental Health Commission 2010, WA Mental Health Towards 2020: Consultation Paper, Government of Western Australia, p. 111.

- develop consistent and clear clinical models and pathways of care;
- integrate governance and reduce duplication;
- maximise funding and resources for ICAYMHS;
- improve inter-sectoral relationships with other child and family related services (for example, NGOs and the Departments of Education, Disability Services, Child Protection, Communities and Justice); and
- increase research, teaching and training.

The Inquiry hopes this move will address many of the concerns raised by the Nurcombe Review and by standardising the differing eligibility criteria and organisational structures of previous approaches will lead to stronger and more consistent mental health service delivery for children and young people.

It will be critical that this structural reform is monitored to ensure it achieves the improved outcomes for the mental health and wellbeing of children and young people.

The overwhelming evidence to the Inquiry is that structural reform alone will not be sufficient to improve mental health outcomes for children and young people. As discussed in detail in Chapter 3 and elsewhere in this Report, the current funding to ICAYMHS means it is *'unable to meet the needs of their target population'.*[204]

Recommendation 13: The Mental Health Commission monitor the operational transfer of the Infant, Child, Adolescent and Youth Mental Health Service into the Child and Adolescent Health Service to ensure there are improved outcomes for the mental health and wellbeing of children and young people.

Recommendation 14: Funding to the State's Infant, Child, Adolescent and Youth Mental Health Service be increased so it is able to provide comprehensive early intervention and treatment services for children and young people across Western Australia, including meeting the needs of those with mild, moderate and severe mental illnesses.

4.4.4 Legislation

Appropriate legislation governing mental health in Western Australia is an important component of an effective mental health system. In Western Australia the *Mental Health Act 1996* (WA) (the *Mental Health Act*) deals with the care, treatment and protection of people with mental illness and, specifically, it deals with the law concerning involuntary assessment and treatment.[205] The *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) (the *CLMIA Act*) covers the treatment of persons who are found unfit to stand trial or who are found not guilty on account of unsoundness of mind.

Mental health laws (that is, both civil and criminal) have the potential to impact upon the wellbeing of children and young people. Hence, it is imperative that the specific interests and needs of children and young people are taken into account in the formulation of mental health laws.

The Inquiry notes that an effective mental health system for children and young people requires more than legislative recognition of the rights and interests of children and young people. It also requires adequate resources to ensure appropriate services are available for children and young people in the community and in custodial settings, as discussed throughout this Report.

A comprehensive review of the *Mental Health Act* was undertaken in 2002 and completed in 2003 (the Holman Review). The MHC website acknowledges that a *'considerable time has now elapsed [since the Holman review] and the Government has created the Mental Health Commission with functions that will impact on some of the*

204 Ibid.
205 Either detained or in the community.

proposed directions for the current Bill'.[206]

At the time of the Holman Review the Western Australian Parliament had not passed the *Commissioner for Children and Young People Act 2006*. The inaugural Commissioner took up her appointment in December 2007. Therefore, it is prudent to reconsider the recommendations of the Holman Review to ensure the rights and needs of children and young people are appropriately recognised.

The Inquiry did not call for evidence specifically regarding the *Mental Health Act*, but notes it includes particular issues that affect children and young people – for example, the use of Electroconvulsive Therapy, restraint and seclusion, and issues of consent.

The Inquiry emphasises that any reform to the *Mental Health Act* should be mindful of the specific needs of children and young people and reflect the following key principles:

1. That the best interests of the child shall be a primary consideration.[207]
2. That a child or young person should have the right and opportunity to be heard in relation to his or her assessment, treatment and placement and the child's views should be taken into account in accordance with his or her age and maturity.[208]
3. That the family and/or carers of a child or young person should have a right to be heard and involved in the care and treatment of a child, unless such involvement is not in the best interests of the child.
4. That mental health laws recognise the special needs of children and young people (for example, the need for specialist child psychologists and psychiatrists and the need for specialist mental health facilities and the need to ensure that children and young people maintain involvement in education, training and recreation); and the need to recognise the differences between children and adults.

The *CLMIA Act* covers accused persons (both adults and children) who are mentally unfit to stand trial or who have been found not guilty on account of unsoundness of mind (mentally impaired accused). The *CLMIA Act* also provides for an assessment process – a court that refuses bail can make a hospital order requiring the accused to be detained in an authorised hospital for an assessment for a period of seven days.

The National Statement of Principles for Forensic Mental Health states that:

> *Offenders with a mental disorder are a highly stigmatised and marginalised group in our community. There are a number of particularly vulnerable populations within this group, including juveniles, Aboriginal and Torres Strait islander peoples, and people from culturally and linguistically diverse backgrounds.*[209]

In Western Australia, more than 70 per cent of children and young people in custody are Aboriginal (as are the majority of children and young people under community justice supervision). Hence, the need to ensure forensic mental health laws recognise the special vulnerability of children and Aboriginal people is especially heightened.

206 Mental Health Commission, Mental Health Bill [website], viewed 3 March 2011, http://www.mentalhealth.wa.gov.au/Initiatives_and_Projects/mh_bill.asp

207 Convention on the Rights of the Child, Article 3.1 [website], viewed 2 March 2011, http://www2.ohchr.org/english/law/crc.htm; Convention of the Rights of Persons with Disabilities, Article 7, viewed 2 March 2011, http://www.un.org/disabilities/convention/conventionfull.shtml

208 Article 12.1 of the Convention on the Rights of the Child provides that a child who is capable of forming his or her views should be provided with the right to express those views in matters affecting the child and that those views should be given due weight in accordance with the age and maturity of the child. Article 12.2 provides that a child should be provided with the opportunity to be heard in any judicial or administrative proceedings affecting the child (either directly or through a representative). Convention on the Rights of the Child, viewed 2 March 2011, http://www2.ohchr.org/english/law/crc.htm

209 Council of Australian Governments 2002, National Statement of Principles for Forensic Mental Health 2002 [website], viewed 2 March 2011, Commonwealth of Australia http://www.health.wa.gov.au/mhareview/resources/documents/FINAL_VERSION_OF_NATIONAL_PRINCIPLES_FOR_FMH-Aug_2002.pdf

Currently, the *CLMIA Act* makes no specific reference to children and young people although age is one of a number of factors to be considered by a court before making a custody order in relation to a mentally-impaired accused.

The major concerns about the impact of the *CLMIA Act* upon children and young people who are found unfit to stand trial or not guilty on account of unsoundness of mind (young mentally-impaired accused) include the:

- lack of suitable facilities for young mentally impaired accused made subject to a custody order (see the later discussion in Chapter 5);
- potential for indefinite detention;
- lack of alternative options (if a young mentally-impaired accused is found unfit to stand trial there are only two options: unconditional release or an indefinite custody order); and
- mandatory custody orders for scheduled offences.

Some of these issues (and others) were addressed by the Holman Review but it is unknown at this stage whether all of its recommendations will be implemented (and, as noted previously, this Review took place prior to the appointment of the inaugural Western Australian Commissioner for Children and Young People).

However, it is worth noting that one matter that appears to have been overlooked in the Holman Review recommendations is the special recognition of children and young people. The Inquiry is of the view that the fundamental principles in the *CLMIA Act* should stipulate that in dealing with young mentally-impaired accused the best interests of the child is a primary consideration and the special needs of young mentally-impaired accused should be recognised.

The Inquiry notes that the MHC is currently progressing a new Mental Health Bill.

Recommendation 15: The *Mental Health Act 1996* (WA) and the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) be reviewed to ensure the rights and needs of children and young people are adequately recognised.

4.4.5 Workforce development

It was submitted to this Inquiry that there is an imperative to develop a highly skilled mental health workforce that is well able to serve children and young people and their families – an issue the Inquiry recognises is applicable throughout Australia.

Importantly, it is also critical to equip a wide range of individuals and professionals, in addition to mental health specialists, to better understand mental health and mental illness. This includes playgroup leaders, child care workers, community child health nurses, teachers, people working in sporting associations and youth organisations, doctors and allied health professionals, and employers. All have direct contact with children and young people and need to be better equipped to identify mental health problems and make or suggest appropriate referrals where required.

The extent to which workforce issues are impacting on the delivery of mental health services throughout Western Australia was a consistent theme of submissions made to this Inquiry.[210] The following factors were seen as impacting on workforce recruitment and retention:

- a general lack of professionals skilled and trained in children and young people's mental health;
- a lack of Aboriginal professionals;
- high rents and lack of housing in regional areas;
- low pay, particularly in comparison to the mining sector;

210 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch; Submission No. 15 from Dr. Prue Stone; Submission No. 132 from State School Teachers Union of Western Australia.

- the distance staff have to travel combined with high case load;
- the reluctance of professionals to work in regional and remote areas;
- inexperienced staff;
- high staff turnover;
- difficulty accessing professional development, training and professional supervision;
- working in isolation;
- working with limited resources including supporting agencies; and
- complex cases.[211]

Mission Australia's submission to the Inquiry identified support for the workforce as vital for a successful program:

> *…the role and capacity of the service workers are pivotal to successful interventions. Appropriate workforce development and ongoing workforce support are therefore integral to the development and ongoing capacity of models of support that provide a continuity of care in a trustworthy, stable and professional environment.*[212]

The Inquiry notes the NACMH call for the development and implementation of a national mental health workforce strategy and that this *'must be at the core of transforming the mental health services of Australia'.*[213]

The Inquiry also heard of ongoing challenges in recruitment of Aboriginal staff in the mental health sector. Ensuring Aboriginal workers are involved in mental health service delivery is an imperative aspect of improving the mental health of Aboriginal children and young people.

Aboriginal staff help to ensure a service is culturally safe, encourage Aboriginal children and young people to feel secure in accessing a service, and build cultural awareness from inside the service.

Without Aboriginal professionals working in this sector, it will be extraordinarily challenging to 'close the gap' on mental health outcomes for Aboriginal children and young people.

There are programs working well in other States, particularly in relation to increasing the Aboriginal health workforce. The Inquiry notes that the Statewide Indigenous Mental Health Service is currently accessing Charles Sturt University Bachelor of Health Science Mental Health, with the first cohort of students having successfully completed their first year of training (see Box 5).

In its work on developing a sustainable, specialist workforce, the MHC should consider the recruitment, training and retention of Aboriginal mental health and health professionals.

Box 5: Charles Sturt University (CSU) – Bachelor of Health Science Mental Health

The Djirruwang Aboriginal and Torres Strait Islander Mental Health Program at Charles Sturt University (CSU) delivers a tertiary level course in mental health. The aim of the program is to have Aboriginal people educated and trained to deliver primary health care services because it is the best way to improve health in Aboriginal communities.

The course was developed in collaboration with Aboriginal community-based organisations, the mental health industry and CSU to meet the needs of Aboriginal and Torres Strait Islander communities. The course aims to prepare graduates to work competently as a mental health worker within their own communities and mainstream

211 Submission No. 15 from Dr. Prue Stone; Submission No. 20 from Catholic Education Office; Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch; Inquiry information sessions.
212 Submission No. 81 from Mission Australia, p. 13.
213 National Advisory Council on Mental Health 2009, A Mentally Healthy Future for all Australians: A Discussion Paper, Canberra, p. 30.

mental health services. It has produced graduates who have been successfully employed at various levels within mainstream mental health, community mental health services, Aboriginal organisations and Aboriginal community-controlled health services.

The program has won several citations for outstanding contributions to student leaning including the 2008 Australian Learning and Teaching Council for 14 years of successful education for Aboriginal mental health students: respecting the integrity of Aboriginal and mainstream cultures and building the Aboriginal mental health workforce.[214]

The MHC has advised the Inquiry that it will be '*working in collaboration with State infant and child mental health experts to develop short and long term initiatives, including initiatives that focus on sustainable specialist workforce.*'[215] Attention to this issue by the MHC is supported by the Inquiry – particularly to ensure the development of specialists who have the specific skills required to work with children and young people.

Recommendation 16: A comprehensive mental health workforce strategy be developed by the Mental Health Commission in collaboration with the Commonwealth Government. This strategy to include cultural competency training and specific planning for the recruitment, training and retention of Aboriginal mental health professionals.

214 Charles Sturt University [website], viewed 2 March 2011, http://www.csu.edu.au/study/science-courses/djirruwang/
215 Submission No. 141 from Mental Health Commission, supplementary information.

5.1 Introduction

In establishing this Inquiry the Commissioner for Children and Young People (The Commissioner) is required, consistent with her responsibilities under the *Commissioner for Children and Young People Act 2006* (the Act), to investigate the mental health and wellbeing of all children and young people.

Additionally, section 20 of the Act requires the Commissioner to give priority to, and have special regard to, the interests and needs of:

- Aboriginal children and young people and Torres Strait Islander children and young people; and
- children and young people who are vulnerable or disadvantaged for any reason.

This Report and its various sections should be read as applying to all children and young people. However, recognising the priority stipulated in section 20 of the Act, this chapter of the Report describes some of the unique needs of Aboriginal children and young people and children and young people who are vulnerable or disadvantaged for any reason.

Acknowledging all the unique and specific needs of the children and young people described in this chapter, and the particular services that are needed to meet those needs, the Inquiry recommends that they be a key consideration in the development of a State plan for the mental health and wellbeing of children and young people.

Recommendation 17: As part of the strategic and comprehensive plan for the mental health and wellbeing of children and young people across Western Australia, the Mental Health Commission identify the unique and specific requirements of and have regard for:

- Aboriginal children and young people; and
- children and young people who are vulnerable or disadvantaged for any reason.

5.2 Aboriginal children and young people

The Commissioner acknowledges the unique contribution of Aboriginal people's culture and heritage to Western Australian society and Aboriginal people's whole-of-life view of mental health that incorporates the importance of connection to the land, culture, spirituality, ancestry, family and community.[216]

The Inquiry acknowledges that this recognition and identity is fundamental to Aboriginal people's social and emotional wellbeing and that mutual resolve, respect and responsibility are required to close the gap on Aboriginal disadvantage and to improve mental health and wellbeing.

As stated in Chapter 3, almost half of the entire Western Australian Aboriginal population is aged under 18 years[217] and Aboriginal children and young people represent 5.7 per cent of all children and young people in Western Australia.[218]

The ongoing disadvantage of Aboriginal children and young people is of great concern and, among other things, is culminating in:

- lower life expectancy (the gap between Aboriginal and non-Aboriginal life expectancy at birth was 12 years

216 Australian Health Ministers Advisory Council 2004, Social and Emotional Wellbeing Framework: A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009, Australian Government Department of Health and Ageing, Canberra, p. 8.

217 Commissioner for Children and Young People WA calculations based on Australian Bureau of Statistics 2010, National Aboriginal and Torres Strait Islander Social Survey, 2008, 'Tables 3, 5, and 9, datacubes: Excel Spreadsheet, cat. no. 4714.0 [website], viewed 10 February 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02008/OpenDocument

218 Ibid.

for males and 10 years for females[219]);
- higher infant mortality (mortality rates for Aboriginal infant and young children remain two to three times higher than those for all infants and young children[220]); and
- very poor mental health outcomes (24 per cent of Aboriginal children aged four to 17 years were at high risk of clinically significant emotional or behavioural difficulties[221]).

This continuing disadvantage has a fundamental impact on the mental health of Aboriginal individuals and communities. Children and young people exposed to such profound disadvantage will inevitably experience far greater risk factors to their mental health – thus compounding the cycle of disadvantage:

> *For many Aboriginal and Torres Strait Islander communities, the occurrence of risks such as early mortality and chronic disease is almost universal. In such communities the consequent increased risk for mental health problems is more or less pervasive. When the general level of risk in a community is high, there are far fewer opportunities for children – for example in high-risk families – to be buffered by other protective influences within the community. It is very difficult to hold the infant in mind when the whole community is suffering. The compounding of family and community risks frequently underlies the vicious cycle of deteriorating conditions affecting children, families and communities.*[222]

Professor Helen Milroy, Child Psychiatrist and Director of the Centre for Aboriginal Medical and Dental Health at the University of Western Australia, describes the inter-generational effects of Aboriginal disadvantage – reaching back to the impact of colonisation – as resulting in extremely high levels of trauma for many Aboriginal children and young people.

> *The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the on-going effects of the original trauma which a parent or other family member has experienced.*[223]

This was confirmed by the Telethon Institute for Child Health Research's (TICHR) survey on Aboriginal child health which explored the impact of 'life stress events' including illness, hospitalisation or death of a close family member, family break-up, arrests, job loss and financial difficulties. The survey found that most people are able to cope with a single stressful event, but multiple stressful or traumatic events which occur simultaneously can be more challenging to cope with.[224]

The survey found that just over one in five Aboriginal children were living in families where seven or more life stress events had occurred in the preceding 12 months. It found that these children were five-and-a-half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children in families where two or less life stress events had occurred.[225]

219 [Based on 2005-2007 data] Steering Committee for the Review of Government Service Provision 2009, Overcoming Indigenous Disadvantage: Key Indicators Report 2009, Productivity Commission, Canberra, p. 12.
220 Ibid, p. 3.
221 Zubrick, S, et al. 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, p. 25.
222 Milroy, H, cited in Zubrick, S, et al. 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, p. xvi.
223 Ibid.
224 Zubrick, S, et al. 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, p. 135.
225 Ibid.

In December 2007 and March 2008 the Council of Australian Governments (COAG) announced six targets under the '*Closing the Gap'* strategy, which aims to reduce Aboriginal disadvantage.[226] The six targets are:

- *life expectancy* – to close the life expectancy gap within a generation;
- *young child mortality* – to halve the gap in mortality rates for children under five within a decade;
- *reading, writing and numeracy* – to halve the gap for Aboriginal students in reading, writing and numeracy within a decade;
- *employment* – to halve the gap in employment outcomes between Aboriginal and non-Aboriginal Australians within a decade;
- *early childhood education* – to provide access to quality early childhood education, within five years, for all Aboriginal four year olds, including those in remote communities; and
- *Year 12 attainment* – to at least halve the gap for Aboriginal students in Year 12 attainment or equivalent attainment rates by 2020.[227]

The ambitious targets of the '*Closing the Gap'* strategy are critical if any progress is to be made on addressing the pervasive disadvantage faced by Aboriginal people. For children and young people particularly, the targets set important goals to help give them a better start in life. They also have the potential to impact positively on the mental health of Aboriginal children and young people.

As a part of the COAG commitment and the associated Western Australian implementation plan, the State Government has committed just over $22 million to establish a Statewide Specialist Aboriginal Mental Health Service (SSAMHS) that will provide specialist clinical interventions to Aboriginal people with severe and persistent mental illnesses across the State. The SSAMHS is not exclusive to children and young people but will include them in the service delivery.[228]

An additional $22 million has been allocated to social and emotional wellbeing programs, the majority of which will be delivered by non-government organisations.[229]

The Inquiry is supportive of the development of the SSAMHS and considers its implementation to be an urgent part of addressing the mental health needs of Aboriginal children and young people. The Inquiry understands, however, that there is currently no link between the SSAMHS and the Infant, Child, Adolescent and Youth Mental Health Service (ICAYMHS). It would be beneficial for the two services to establish a close working relationship and a seamless referral process in order to ensure the best possible outcomes for children and young people.

The Inquiry recognises that the six '*Closing the Gap'* targets and the $22 million for the SSAMHS are just a starting point, and that there are many issues that affect Aboriginal social and emotional wellbeing:

> *In essence, issues of social and emotional well being cover a broad range of problems which can result from unresolved grief and loss issues, trauma and abuse, domestic violence, issues associated with the legislated removal of children, substance misuse, physical health problems, genetic and child developmental problems, gender identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.*[230]

226 Social Inclusion [website] [website], viewed 2 March 2011, http://www.socialinclusion.gov.au/initiatives/pages/closingthegap.aspx.
227 Steering Committee for the Review of Government Service Provision 2009, Overcoming Indigenous Disadvantage: Key Indicators Report 2009, Productivity Commission, Canberra, pp. 2-3.
228 Submission No. 141 from Mental Health Commission, p. 76.
229 Ibid.
230 Social Health Reference Group for National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group 2004, Social and Emotional Wellbeing Framework: A National Strategic Framework for Aboriginal and Torres Straight Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009, p. 9.

This Report highlights in Chapters 6 to 9 the specific challenges facing Aboriginal children and young people from conception through to adulthood. In addition to the need for universal services and programs that reduce risk factors and promote protective factors for mental health, the evidence points to the need to have strategies in place across the life of an Aboriginal child that are culturally appropriate, culturally secure and relevant.

Box 6: Cultural healing

The nature of unresolved trauma and the intergenerational effects in Aboriginal communities as a result of past policies of removal of children is well documented. For Aboriginal people, healing is a process of spiritual and cultural renewal and therapeutic change.

A 2009 report by the Aboriginal and Torres Strait Islander Healing Foundation Development Team outlined four primary principles that must be observed if Aboriginal people are to be adequately supported in their healing journey:

> *First, we must focus on addressing the causes of community dysfunction, not its symptoms. Second, we must recognise the fundamental importance of Aboriginal and Torres Strait Islander ownership, definition, design and evaluation of healing initiatives. Third, and by extension, the way we design initiatives must be based on Aboriginal and Torres Strait Islander worldviews, not western health understandings alone. Finally, we must strengthen and support initiatives that use positive, strength-based approaches.*[231]

The Inquiry notes the recent release of the book *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* developed by the Australian Council for Educational Research and the Kulunga Research Network and TICHR with funding through the Office for Aboriginal and Torres Strait Islander Health, Commonwealth Government Department of Health and Ageing.[232]

This is an important publication, offering a comprehensive examination of issues influencing Aboriginal mental health and social and emotional wellbeing. The Inquiry suggests it be used widely as a useful reference tool and for improving cultural awareness in service delivery.

5.3 Children and young people living in regional and remote communities

Approximately 146,600 children and young people, or 28 per cent of all Western Australian children and young people (0 to 17 years of age), live in regional and remote Western Australia.[233] Of these, 14 per cent or 21,000 children and young people are Aboriginal.[234] For these children and young people, a number of issues are unique to where they live – particularly issues related to access to services.

Evidence to this Inquiry consistently submitted that children and young people in regional and remote Western Australia experience limited assessment, early intervention and treatment services.[235]

231 The Aboriginal and Torres Strait Islander Healing Foundation Development Team 2009, Voices from the Campfires: Establishing the Aboriginal and Torres Strait Island Healing Foundation, pp. 16-17. [website], viewed 15 March 2011, http://www.fahcsia.gov.au/sa/indigenous/pubs/healing/voices_campfire/Documents/HealingFoundationReport.rtf

232 Purdie, N, et.al 2010, Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, Commonwealth of Australia, Perth.

233 Australian Bureau of Statistics 2009, Population by Age and Sex, Regions of Australia, 2009, 'Table: Population Estimates by Age and Sex, Western Australia by Geographical Classification [ASGC 2009], 2004 and 2009', datacube: Excel Spreadsheet', cat. no. 3235.0 [website], viewed 17 February 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02009?OpenDocument

234 Australian Bureau of Statistics 2008, National Aboriginal and Torres Strait Islander Social Survey, 2008, 'Tables 2, 6 and 8: Indigenous children by Remoteness area', datacube: Excel Spreadsheet', cat. no. 4714.0 [website], viewed 17 February 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02008?OpenDocument

235 Submission No. 15 from Dr. Prue Stone; Submission No. 20 from Catholic Education Office (Submission No. 27, 38, 75, 109, 118, 132, 139 also referenced).

The limited extent of services assumes greater significance given that the level of need is in some cases greater in regional and remote areas. Significant numbers of Aboriginal children and young people in the more remote areas of the State are experiencing multiple disadvantages, including poor nutrition and inadequate housing, and complex issues including grief and loss, trauma, alcohol and substance abuse, violence and Fetal Alcohol Spectrum Disorder.

A description of the ICAYMHS service in regional and remote areas was given by one submission:

> *Practitioners are few in number (40 FTE ICAYMHS clinicians across a State of 2.5 million square kilometres) and work as lone practitioners in adult Mental Health teams or in very small ICAYMHS teams. There is only one full-time Child and Adolescent Psychiatrist in the public sector and no Child and Adolescent Psychiatrists in the private sector outside Perth… There are no or only infrequent ICAYMHS services for most Indigenous communities.*[236]

The Royal Australian College of Psychiatrists (WA Branch) submitted:

> *Consultation with rural and remote CAMHS highlighted significant issues such as clinicians required to service vast geographical areas, sole clinicians working in isolation, limited support from visiting psychiatrists, ad hoc professional supervision, a lack of government and community support services in towns, isolation from inpatient options, limited or no access to training and significant difficulties with recruitment and retention of suitably trained and experienced clinicians. Further… in some centres, particularly the smaller, more remote towns, there is no access to the range of services required to effectively treat consumers, such as psychiatry or clinical psychology.*[237]

Evidence to the Inquiry identified the significant distances professionals (including community child health nurses, school psychologists and mental health professionals) must travel to deliver a service in both regional and remote areas and the negative impact this has on already limited service capability.[238]

Schools in rural and remote areas, especially remote Aboriginal communities, are a significant point of contact for children and young people. Submissions from the education sector highlighted the difficulty staff face in accessing assessment and treatment services for their students when needed. Submissions advised it was even more difficult to obtain ongoing and culturally-sensitive services.[239] For example, the Association of Independent Schools commented:

> *There are currently only three Non Government School Psychologists who service the rural and remote independent schools in WA. The majority of these schools are in the Kimberley and Pilbara, however these psychologists are based in Bunbury, Albany and Geraldton due to a lack of financial and other incentives to work in a remote location. This means that there are vast areas of the State without regular access to School Psychology services, because they are only able to access the services of visiting metropolitan based psychologists when they have time available in an already over-committed workload. Access to Clinical Psychologists and Child Psychiatrists is even more limited because of the shortage of professionals in this area across Western Australia, resulting in waiting lists being extremely long and access time limited due to the high demand for services.*[240]

236 Submission No. 15 from Dr. Prue Stone; p. 3. Note that information provided to the Inquiry by the Department of Health indicates 45 FTE including the Child and Adolescent Psychiatrists and FTE in generic community mental health positions.
237 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch.
238 Submission No. 15 from Dr. Prue Stone; Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch; Submission No. 45 from Northcliffe Family & Community Centre; Broome and Northam Information Sessions.
239 Submission No. 3 Confidential; Submission No. 20 from Catholic Education Office; Submission No. 109 from Aboriginal Legal Service WA (Submission No. 118, 132 also referenced).
240 Submission No. 118 from Association of Independent Schools of Western Australia.

The Aboriginal Community Controlled Health Service (ACCHS), which provides maternal health services including services that are culturally appropriate, identified a lack of access to mental health professionals. Given the shortages of mental health professionals in some regions it may not be possible to arrange referrals when mental health issues are identified.[241]

A number of submissions also addressed the issues around the attraction and retention of a suitably qualified workforce.[242] The submissions covered the rates of pay, training, isolation, lack of suitable accommodation and/or affordable accommodation for workers.

Considerable distances must also be travelled by children and young people and their families to access services, particularly the specialised statewide services (such as the Bentley Adolescent Unit (BAU), Princess Margaret Hospital (PMH) services, King Edward Memorial Hospital's Mother and Baby Unit and the Complex Attention and Hyperactivity Disorder Services). Much of the evidence expressed concern about the impact this has on young people.[243]
The Council of Official Visitors noted the following in regard to the BAU:

> *…many of the children brought into the BAU from regional areas are flown in on the Royal Flying Doctor Service and some have been sedated to the extent that they need to be catheterised.*[244]

Ideally services would be provided at a local level. However, subsidised travel and accommodation (if needed), for children and young people and their families, would be a significant support.[245]

Submissions endorsed an expansion and further support for the statewide Clinical and Service Enhancement Program (SCSEP) which provides a video-conferencing service with a child and adolescent psychiatrist in Perth.[246] The Mental Health Commission (MHC) has indicated its intention to continue to fund and support the SCSEP.[247]

In 2009, 38 per cent of the telephone calls and 21 per cent of the online contacts to Kids Helpline were from regional and remote areas. Of the contacts concerned with mental illness or emotional and behavioural management, 17 per cent were from regional areas. Kids Helpline suggests that online counselling is one of the preferred communication methods for children and young people when they are seeking help about mental health and other complex issues.[248]

The importance and effectiveness of information technology and the online environment in providing information and counselling for young people is well supported by research, as is the effectiveness of initiatives such as ReachOut.com and ActNow.[249] The Inquiry notes that headspace is piloting the e-headspace counselling service as part of the Commonwealth drought package to support 12 to 25 year olds in designated areas of WA.[250] Online methodologies are also effective ways to promote mental wellbeing, early intervention programs and services.

Young people in the Wheatbelt raised concerns about confidentiality, lack of anonymity, stigma and very limited services.[251] [252] The views of young people together with the evidence suggest that not only do services need to be extended but they also need to take into account these concerns.

241 Submission No. 102 from Aboriginal Health Council of WA, p. 72.
242 Submission No. 15 from Dr. Prue Stone; Submission No. 20 from Catholic Education Office; Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch; Inquiry information sessions.
243 Submission No. 45 from Northcliffe Family & Community Centre; Submission No. 80 from West Australian Foundation for Deaf Children; Submission No. 118 from Association of Independent Schools of Western Australia (Submission No. 113 also referenced)
244 Submission No. 22 from Council of Official Visitors.
245 Submission No. 15 from Dr. Prue Stone; Submission No. 45 from Northcliffe Family & Community Centre; Submission No. 139 from Health Consumers Council.
246 Submission No. 15 from Dr. Prue Stone; Submission No. 141 from Mental Health Commission.
247 Mental Health Commission 2010, WA Mental Health Towards 2020 Consultation Paper, Government of Western Australia.
248 Submission No. 82 from BoysTown.
249 Submission No. 90 from Inspire Foundation.
250 Submission No. 69 from headspace National.
251 Submission No. 113 from Regional Development Australia Wheatbelt.
252 Submission No. 69 from headspace National; Submission No. 83 Confidential; Submission No. 90 from Inspire Foundation (Submission No. 134 also referenced)

Royalties for Regions is a program whereby the equivalent of 25 per cent of the State's mining and onshore petroleum royalties will be returned to the State's regional areas each year as an additional investment in projects, infrastructure and community services. The money is in addition to regular Budget programs.[253]

The Inquiry was informed that Royalties for Regions funding has been provided to support important mental health and wellbeing projects in regional Western Australia such as the Regional Men's Health Program.[254]

The Inquiry found that, as with many other human services in regional and remote areas, mental health services for children and young people are under-resourced, stretched and, in some cases, non-existent. Royalties for Regions presents an opportunity for funding to be directed into crucial mental health programs and services for children and young people in regional and remote areas of Western Australia.

The overwhelming evidence to this Inquiry is the lack of services and programs in regional and remote communities to address the mental health and wellbeing of children and young people. In particular there is an acute shortage of services and programs for children and young people who require early intervention and/or treatment services because they have a mental health illness.

Recommendation 18: The allocation of funding from the Royalties for Regions program be considered for the provision of mental health services for children and young people living in regional and remote communities.

5.4 Children and young people in contact with the criminal justice system

It is known that significant numbers of young people who come into contact with the justice system have mental health problems.[255] How the justice system deals with these young people – from first contact by the Western Australia Police (WAPOL) to services within the court system and through to management in the custodial setting – was raised in a number of submissions to the Inquiry.[256]

In 2008, the Western Australian Auditor General found there are significant numbers of young people with high levels of offending who have mental health problems. He also found there is no *'structure or process to ensure that mental health and substance abuse problems associated with repeated offending are identified and treated'*.[257] He noted there is limited identification of young people with mental health problems in the justice system and that no agency takes responsibility for case managing these young people. The submissions received by this Inquiry would suggest this situation remains largely the same at the time of writing.

WAPOL is often the first to come into contact with children and young people suffering from acute mental health episodes – either those who have committed an offence or those who are non-compliant and require transportation to hospital for assessment or treatment.[258] WAPOL submitted to the Inquiry that the limited resources of ICAYMHS and emergency response teams has resulted in WAPOL being called to assist in mental health emergency situations involving children and

253 Department for Regional Development and Lands 2011, Royalties for regions – putting it back into our communities, [website], viewed 6 January 2011, http://www.royaltiesforregions.wa.gov.au
254 Correspondence to the Commissioner for Children and Young People from Hon Terry Redman MLA, Minister for Agriculture and Food, received 31 August 2010.
255 Auditor General for Western Australia 2008, Performance Examination The Juvenile Justice System: Dealing with Young People under the Young Offenders Act 1994, Perth, p. 16.
256 Submission No. 22 from Council of Official Visitors; Submission No. 38 from Legal Aid WA (Submission No. 67, 4, 17, 21, 29 also referenced).
257 Auditor General for Western Australia 2008, Performance Examination The Juvenile Justice System: Dealing with Young People under the Young Offenders Act 1994, Perth, p. 16.
258 Submission No. 24 from Western Australia Police, p. 4.

young people increasingly frequently. This Inquiry concurs with WAPOL that:

> *…Police should [not] engage in the delivery of mental health services because appropriate mental health services are unavailable…The presence of police officers can often exacerbate responses and has the propensity to criminalise a health condition.*[259]

The Inquiry has recommended that a specialised 24/7 emergency service be established for children and young people experiencing a mental health crisis (see Chapter 7).

Another setting where children and young people with a mental illness intersect with the justice system is in the Western Australian Children's Court. This Court has exclusive jurisdiction in respect of children who have been charged with committing criminal offences[260] and sees many children and young people suffering a range of disadvantage.

> *It is almost always the case that young people who appear in court regularly, or on serious criminal charges suffer a range of disadvantages. These include drug and/or alcohol misuse by family members, carers and often the young person, family dysfunction and mental illness.*[261]

Children's Court Magistrate Deen Potter, in an article for the *Journal of the Law Society WA*, described the frustrations felt by parents or caregivers attending Court about their child's mental illness, and the failed attempts to receive supports prior to the criminal activity:

> *It is not uncommon for parents or caregivers attending Court to voice their frustrations at the escalating nature of their child's criminal behaviour and it is not uncommon for those same parents, or caregivers, to give the Court a history of their attendances upon a variety of agencies seeking assistance for dealing with their child's increasingly problematic behaviour. Often at the heart of these frustrations and concerns is a suggestion that the child is suffering from a chronic mental illness.*[262]

Many children and young people with mental illness could, with appropriate prevention, early intervention or treatment, be diverted from the criminal justice system.

The Inquiry notes the particular disadvantage facing children and young people from regional and remote areas who have been required to travel to Perth and may be suffering additional trauma,[263] as well as the complex needs of many Aboriginal children and young people (who have comprised between 60 and 90 per cent of the population of Western Australia's youth custodial facilities in recent years[264]).

Nevertheless, despite the high prevalence of mental illness in young people entering the justice system, and despite the extremely complex needs of many children and young people facing court, there is no comprehensive mental health service attached to the Children's Court,[265] nor is there any comprehensive process for the identification or assessment of children and young people with underlying mental health problems.[266]

Where the Court is concerned about a child or young person's mental health, it may request a psychological report but these cases must be chosen sparingly:

259 Submission No. 141 from Mental Health Commission, p. 13.
260 A child charged with an indictable offence can elect to be tried by a superior court – see Children's Court of Western Australian Act 1988, sections 19 and 19B.
261 Submission No. 38 from Legal Aid WA, p. 2.
262 Potter, D 2010, 'Mental Health Issues in the Children's Court Jurisdiction', Brief, Journal of the Law Society WA, vol. 37, no. 9, p. 16.
263 Submission No. 141 from Mental Health Commission, supplementary information from Department of Corrective Services.
264 Submission No. 21 from the Office of the Inspector of Custodial Services, p. 6.
265 Submission No. 67 from South Metropolitan Mental Health Advisory Group (SuMMat), p. 3.
266 Auditor General for Western Australia 2008, Performance Examination The Juvenile Justice System: Dealing with Young People under the Young Offenders Act 1994, Perth, p. 16.

Because there must be appropriate allocation of scarce resources to the most immediate cases, rote requests for psychological or psychiatric reports cannot be countenanced as it would lead to grid-lock in the system and children, invariably, spending more time in custody.[267]

The Department of Corrective Services advised the Inquiry there had been a 17 per cent increase in referrals for psychological reports for court over a 12 month period.[268] The Department noted that a priority area for action might include:

An integrated and coordinated State-wide Forensic Mental Health service for children and young people [that] would include court liaison, community forensic mental health services, ambulatory care for custodial setting, inpatient care and an in-patient facility which provides rehabilitative services for young people.[269]

Box 7: Adolescent Forensic Health Service (Victoria)[270]

In other Australian jurisdictions more comprehensive forensic mental health services are offered for children and young people in contact with the justice system. For example, in Victoria the Adolescent Forensic Health Service (AFHS) offers specialist forensic assessment and clinical counselling services to young people who are involved in the Victorian youth justice system on community based orders, custodial sentences and exiting custodial institutions on parole.

The AFHS is staffed by a multi-disciplinary team of professionals including nurses, medical officers, psychologists, social workers, dual diagnosis clinicians, health promoters, criminologists and occupational therapists. AFHS provides primary health care, mental health care, offence specific programs, health promotion programs, alcohol and drug treatment, dual diagnostic care, clinical counselling and group based interventions to young people who access the service.

Due to the significant mental health needs of many children and young people appearing before the Children's Court, the Inquiry recommends that comprehensive and appropriate mental health assessment, referral and treatment services be available to them.

Recommendation 19: Children and young people appearing before the Children's Court of Western Australia have access to appropriate, comprehensive mental health assessment, referral and treatment services.

The mental health needs of children and young people in custody are an additional issue for the juvenile justice system. Western Australia has one of the highest numbers of young people in juvenile detention in the country[271] and has the highest rate of over-representation of Aboriginal young people in detention.[272]

Although there is no accurate data available, it is estimated that there is a high number of children and young people in detention who have mental health problems and that the proportion of children in custody with mental health issues significantly exceeds their numbers in the general population.[273] The Inspector of Custodial Services estimates that at any given time up to 50 per cent of the children and young people in custody could be experiencing mental health issues that are impacting on their safety or wellbeing.[274] Concerns were raised to the Inquiry about whether these

267 Potter, D 2010, 'Mental Health Issues in the Children's Court Jurisdiction', Brief, Journal of the Law Society WA, vol. 37, no. 9, p. 16.
268 [Comparing the 12-month periods from November 2008 to October 2009 and November 2009 to October 2010] Submission No. 141 from Mental Health Commission, supplementary information from Department of Corrective Services.
269 Submission No. 141 from Mental Health Commission, supplementary information from Department of Corrective Services.
270 The Royal Children's Hospital Melbourne, Adolescent Forensic Health Service [website] http://www.rch.org.au/afhs/services.cfm?doc_id=12092, viewed 15 March 2011.
271 Productivity Commission 2010, Report on Government Services 2010, (2007-08 data), Canberra, p. 15.57.
272 Taylor, N 2007, Juveniles in detention in Australia 1981-2007, Australian Institute of Criminology, p. 30.
273 Potter, D 2010, 'Mental Health Issues in the Children's Court Jurisdiction', Brief, Journal of the Law Society WA, vol. 37, no. 9, p. 16.
274 Submission No. 21 from the Office of the Inspector of Custodial Services, p. 2.

children are receiving adequate mental health care to address a wide range of issues.[275]

> *The prime focus for psychological services in the juvenile detention centres is the suicide and self-harm risk management of young people in custody. A secondary focus is assessing criminogenic needs and therapeutic intervention for high risk offenders such as sex offenders and other seriously violent offenders. While some therapy is provided to those with acute mental health issues, there is little capacity for sustained treatment of others with chronic mental health needs and little direction on the management or prevention of emerging mental health issues among detainees.*[276]

A Consultation with young people in the Banksia Hill Juvenile Detention Centre[277] found that most valued the assistance of the psychologists employed by the Centre. The young people also mentioned that "just about everyone" in Banksia Hill is dealing with a drug problem and that violence in the home was also a major issue for most of the boys.

Box 8 provides an example of how a comprehensive approach to mental health services may be provided in Western Australia's custodial settings.

Box 8: Community Integration Team (NSW)[278]

In 2008, New South Wales (NSW) implemented the Community Integration Team (CIT) initiative. CIT works with young people in custody who have a serious mental illness, emerging mental illness and/or problematic drug and alcohol use or dependence. CIT clinicians coordinate care prior to and during the critical post release period with links made to specialist and general community services.

The objectives of CIT are to:

- promote positive outcomes for young people and address the gap in service provision;
- provide referral to community services;
- facilitate the re-integration of young people with mental health and/or drug alcohol problems into the community upon release from custody;
- undertake assessment and intervention recommendations in consultation with the YP and their families; and
- provide coordination of care and follow up in the community.

The CIT clinician maintains involvement with the young person and assists them to access community services for up to three months with an extension to six months if required.

There is no dedicated, secure forensic mental health facility for children and young people with a mental illness in Western Australia. This means that there is no place where a child or young person with a mental illness who needs to be held in custody – on remand or detention – can go to be treated in secure, fit-for-purpose accommodation.

The only dedicated facility in Western Australia for a person with a mental illness in custody is the Frankland Centre at Graylands Hospital – a centre designed for adults and accommodating *'some of the most criminally and mentally unwell individuals in the state as its patients'*.[279]

This is an entirely inappropriate environment for a child or young person and the lack of a specific facility for children and young people was an issue of concern raised in several submissions.[280] The MHC's submission to the Inquiry

275 Submission No. 22 from Council of Official Visitors, p. 5.
276 Submission No. 21 from the Office of the Inspector of Custodial Services, p. 2.
277 Submission No. 136 from Halo Leadership Development Agency.
278 Carter, J 2010, Adolescent Health Justice Overview, paper presented to Correctional Services Healthcare Summit, Melbourne, 27-28 October, 2010.
279 Potter, D 2010, 'Mental Health Issues in the Children's Court Jurisdiction', Brief, Journal of the Law Society WA, vol. 37, no. 9, p. 16.
280 Submission No. 15 from Dr. Prue Stone; Submission No. 22 from Council of Official Visitors (Submission No. 38, 21, 67, 29 also referenced).

conceded that that the absence of a youth forensic mental health service, including a maximum security standard mental health facility, is a 'major' mental health service gap and area of need for young people.[281]

The Inspector of Custodial Services reported to the Inquiry that:

> *[The Frankland Centre at Graylands Hospital] … is chronically full with adult prisoners and, in the view of this Office, unsuitable for young people. The youth custodial centres lack either specialist mental health staff or a residential clinic area where young people with acute mental health issues could safely and humanely be managed whilst being assessed and stabilised in their treatment.*[282]

Currently, an informal arrangement has been established between Rangeview Remand Centre (Supervised Bail Team) and the BAU[283] whereby young people who are on remand and who are mentally unwell can be placed on conditional bail and sent as voluntary patients to the BAU.

While it is positive that these children are receiving treatment and are being diverted from the adult facility, the Council of Official Visitors and the Inspector of Custodial Services submitted that the nature of this arrangement is inadequate for several reasons:[284]

1. The BAU is not set up as a secure, forensic facility and its staff are not trained to provide forensic services. It is not appropriate that it should provide this service without the necessary planning, resources, safety procedures or training.
2. Although nominally the young people from Rangeview are admitted on a 'voluntary' basis to the BAU, they are not free to leave the BAU and a warrant will be issued for their arrest if they do.[285]
3. As a voluntary patient, the young person does not have the same rights under the *Mental Health Act 1996* accorded to involuntary patients – including access to the Council of Official Visitors and review by the Mental Health Review Board.[286]
4. The facilities of the BAU itself are inadequate to provide therapeutic care for children and young people.[287] [288]

Children's Court Magistrates Potter and Horrigan also expressed their concern at this arrangement, noting that the situation for children and young people who have their bail refused is even less ideal:

> *It is inconceivable that there is still no secure location for mentally unwell Western Australian children. Where there is a refusal of bail, the child is then kept in a custodial setting, often in an isolation ward, restrained and sedated. The child has psychiatric needs which may not be met.*[289]

They went on to propose that a solution is to convert a portion of the BAU into a dedicated forensic facility.[290] However, given the acknowledged poor state of the BAU,[291] [292] (see Chapter 8) and the opportunity presented by the planned $30 million expansion of the Banksia Hill Juvenile Detention Centre,[293] the Inquiry believes one option to be considered is that of building a dedicated forensic mental health unit in Banksia Hill Juvenile Detention Centre.

281 Submission No. 141 from Mental Health Commission, p. 100.
282 Submission No. 21 from Office of the Inspector of Custodial Services, p. 5.
283 The BAU is Western Australia's only facility providing involuntary mental health treatment for children and young people (aged 9 to 17).
284 Submission No. 22 from Council of Official Visitors; Submission No. 21 from Office of the Inspector of Custodial Services.
285 Council of Official Visitors 2009, Annual Report 2008-09, Western Australia, p. 19.
286 Submission No. 21 from Office of the Inspector of Custodial Services, p. 5.
287 Council of Official Visitors, Annual Report 2008-09, p. 19.
288 Submission No. 42 Confidential.
289 Submission No. 29 from Children's Court of Western Australia, p. 2.
290 That is, a Declared Place in an Authorised Hospital under the Criminal Law (Mentally Impaired Accused Act) 1996
291 Council of Official Visitors, Annual Report 2008-2009, 2009, p.4.
292 Hon Linda Savage MLC, Member for East Metropolitan, Legislative Council, Thursday 14 October 2010, pp. 7685d-7696a.
293 Porter, C 2010, Groundbreaking ceremony starts $30 million project to boost youth custodial services, Ministerial Media Statements [website], viewed 20 January 2010, http://www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=133032&minister=Porter&admin=Barnett

The Inquiry emphasises that children as young as 10 can become involved with the criminal justice system and that any forensic mental health service must appropriately accommodate children and not solely be designed for young people.

Recommendation 20: A dedicated forensic mental health unit for children and young people be established.

5.5 Children and young people in care

A number of submissions raised concerns about the mental health and wellbeing of children and young people in care and emphasised this was a high risk group with significant needs and for whom current services were not adequate.[294]

> *Compared to their peers in the general population the research evidence indicates that children and young people in out-of-home care often have unrecognised and unmet complex health needs, are more likely to have mental health problems and unmet emotional needs and are more likely to experience significant barriers in accessing effective health care provision.*[295]

As at February 2010, there were 3,276 children and young people in the care of the Chief Executive Officer, Department for Child Protection (DCP). Forty-five per cent were Aboriginal.[296]

Children in out-of-home care have a higher prevalence of mental health problems than in the general population of children and young people, including conduct disorder, anxiety, attention and social problems and depression.[297] A study of children in out-of-home care in four Australian States including Western Australia found the main factors associated with the need for out-of-home care were domestic violence, physical abuse and parental substance abuse.[298] These are significant risk factors for mental health problems in children and young people (see Chapter 2). Research has found that children exposed to abuse and trauma have high levels of disorganised attachment and that this is a strong predictor of a subsequent mental health disorder.[299]

For some families, particularly in some Aboriginal communities, there can be the presence of multiple additional risk factors such as poverty, inadequate housing, unemployment, poor education and limited access to services.[300] Parental mental health is also a factor associated with the placement of children into care, being the case for half the children in the aforementioned study.[301] These factors not only place children at greater risk of needing out-of-home care, they also increase the risk of children developing mental health problems.

Having a stable living environment was identified by young people in care as important in the prevention of mental health problems:

> *A stable living environment would stop mental health issues from happening.* (Female, 13)[302]

294 Submission No. 16 from Department of Education; Submission No. 23 from Western Australian Secondary School Executives Association; Submission No. 24 from Western Australia Police (Submission No. 27, 55, 61, 67, 104, 107, 126, 132, 134, 140 also referenced)
295 Submission No. 55 from The Children's Guardian (NSW), p. 1.
296 Department for Child Protection 2010, Department for Child Protection Annual Report 2009-2010, p.12.
297 Royal Australian and New Zealand College of Psychiatrists 2008, The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry, p. 5 [website], viewed 17 February 2011, http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/FCAP_paper_on_Out_of_Home_Care_June_2008.pdf
298 Osborn, A & Delfabbro, P 2006, National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-home Care, University of Adelaide, p. 39.
299 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth, p. 5.
300 Steering Committee for the Review of Government Service Provision (SRGSP) 2009, Overcoming Indigenous Disadvantage: Key Indicators 2009, pp. 4,116, Productivity Commission, Canberra.
301 Osborn, A & Delfabbro, P 2006, National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-home Care, University of Adelaide, p. 39.
302 Submission No. 115 from CREATE Foundation, p. 4.

Similarly, DCP identifies stable out-of-home care as a vital factor impacting on the mental health of children and young people in care.[303]

Both the Children's Guardian (NSW) and the Royal Australian and New Zealand College of Psychiatrists (WA) (RANZCP) submitted to the Inquiry that children and young people, both when in care and when transitioning from care, require timely and responsive access to assessments and services that meet their needs.[304] The Children's Guardian (NSW) listed the following as requirements:

> *…to have a multi-modal mental health assessment; to have timely access to multi-disciplinary teams that are competent and sensitive to meeting their needs; to have coordinated health care and service pathways that facilitate equitable access and to experience interventions that are culturally appropriate, that enables their participation and that of their carers and where appropriate their parents.*[305]

Early intervention is crucial and involves detecting problems, preferably at the pre-clinical stage through adequate assessment, for example, on entering out-of-home care.[306]

Information provided to the Inquiry by DCP detailed the implementation of health screening for children coming into care. Under the *Children and Community Services Act 2004* (WA) all children and young people in care will have a care plan to be reviewed annually. For children and young people who come into care and for those who are already in care, a health assessment as part of this planning will also occur annually.

The assessment is conducted by a community health nurse and includes mental health screening. If mental health problems are identified, referral to DCP's psychologists for further assessment and intervention will result, with referrals then made as necessary to ICAYMHS or other services.[307]

The Inquiry commends the introduction of mental health screening. However, two additional components are needed to ensure the implementation of health assessments and personalised health plans will result in improved mental health for children and young people in care:

1. Monitoring to ensure consistent and equitable implementation for all children and young people entering, in or leaving care. The Children's Guardian (NSW) contends:

   Monitoring and evaluation play an important part in strategic planning and continuous quality improvement – where identified gaps in service provision and evidence for service improvements can be usefully used to reform service delivery for the benefit of children and young people.[308]

   The Children's Guardian (NSW) found that outcomes were improved by auditing designated performance areas within case files, for example, examining the way mental health care needs are being met.[309]

The Inquiry notes that the health screening and monitoring processes in place in NSW and Queensland enable a more comprehensive assessment of how children in out-of-home care are faring. For example, in 2007–2008, the Children's

303 Submission No. 141 from Mental Health Commission, pp. 84, 85.
304 Submission No. 55 from The Children's Guardian (NSW); Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch.
305 Submission No. 55 from The Children's Guardian (NSW), pp. 2-3.
306 Royal Australian and New Zealand College of Psychiatrists 2008, The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry, pp. 19-20 [website], viewed 17 February 2011, http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/FCAP_paper_on_Out_of_Home_Care_June_2008.pdf
307 Submission No. 141 from Mental Health Commission, supplementary information from Department for Child Protection.
308 Submission No. 55 from The Children's Guardian (NSW), p. 4.
309 Ibid, pp. 4-6.

Guardian (NSW) audit program found almost a quarter of the audited files showed that psychotropic medication was prescribed.[310] Thorough monitoring can alert agencies to systemic issues and direct appropriate and responsive action.

2. Collaboration between agencies – about information sharing, referral and service pathways and about having a shared clinical framework.

   This was considered extremely important in many submissions[311] with an emphasis on an integrated holistic service model and developing 'standardised care coordination protocols' between key agencies.[312] [313] [314]

The Inquiry recognises that DCP is undertaking significant policy reforms aimed at improving the way agencies work together. This includes the sharing and exchange of information and the development and implementation of an across-government Rapid Response framework.[315] DCP has suggested that Rapid Response should include priority access to mental health services and specific mental health services for children and young people.[316] The Inquiry supports this action but also notes the extra burden this will place on services such as ICAYMHS and the need to ensure these supporting services are resourced adequately to cope with the higher demand.

Rapid Response (and mental health screening) needs to result in better outcomes for the children and young people involved, including through timely access to treatment services and continuity of treatment.[317]

Young people consulted by CREATE placed great importance on the need for holistic, consistent services which are easy to access and responsive to their individual needs, believing it is necessary for them to be involved in planning their health services. They called for more to be done to raise awareness of children and young people in care about their mental health and where they can go for help:[318]

> *There needs to be more information available. I wouldn't know where to go if I thought I was becoming mentally ill.* (Male, 15)[319]

> *An adolescent centre where we could go to speak to someone and that was free.* (Female, 14)[320]

Recommendation 21: The Rapid Response framework identify and respond to the mental health requirements of individual children and young people in care and that this be monitored on a regular basis by the Department for Child Protection.

310 The Children's Guardian (NSW), Annual Report 2007-2008, NSW Office for Children, New South Wales, p. 97.
311 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch; Submission No. 55 from The Children's Guardian (NSW); Submission No. 104 Confidential (Submission No. 107, 140 also referenced).
312 Submission No. 107 from Parkerville Children & Youth Care Inc.
313 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch
314 Submission No. 141 from Mental Health Commission, supplementary information from Department for Child Protection [A Strategic Bilateral Memorandum of understanding will potentially be developed with the Mental Health Commission].
315 The Rapid Response Framework is an across government framework which seeks to address the specific and complex needs of children and young people in care across a range of areas.
316 Submission No 141 from Mental Health Commission, supplementary information from Department for Child Protection.
317 Submission No. 55 from The Children's Guardian (NSW), pp. 5–6.
318 Submission No. 115 from CREATE Foundation, p. 7.
319 Ibid, p. 4.
320 Ibid, p. 6.

5.6 Children and young people of parents with mental illness

It is estimated that, for the general population, 25 to 50 per cent of children of parents with a mental illness will experience mental health problems, as compared to 10 to 20 per cent of children with a parent without a mental illness.[321]

The *Western Australian Aboriginal Child Health Survey* found that 17.5 per cent of male carers and 25.5 per cent of female carers had contact with mental health services.[322] About one-third of Aboriginal children and young people whose primary carer had used mental health services, were at high risk of clinically significant emotional or behavioural difficulties.[323]

Given this higher risk, targeted mental health promotion, prevention and early intervention programs are crucial. Several early intervention programs specifically designed for children of parents with mental illness are provided in Western Australia through organisations such as Ruah Community Services, Arafmi, Wanslea Family Services, and COMIC.[324] [325] [326]

A significant barrier to the systematic provision of services and support is that children and young people of a parent with mental illness are not necessarily being identified.

Although there are programs seeking to increase the awareness of professionals about the needs of children and young people with a parent with a mental illness (for example, the *Perspectives* Resource Unit[327]) a more comprehensive approach to identification and referral is needed. Arafmi provided its view on the current situation:

> *…generally organisations that provide services to families need the person with the mental health issue, and the rest of the family to agree to be involved with the service; and organisations providing services to young carers need the agreement of their parents to receiving services (even if their parents don't want to be involved themselves). However if the parents won't let their children receive services, or no one takes the initiative to refer young carers to services, then these marginalised young people won't receive services.*[328]

The early identification of mental health problems is critical to ensure timely intervention, treatment programs and services are provided. If those providing services to an adult with a mental illness recognise and respond to the needs of the children in the family, a more comprehensive and integrated approach to meeting the mental health needs of the children and young people will be facilitated:

> *Services whose primary focus is on adults have a responsibility to children when there are factors relating to the parent which make children more vulnerable…Given that children of parents with an alcohol or drug problem, a mental illness or an intellectual disability are at much greater risk than other children, especially in a single parent family or where both parents have such conditions, organisations servicing these client populations need to build their capacity to respond to children's needs.*[329]

321 Moodie 2002, Promoting the Mental Health of Children and their Families -Together We Do Better. Paper presented at the First National Conference for all involved in Meeting the Challenge for Children and Families where Parents have a Mental Illness cited in Smith, W. and Nicholls, D.S., 2002, Pathways To Resilience. Children Of Parents With A Mental Illness Project Report, Department of Health.
322 Zubrick, S, et al 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, p. 427.
323 Ibid, p. 120.
324 Ruah Community Services, Family to Family Workshops [website], viewed 17 March 2011, http://www.ruah.com.au/page/COPMI_FamilyToFamily
325 COMIC Children of Mentally Ill Consumers [website], viewed 17 March 2011, http://www.howstat.com/comic/Home.asp
326 Submission No. 44 from Wanslea; Submission No. 128 from Arafmi Mental Health Carers & Friends Association WA.
327 Ruah Community Services [website], viewed 3 March 2011, http://www.ruah.com.au/page/COPMI
328 Submission No. 128 from Arafmi Mental Health Carers & Friends Association WA, p. 2.
329 Cashmore, J, Scott, D & Calvert, G 2008, Think Child, Think Family, Think Community: Submission to the Special Commission of Inquiry into Child Protection Services in NSW, p. 38.

Adult mental health services have an obligation when treating an adult to ask whether there are children in the family, identify whether those children need support and then to facilitate referrals to appropriate services.

The Victorian Government's *Families where a Parent has a Mental Illness Strategy*[330] is an example of how government policy can support a child-centred approach to service delivery. The Inquiry also notes the activity of the Western Australia Children of Parents with a Mental Illness (COPMI) Collaboration Implementation and Monitoring Committee.

Recommendation 22: To meet the mental health needs of children and young people of parents with a mental illness, the Mental Health Commission in partnership with relevant agencies identify and support a strategic and coordinated approach to services and programs.

5.7 Children and young people experiencing difficult circumstances

The Inquiry recognises the needs of children and young people who are at greater risk of mental health problems due to challenging family or other circumstances. This includes those children and young people with a parent or sibling with a mental or physical illness, disability or alcohol or substance abuse problem; who may have a parent in prison; who have experienced family and domestic violence, or who may be experiencing divorce, separation or the death of a parent or close family member.

Although their experiences vary, there is evidence that children and young people in these circumstances are affected by grief, loss, trauma, social isolation, stigma, stress, anxiety, low self-esteem and depression.[331] [332] [333] [334] [335] The Inquiry received many submissions concerned with the needs of these children and young people.[336]

There is general consensus that these vulnerable children and young people are, to a large degree, 'hidden' and 'voiceless',[337] with particular reference in the submissions made to those who are carers, have a parent with cancer or a parent in prison.[338]

In many cases, adults in these challenging circumstances are receiving services that meet their particular needs. However, adult-focused service does not always acknowledge or provide for the needs of the child or young person in the family and, as such, the child or young person has only minimal supports.

The following example provided by Carers WA of a young person caring for a parent with a health condition is illustrative of this in practical terms:

> *K is a 14 year old Aboriginal girl living in a suburb of Perth. She is the oldest of 6 children in a sole parent family. Her mother is often unwell due to frequent epileptic seizures so K provides care for her mother and*

330 Victorian Government Department of Human Services 2007, Families where a parent has a mental Illness: A service development strategy [website], viewed 17 February, http://www.health.vic.gov.au/mentalhealth/families/families.pdf
331 Stephens-Reicher, J, Metcalf, A, Blanchard, M, Mangan, C & Burns, D 2010, Reaching the hard-to-reach: How Information Communication Technologies (ICT) can reach young people at greater risk of mental health difficulties [website], viewed 10 August 2010, www.inspire.org.au/uploads/files/pdfs/100702%20Reaching%20the%20hard-to-reach_Diversity%20Paper.pdf
332 Submission No. 56 from CLAN WA.
333 Woodward, R 2003, Occasional Paper No. 10: Families of prisoners: Literature review on issues and difficulties, Australian Government Department of Families and Community Services, pp. 9-10.
334 Pat Thomas Memorial Community House Inc 2008, The World of the Child, p. 5, Western Australia.
335 Community Services (NSW), Domestic Violence and its impact on children's development, presented at the Department of Community Services' Fourth Domestic Violence Forum on 24 September 2002 [website], viewed 17 February 2011 http://www.community.nsw.gov.au/docswr/_assets/main/documents/dv_paper.pdf
336 Submission No. 6 from Samaritans Crisis Line; Submission No. 16 from Department of Education; Submission No. 36 Confidential (Submission No. 44, 56, 61, 79, 88, 90, 93, 104, 105, 112, 128, 131, 134, 137, 138, also referenced).
337 Submission No. 90 from Inspire Foundation; Submission No. 93 from Hon Alison Xamon MLC; Submission No. 128 from Arafmi Mental Health Carers and Friends Association WA Inc (Submission No. 134 also referenced).
338 Submission No. 56 from CLAN WA; Submission No. 79 from Eika Counselling; Submission No. 112 from Carers WA.

her younger siblings… K attends the local high school where she is doing quite well despite missing a lot of school. Her absences have meant that the Department of Child Protection has been involved in the family situation, however no support services have been made available to the family. Staff at the high school are aware of the family situation but no additional services have been put in place to support K or her siblings.[339]

Carers WA submitted that there needs to be increased awareness about the services available and the needs of these children and young people, as well as stronger referral systems so they are directed to the supports that can assist them.

Young carers need to be referred to appropriate services by GPs, schools and mental health clinics. Many of these professionals are unaware of the role of young carers and unaware of the services available to young carers, or misunderstand the eligibility criteria or nature of particular services and make inappropriate referrals which then discourages young people from seeking services in future.[340]

The Inquiry found that those agencies providing services to adults need to ensure they implement a child-centred approach, thereby acknowledging the needs of the children and young people 'behind' the adult and referring the child for additional supports where necessary. Kids in Focus WA is an example of such an approach (see Box 9).

Box 9: Kids in Focus WA

This Western Australian partnership between Women's Health Services, Cyrenian House and Community Link and Network (CLAN WA) is based on Kids in Focus SA. It aims to provide integrated support for families impacted by drug and alcohol abuse across the continuum of care from early intervention, intensive support and rehabilitation, to managing the transition to living and thriving in the community. Features of the program include collaboration with specialist alcohol and drugs services, a wrap-around case management model and a child-focused intervention.[341]

Recommendation 23: Agencies providing services for adults in the areas of domestic violence, mental or chronic illness, disability, alcohol or drug abuse or prison, recognise that children and young people in these families are a vulnerable group who have specific mental health needs and incorporate a child-centred approach to the services they deliver.

5.8 Children and young people from culturally and linguistically diverse communities

A significant number of submissions identified the specific needs of culturally and linguistically diverse (CaLD) children and young people,[342] as well as children and young people from a refugee background. Not only do these children and young people have a higher risk of mental health problems but they also face additional barriers to accessing services. The Office of Multicultural Interests (OMI) submitted:

Children and young people from CaLD backgrounds share the same risk factors that may predispose them to mental health problems as other children and young people. However… Research suggests that some children and young people from CaLD backgrounds, particularly those with a refugee experience, are at risk of having or developing low self-esteem, poor self-concept and mental health problems (including depression and anxiety, post traumatic stress disorder, and heightened psychosomatic symptoms).[343]

OMI advised the Inquiry that ICAYMHS currently has only one specialist psychologist to address the needs of CaLD

339 Submission 112 from Carers WA, p. 9.
340 Submission 112 from Carers WA, p. 15.
341 Information provided to the Commissioner for Children and Young People from Womens Health Services, 21 September 2010; Kids in Focus, [website] viewed 21 March 2011, http://www.kidsinfocus.org.au/Home.aspx
342 Submission No. 16 from Department for Education; Submission No. 28 from City of Melville; Submission No. 48 from Fremantle Multicultural Centre (Submission No. 63, 92, 93, 104, 122, 126, 129, 132, 134, 137, 138 also referenced).
343 Submission No. 92 from Office of Multicultural Interests, p. 1.

children and young people.

Approximately 49 per cent (3,276) of humanitarian entrants and 16 per cent (1,054) of non-humanitarian entrants who came to Western Australia in the five-year period 2002-03 to 2006-07 were under the age of 18 years.[344] A proportion of children and young people from each of these groups will have had a refugee experience.

OMI and other agencies described a number of factors that, depending on individual circumstances, could impact on these children and young people's mental health. These include:

- experiences of war, torture, trauma and refugee camps;
- loss of and separation from family;
- interrupted education;
- identity issues and the challenge of belonging to two cultures;
- intergenerational conflict;
- loss of friends and social support networks;
- responsibility for taking care of the family's practical needs (through greater competence in English);
- isolation;
- language barriers;
- trouble making friends; and
- the experience of racism and/or cultural and religious discrimination.[345]

Parents in migrant families are making the same cultural adjustments and may face the same issues as their children. The resulting stress can impact negatively on their parenting, particularly when the family has experienced significant trauma. For example, parents can be suffering their own experience of trauma while parenting children whose own response to trauma may result in significant behavioural issues.[346]

Promotion and prevention programs are essential for improving the mental health and wellbeing of all children and young people and are discussed throughout this Report. The specific cultural and mental health needs of CaLD children and young people should be considered in the development and delivery of these programs. It is important that parenting programs are culturally appropriate and address the specific circumstances of these families (see Box 10). Similarly, programs to develop a positive school community free of racism and which address bullying and discrimination are considered particularly important.[347]

Box 10: Bending Like a River[348]

This project, developed and delivered through a partnership between the Multicultural Services Centre WA (MAITRI Mental Health) and Relationships Australia (WA), is a nine-week course for people at risk of using violence within the family. The aim of the program is to assist with the challenges of parenting and intimate relationships within the Australian context, including child protection laws and different cultural values around parenting and changing gender roles. By building on the capacity of families and communities to maintain safe, supportive and nurturing relationships, the program enhances the mental health of all family members and contributes to successful settlement in Australia.

The program has been run with a variety of refugee groups over the past 12 months and is receiving positive feedback from participants and community members.

344 Department of Immigration and Citizenship 2007, Western Australia: Settlement trends and needs of new arrivals, cited in Submission No. 63 from ASeTTS, p. 1.

345 Submission No. 92 from Office of Multicultural Interests, p.1; Submission No. 28 from City of Melville; Submission No. 48 from Fremantle Multicultural Centre (Submission No. 129, 134 also referenced)

346 Sims, M, Guilfoyle, A, Kulisa, J, Targowska, A. & Teather, S 2008, Achieving Outcomes for Children and Families from Culturally and Linguistically Diverse Backgrounds [website], viewed 16 February 2011, http://www.aracy.org.au/publicationDocuments/TOP_Achieving_Outcomes_for_Children_and_Families_from_Culturally_and_Linguistically_Diverse_Backgrounds_2008.PDF

347 Submission No. 92 from Office of Multicultural Interests; Submission No. 104 from Relationships Australia; Submission No. 126 from The Royal Australasian College of Physicians.

348 Submission 104 from Relationships Australia, p. 5.

The additional barriers to accessing services were highlighted by OMI which submitted that CaLD communities access mental health services substantially less – including lower use of services by children and young people – than other Australian communities.[349] This is not the result of lower rates of mental health problems, but is the result of differences in the understanding, care and treatment of mental health across cultures, lack of culturally appropriate information and education about mental health problems and disorders and services, stigma about mental health problems (within their community), and parents or guardians failing to recognise trauma resulting from the refugee experience.[350]

A second set of barriers to accessing services is the nature of the services themselves. There was general agreement from those who made submissions that:

> *…there is significant unmet need in the provision of culturally sensitive and linguistically appropriate mental health services for culturally and linguistically diverse (CaLD) families and young people in Western Australia.*[351]

In its submission, the Youth Affairs Council of WA explains:

> *A qualitative study of CaLD young people from Western Australia, South Australia and Queensland found that services were under-utilised by this group due to a lack of cultural understanding on the part of counsellors, a lack of culturally specific services and difficulty in sourcing bi-lingual workers.*[352]

For services to be effective a culturally competent workforce (which may include staff who are bilingual or from CaLD backgrounds) and cultural competency training for staff are crucial.[353]

Mental health stigma reduction programs in CaLD communities, engaging with CaLD community leaders in educating their communities about mental health and providing multilingual information (at an early stage to new arrivals) were considered important strategies to improve the number of children and young people accessing services.[354]

Targeted early identification processes which result in culturally appropriate early intervention and treatment services are needed in settings readily accessed by children, young people and their families.

A number of submissions referred to schools as being particularly important places for program and service delivery. This would require additional staff and resources.[355] In addition, submissions stated that both youth-friendly and/or family-centred services were very important for children and young people from CaLD and refugee backgrounds.[356]

The Integrated Services Centres[357] (ISCs) located at Parkwood Primary School and Koondoola Primary School were considered an effective holistic service delivery model (see Box 11) which could be expanded to other Intensive English

349 Submission No. 92 from Office of Multicultural Interests, p. 2.
350 Submission No. 63 ASeTTS; Submission No. 92 from Office of Multicultural Interests; Submission No. 129 from Multicultural Youth Advocacy Network of Western Australia (Submission No. 137, 138 also referenced).
351 Submission No. 93 from Hon Alison Zamon MLC; Submission No. 63 from ASeTTS; Submission No. 92 from Office of Multicultural Interests. (Submission No 126, 129 also referenced).
352 Gormon, D, Brough, M, & Ramirez, E 2003, 'How young people from culturally and linguistically diverse backgrounds experience mental health', International Journal of Nursing, no 12, p. 99, cited in Submission No. 134 from Youth Affairs Council of Western Australia, p. 5.
353 Submission No. 92 from Office of Multicultural Interests; Submission No. 63 from ASeTTS
354 Submission No. 28 from City of Melville; Submission No. 92 from Office of Multicultural Interests, p. 5, Submission No. 138 from Ethnic Disabilities Advocacy Centre, p. 10.
355 Submission No. 48 from Fremantle Multicultural Centre; Submission No. 63 from ASeTTS, p. 4; Submission No. 92 from Office of Multicultural Interests, p. 5. (Submission No. 104, 132 also referenced).
356 Submission No. 63 from ASeTTS; Submission No. 129 from Multicultural Youth Advocacy Network of Western Australia; Submission No. 134 from Youth Affairs Council of Western Australia.
357 The 'Integrated Services Centres' at Parkwood and Koondoola should not be confused with the integrated services on school sites mentioned elsewhere in the Report.

Centres (IECs), including in secondary schools.[358]

The ISCs were evaluated positively in 2008 and the evaluation recommended that service delivery be extended to include more IECs.[359]

Box 11: Integrated Services Centres

Integrated Services Centres (ISCs) are an innovative model of coordinated service delivery. Based on the 'schools as a hub' concept, they operate as a 'one-stop-shop' to address the complex needs of humanitarian entrants. They were established through a partnership between OMI and the Departments of Health and Education.

Services are provided by a mix of government and non-government agencies both on-site and off-site as necessary. The wide range of services provided by ISC staff to clients include: nursing assessments and treatment; health advocacy; health education and immunisation; child and adult health issues; housing advocacy; referrals to mainstream and other related services; support in transition to mainstream schooling; information sessions on life skills, rights and settlement issues; healthy eating and kitchen safety workshops; after school sports programs; family reunion through referrals and liaison with other agencies; transportation to medical and dental appointments; psychosocial education and family support; group work therapy; psychosocial assessments; directive play techniques; child-centred play therapy; and holiday programs for children.

An evaluation of the pilot program, conducted by Edith Cowan University in 2008, found the ISCs had relieved pressure on, and were more effective than, existing mainstream services, particularly through both their use of schools as a hub and their in-reach and out-reach approach. It found the co-location of services and the holistic approach to the delivery of services to be supportive of families' wellbeing and promoted integration of newly arrived humanitarian entrants into mainstream society.

A significant benefit of the ISCs is that they provide an effective and coordinated service delivery model with a primary focus on children, which differentiates them from other programs and service providers that tend to target parents when addressing the needs of families. Of all the clients accessing the ISCs, the proportion of children and young people (under the age of 18) increased from 47 per cent in 2008 to 73 per cent in 2009.[360]

Special consideration needs to be given to the mental health and wellbeing needs of children and young people being held in immigration detention.

Following a visit to the Leonora Alternative Place of Detention the Human Rights Commissioner expressed serious concern about the impact of prolonged detention on the mental health and wellbeing of detainees, including children and young people, and the provision of mental health services.[361]

An important issue in addressing the mental health needs of children and young people from CaLD and refugee backgrounds is whether their unique needs can be adequately addressed through mainstream services or whether there is a need for specialist, culturally-specific services.

Recommendation 24: The Integrated Services Centres at Parkwood and Koondoola be maintained and consideration be given to expanding this model on additional school sites.

358 Submission No. 92 Office of Multicultural Interests; Submission No. 63 from ASeTTS.
359 Bahn, S, Hancock, P, & Cooper, T 2008, Evaluation of the Integrated Services Centre Pilot Project, Social Justice Research Centre, Edith Cowan University, p. 47.
360 Information provided to the Commissioner for Children and Young People from the Office for Multicultural Interests, 23 February 2011.
361 Australian Human Rights Commission 2011, 2011 Immigration Detention in Leonora: Summary of observations from visit to immigration detention facility Leonora, Australian Human Rights Commission, p. 10.

5.9. Children and young people with diverse sexuality, sex and/or gender

Several submissions raised concerns about the mental health and wellbeing of young people with diverse sexuality, sex and/or gender (DSSG).[362] The MHC also identified DSSG young people as a high risk group.[363]

DSSG young people have disproportionate rates of suicide, self-harm, anxiety, depression, social isolation, homelessness and substance misuse and reduced help-seeking behaviour.[364] The Youth Affairs Council of WA (YACWA) describes the negative experiences stemming from other people's response to young people's sexuality as including family pressure or conflict, bullying, discrimination and rejection from peers and family.[365] Young people consulted by the Freedom Centre recounted some of these experiences, for example:

> *"I was bullied in high school for looking, talking, walking and acting like a gay male. Obviously this didn't encourage me to come out… until I was 'outed' by a friend. Soon after I learned to deal with bullying… What I need whoever reads this to understand… is that; being a teen is so so soooo hard. Add discrimination, fear, anxiety, stress, depression because of your sexuality and you become a headcase and end up in hospital."* (Male, 17)[366]

Marginalisation and discrimination are barriers to the use of mainstream services.[367] The Freedom Centre's consultation with young people confirmed this and the Centre submitted that the provision of training programs for schools and mainstream mental health service providers to ensure non-discriminatory environments and services was a priority.[368]

5.10 Children and young people with a disability

Children and young people with a disability are at higher risk of developing mental health problems than those without a disability.[369] [370]

> *Research tells us that children with disabilities have a greater chance of developing mental health problems than children without disabilities. For example, 41% of young people with intellectual disability aged 4–18 years had also been diagnosed with emotional and behaviour disorders like depression and Attention Deficit Disorder. Young people with Autism were found to have even higher rates of emotional and behavioural difficulties than did those with intellectual disability. High rates of mental difficulties have also been found in young people who are hearing impaired, have cerebral palsy, epilepsy or chronic illness.*[371]

As well as being subject to the risks facing all children, children with a disability are subject to significant additional stressors. Depending on the disability or illness, the challenges can include difficulties in communicating, difficulties in

362 Submission No. 16 from Department of Education; Submission No. 93 from Hon Alison Xamon MLC; Submission No. 114 from WA AIDS Council's Freedom Centre (Submission No. 134 also referenced)
363 Submission No. 141 from Mental Health Commission, p. 89.
364 Submission No 141 from Mental Health Commission, pp. 89-90; Submission No. 16 from Department of Education; Submission No. 93 from Hon Alison Xamon MLC (Submission No. 114, 134 also referenced)
365 Submission No. 134 from Youth Affairs Council of Western Australia, p. 5.
366 Submission No. 114 from WA Aids Council's Freedom Centre, p. 17.
367 Lifeline Australia et al 2010, Suicide and Suicide Prevention in Australia: Breaking the Silence, viewed 16 February 2011, http://cmhr.anu.edu.au/pdf/Breaking%20the%20Silence.pdf
368 Submission No. 114 from WA Aids Council's Freedom Centre, p. 24.
369 Submission No. 141 from Mental Health Commission, p. 95; Submission No. 105 from Department of Families, Housing, Community Services and Indigenous Affairs, pp. 30-31; Submission No. 80 from West Australian Foundation for Deaf Children.
370 Australian Institute of Health and Welfare 2006, Disability updates: children with disabilities, Issue 42, July 2006, p. 1, viewed 15 February 2011, http://www.aihw.gov.au/publications/aus/bulletin42/bulletin42.pdf
371 KidsMatter 2009, Understanding the mental health needs of children with disabilities, p. 3 [website], viewed 15 February 2011, http://www.kidsmatter.edu.au/uploads/2009/09/additional-needs-overview.pdf

forming and maintaining relationships, difficulty accessing programs and services including recreation and education, pain, stress, social isolation, bullying, alienation and discrimination.[372] [373] [374]

The higher risk of mental health problems for those with a disability has been formally recognised, as has the need for an enhanced and specific response in terms of the services provided. The *Fourth National Mental Health Plan* acknowledges that mental health problems are more likely to occur in association with disability and physical illness. It identifies better coordination between the range of service sectors providing treatment and care as essential to meeting the needs of the whole person, whether those needs arise from their disability or their mental health.[375]

The WA Disability Services Commission's (DSC) future directions document *Count Me In: Disability Future Directions* states:

> *People with disabilities have the right to receive the same quality of services as others in the community – this includes appropriate health and medical services.*[376] [377]

Specifically, in the section titled Priority Area, Health and Access to Mainstream Services, DSC suggests that the pathway to achieving this is to:

> *Coordinate effective and timely service responses between disability services and mainstream agencies for people with disabilities who also have … mental health disabilities … and ongoing and intensive medical needs.*[378]

A number of agencies in Western Australia provide for the specific needs of children and young people with a disability in their delivery of mental health promotion and prevention programs. The *KidsMatter* framework provides specific information about tailoring social and emotional learning programs to children with disabilities, attention deficit disorder and autism spectrum disorders. The importance of paying attention to the mental health needs of children with a disability and having a positive and inclusive school community are also highlighted.[379]

Other programs include DSC's *Stepping Stones* (an evidence-based adaption of the *Triple P - Positive Parenting Program* for parents of children with an intellectual disability), *Therapy Focus* (therapy services for children and young people with a disability)[380] and the *Paediatric Consultation Liaison Program* within PMH to support the psychological wellbeing of children and young people receiving medical treatment.[381]

The Department of Education (DET) provides for students with a disability through the *Schools Plus* program which *'provides funding for students with a diagnosed disability…for education assistant time and/or extra teacher time to allow the school to make appropriate teaching and learning adjustments for the student'*.[382] Other DET services include the Centre for Inclusive Schooling – Autism Education Service, Education Support Centres, the Hospital Schools Service and the Western Australian Institute for Deaf Education, which includes the support of school psychologists.[383]

372 Ibid.
373 National People with Disabilities and Carer Council 2009, Shut Out: The Experience of People with Disabilities and their Families, p. 11 [website], viewed 15 February 2011, http://www.fahcsia.gov.au/sa/disability/pubs/policy/community_consult/Documents/NDS_report.pdf
374 Submission No. 19 from Equal Opportunity Commission; Submission No. 72 from Starlight Children's Foundation; Submission No. 80 from West Australian Foundation for Deaf Children.
375 Commonwealth of Australia 2009, Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014, ACT, pp. 33, 41, 68.
376 Disability Services Commission Western Australia 2009, Count me in: Disability Future Directions, Western Australia, p. 9.
377 This policy is also consistent with Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities Article 25.
378 Disability Services Commission Western Australia 2009, Count me in: Disability Future Directions, Western Australia, p. 20
379 KidsMatter, Component 1A Positive School Community Resources [website], viewed 16 February 2011, http://www.kidsmatter.edu.au/resources/information-resources/component-1-a-positive-school-community-resources/
380 Therapy Focus, [website] viewed 9 March 2011, http://www.therapyfocus.org.au/.
381 Submission No. 141 from Mental Health Commission.
382 Submission No. 16 from Department of Education, p. 2.
383 Ibid.

While these programs are of assistance, many submissions spoke of the need to provide dedicated mental health early intervention or treatment services for children and young people with a disability. A more systematic approach is needed across all types of disability and for all ages as submissions suggest there is significant unrecognised comorbidity. In some cases the mental health needs of children and young people with a disability are unknown or unrecognised and children and young people presenting with mental health problems have unrecognised learning difficulties, sensory-motor problems, attention, speech and language problems.

Submissions also reported that older children with these developmental difficulties are unable to access services in the public health system (for example through Child Development Centres).[384]

> *Delays in timely access to assessment, diagnosis and intervention of learning difficulties can exacerbate mental health and wellbeing issues in children and young people. Delays in timely access to assessment, diagnosis and intervention to address mental health and wellbeing issues in children and young people can lead to learning difficulties.*[385]

A number of submissions identified that a dual diagnosis of disability (particularly intellectual disability) and mental health problems or disorders presents a significant barrier to accessing treatment services.[386] This issue has also been raised with the Commissioner on a number of occasions prior to the Inquiry. The following statement by the Ethnic Disability Advocacy Centre (EDAC) is indicative of the concerns of all who raised this issue:

> *Limited service access for children and young people with a dual diagnosis of disability and mental illness has become a major concern for EDAC, as both the Disability Services Commission and Mental Health Commission tend to pass clients through a never ending revolving door… Children and young people who are in one Commission may find they lack supports for their other disability, where both commissions are under a misconception that the other is well equipped to manage the other disability. In reality, the Disability Services Commission (DSC) and the Mental Health Commission (MHC) have two important but significantly different areas of specialty and should develop an effective interdepartmental strategy to address this service gap, regardless if one illness is symptomatic of the other.*[387]

It would appear the policy of delivering services based on particular diagnoses and criteria across the disability and health sectors is resulting in significant gaps in service when:

- a child or young person has a dual diagnosis; and
- a diagnosis forms the criteria for a service and children and young people without this diagnosis are unable get a service from any agency.

These children and young people, due to their specific and complex needs, are often in need of specialist services provided by appropriately trained professionals.

RANZCP also raised concern about children and young people with exceptionally complex needs including acquired brain injury, physical health problems and intellectual disability. It stated:

> *These very high risk groups, with exceptionally complex needs, demand new treatment paradigms, models of service delivery and service interfaces.*[388]

384 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch; Submission No. 36 from Bentley Family Clinic; Submission No. 64 Confidential (Submission No. 80, 132 also referenced).
385 Submission No. 132 from State School Teachers Union, p. 3.
386 Submission No. 16 from Department of Education; Submission No. 65 from Mandurah Area Public School Principals (Submission No. 79, 84, 89, 118, 138 also referenced).
387 Submission No. 138 from Ethnic Disability Advocacy Centre, p. 6.
388 Submission No. 27 from The Royal Australian and New Zealand College of Psychiatrists WA Branch p. 1.

Along with others who made submissions, RANZCP proposed formal processes to improve coordination between agencies and thereby improved services to children and young people with dual diagnosis:

> *Develop standardised care coordination protocols with key stakeholder services and agencies. Currently, there are few documented agreements with key services on the management of mutual clients or on referral to and from CAMHS. Key agencies include Adult Mental Health Services, Child Health, Child Development Services (MOU signed in 2009), Drug and Alcohol Services, Department of Education and Training (MOU current), Department of Child Protection (MOU in development), and Disability Services Commission.*[389]

Staff at all levels of an agency should be made aware of and be supported to implement Memorandums of Understanding and other formal coordination agreements to ensure they result in direct improvements to services.[390]

Recommendation 25: The Disability Services Commission work with the Mental Health Commission to identify the services required to address the unique needs and risk factors of children and young people with disabilities in a coordinated and seamless manner.

389 Ibid.
390 Submission No. 65 from Mandurah Area Public School Principals.

Over the past decade the number of births per year in Western Australia has steadily increased by 24 per cent and for the past few years the number of babies born in Western Australia has been over 30,000 per year.[391]

6.1 Introduction

Mental health protection should start before birth...[392]

This chapter examines the mental health and wellbeing needs of children at birth, infancy and early childhood – prior to their entrance to school. It also looks at the needs of the pregnant mother and new parents, due to the intertwined nature of the young child's mental and physical health with that of its parents.

The Inquiry received many submissions about these critical stages of life.[393]

The importance of mental health and wellbeing in pregnancy, infancy and early childhood

Virtually every aspect of early human development, from the brain's evolving circuitry to the child's capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning early in the prenatal period and extending throughout the early childhood years.[394]

Extensive research in neurobiological and social sciences has provided a strong and well recognised evidence base for understanding how children's development is influenced by the very earliest years of their lives. This research confirms that early life experiences have a major impact on the development of the brain, social and emotional skills, and play a central role in favourable or unfavourable health and development outcomes for children.[395] [396] [397] In summary, a strong foundation in the early years increases the probability of positive outcomes in the future, and a weak foundation increases the odds of later difficulties.[398] [399] [400] [401]

Therefore, the broad health and development experiences of children in this early life stage have a significant part to play in determining whether mental illnesses will emerge later in life, as well as the extent to which they will manifest.[402] The *WA Pregnancy Cohort (Raine) Study*, published in 2008 has reported that 11.5 per cent of children aged two years had clinically significant behavioural problems and more than six per cent of the children had clinically significant mental health problems at age two.[403]

391 Australian Bureau of Statistics 2010, Births, Australia, 2009 [website], viewed 8 February 2011, http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/3301.0
392 Zubrick, S cited in McKinnie, M 2010, 'Lack of Leadership', The West Australian Newspaper, Health and Medicine Liftout, 1 December 2010, p. 3.
393 Submission No. 37 from National Investment for the Early Years (NIFTeY); Submission No. 120 from Community Health Nurses Western Australia; Submission No. 91 from Australian Association for Infant Mental Health (Submission No. 13, 15, 46, 56, 58, 60, 64, 65, 67, 77, 83, 93, 94, 95, 100, 102, 117, 119, 125, 126, 131, 132, 133, 137, 140 also referenced).
394 Shonkoff, J, & Phillips, D 2000, From Neurons to Neighbourhoods: The Science of Early Childhood Development, National Academy Press, Washington. D.C., p. 6.
395 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth, p. 3.
396 National Scientific Council on the Developing Child 2004, Young children develop in an environment of relationships, Working Paper No.1, Harvard University, Massachusetts, p. 1.
397 Shonkoff, J, & Phillips, D 2000 From Neurons to Neighbourhoods: The Science of Early Childhood Development, National Academy Press, Washington. D.C., p. 5.
398 National Scientific Council, Center on the Developing Child at Harvard University 2007, The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do, p. 5-8 [website], viewed 8 February 2011, http://developingchild.harvard.edu/library/reports_and_working_papers/science_of_early_childhood_development/
399 UNICEF 2008, The childcare transition: A league table of early childhood education and care in economically advanced countries, Innocenti Report Card 8, UNICEF Innocenti Research Centre, Florence pp. 5-7.
400 Cooke, R, 'Early childhood stress affects developing brain: Impacts real and long lasting', Harvard Science [website], viewed 25 November 2010, http://news.harvard.edu/gazette/story/2008/02/early-childhood-stress-affects-developing-brain/
401 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth, p. 3.
402 National Research Council and Institute of Medicine, 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington DC. p. 77.
403 Robinson, et al 2008, 'Pre- and postnatal influences on preschool mental health: a large-scale cohort study', The Journal of Child Psychology and Psychiatry, 49 (10), pp. 1118-28.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) submitted to the Inquiry that:

> *There is now unequivocal evidence that early experiences during the period from birth to five years of age determine brain architecture and that, once formed, this provides the foundation for all future learning, behaviour, and physical and mental health. While genes determine when neural circuits in the brain are formed, early experiences shape how that formation unfolds.*[404]

It is necessary to place the mental health and wellbeing of children within the broader context of child development.[405] As the Telethon Institute for Child Health Research (TICHR) presented in its submission to the Inquiry:

> *Positive mental health and wellbeing is an important outcome of successful child development and is the result of effectively negotiating the key developmental tasks of childhood. Mental health problems are just one of several possible negative outcomes for children and young people where key developmental tasks are delayed or problematic. In many cases the risk and protective factors that relate to mental health problems are also the factors that relate to other negative developmental outcomes for children and young people.*[406]

6.2 Promotion and prevention

6.2.1 Family

For infants and young children, positive and appropriate parenting and a stable and harmonious family environment are arguably among the most significant factors affecting their wellbeing.[407] [408] That is, in their earliest years, many children experience few influences external to the family and, as such it, is the primary avenue for their being taught, nurtured, guided and loved.[409] [410] Families and parents also have primary responsibility for ensuring their child's physical and mental health needs are met.

> *Families are the primary socializing agent of young people. Whether young people develop successfully depends substantially on whether families provide the physical and psychological conditions children need to acquire developmental competencies.*[411]

Health during pregnancy

Research has confirmed that the mother's health and experiences during pregnancy are significant factors in mental health outcomes for young children.[412] Pregnancy has been proven to be a key intervention point to ensure the child has the best possible start in life.[413]

404 Submission No. 27 from Royal Australian and New Zealand College of Psychiatrists, p.1
405 National Research Council and Institute of Medicine, 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington DC., p. 71.
406 Submission No. 125 from Telethon Institute for Child Health Research, p. 5.
407 Council of Australian Governments 2009, Investing in the early years: a national early childhood development strategy, Commonwealth of Australia, p. 4.
408 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., p. 158.
409 Carbone et al 2003, cited in Centre for Community Child Health 2007, Policy Brief No 9: Parenting Young Children, The Royal Children's Hospital Melbourne [website], viewed 1 March 2011, http://www.rch.org.au/emplibrary/ccch/PB9_Parenting.pdf
410 Stanley, F, Richardson, S, & Prior, M 2005, Children of the lucky country? How Australian society has turned its back on children and why children matter, Pan MacMillan, Sydney. p. 21.
411 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., p. 158.
412 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth. pp. 7, 157.
413 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch; Robinson et al, 2008, 'Pre-and postnatal influences on preschool mental health - a large cohort study' [website], viewed 1 March 2011, http://www.ncbi.nlm.nih.gov/pubmed/19017026?ordinalpos=7&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum; Telethon Institute for Child Health Research 2010, Maternal stress during pregnancy [website], viewed 1 March 2011,<www.ichr.uwa.edu.au/research/highlights/social/maternal

For example, the Raine Study, which tracked 2,900 mothers through pregnancy, has shown there are several triggers in pregnancy that determine the unborn child's subsequent health and disease.[414] Researchers found that children whose mothers experienced stress and low incomes during pregnancy and multiple 'baby blues' symptoms after birth are at higher risk of developing behavioural and emotional problems.[415]

RANZCP's submission described the intertwined nature of the mother's mental health with the mental health and health of her newborn:

> *Maternal depression and anxiety in the antenatal and postnatal periods have long term adverse effects on the foetus, infant and children, resulting in emotional, behavioural and cognitive problems… The effects of maternal anxiety during pregnancy on infant development are explained by biological processes with the release of catecholamines resulting in vasoconstriction of maternal blood vessels, diminished blood flow to the foetus and consequent restriction of oxygen and nutrients that interfere with central nervous system development…*[416]

Emerging evidence is also demonstrating the serious impact of alcohol consumption during pregnancy resulting in some cases in Fetal Alcohol Spectrum Disorder.[417]

Several submissions raised the importance of supporting parents and infants throughout the antenatal and postnatal period[418] and the need to focus on interventions targeting adverse influences during this stage in order to improve health and wellbeing outcomes for children in the early years.[419] National Investment for The Early Years (NIFTeY) submitted:

> *Maternal health and wellbeing during pregnancy with support and advice concerning not only preparation for birth, but also preparation by both parents for the task of parenting can assist understanding and attitudes in the best interests of children… It is an ideal time to form partnerships that go beyond the pregnancy and delivery time – for support in breast feeding, nutrition, secure attachment, developmental and child rearing as well as child health advice – and the linking of new parents into community supports as required.*[420]

The State Perinatal Mental Health Group identified working with the mother during pregnancy as an important strategy to address future infant mental health concerns.[421] Similarly, the Royal Australasian College of Physicians submitted that working with the mother in the antenatal period was an effective way to identify unborn children who may be 'at risk' from factors such as substance abuse, mental illness or homelessness.[422]

The Inquiry did not learn of any universal mental health promotion or prevention program for mothers during pregnancy. However, pregnancy presents a time when opportunities – and often motivation – for change are paramount.[423] It is also a time of frequent visits to health professionals where, with the right identification, support and intervention, a mother's health issues can be treated, intergenerational disadvantage can begin to be addressed, and

414 Newnham, J, Beilin, L & Pennell, C, 2010, Developmental Origins of Health and Disease, viewed 8 February 2011, <http://www.rainestudy.org.au/studies/research/dohad>.

415 [Researchers found that children whose mothers experienced stress and low incomes during pregnancy and multiple 'baby blues' symptoms after birth are at higher risk of developing behavioural and emotional problems. Smoking during pregnancy is also emerging as a strong predictor of increased risk of mental health problems or illness for the child.] Telethon Institute for Child Health Research, 2010, Maternal stress during pregnancy [website], viewed 8 February 2011, www.ichr.uwa.edu.au/research/highlights/social/maternal

416 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch, pp. 1-2.

417 Department of Health, Western Australia 2010, Fetal Alcohol Spectrum Disorder Model of Care. Perth, Health Networks Branch, Department of Health, Western Australia.

418 Submission No. 37 from National Investment for the Early Years (NIFTeY); Submission No. 46 Confidential, Submission No. 100 from State Perinatal Mental Health Reference Group; Submission No. 117 from Ngala (Submission No. 120,126 also referenced).

419 Telethon Institute for Child Health Research 2010, Maternal stress during pregnancy [website], viewed 8 February 2011, http://www.ichr.uwa.edu.au/research/highlights/social/maternal

420 Submission No. 37 from National Investment for the Early Years (NIFTeY), p. 2.

421 Submission No. 100 from State Perinatal Mental Health Reference Group, p. 1.

422 Submission No. 126 from The Royal Australasian College of Physicians, p. 3.

423 Carbone et al 2003, cited in Centre for Community Child Health 2007, Policy Brief No 9: Parenting Young Children, The Royal Children's Hospital Melbourne.

the unborn child can benefit in terms of improved outcomes.

Pregnant women with a history of mental or physical health problems are often known to their general practitioner (GP) or medical specialist, yet often do not receive any additional supports or advice relevant to their condition and pregnancy.

A recent survey by SANE Australia, in which a majority of respondents had a diagnosis of mental illness before becoming pregnant, found that most (73 per cent) were offered no support or information on how to plan for the stresses of pregnancy and parenthood on their mental health.[424] This is of particular concern – especially considering 93 per cent of the survey respondents felt that mental illness had a negative impact on their parenting to some degree.[425]

The critical stage of pregnancy is generally overlooked in a mental health context. It is known that approximately 88 per cent of Australians visit a GP at least once each year[426] – and that GP's are often the first contact point for pregnant women, as well as the primary referral point when children and young people are assessed by community health staff as needing additional services or more detailed assessments.

As the Department of Health (DoH) submitted, however, the capacity of general practitioners is stretched and they are often unable to provide the coordinated care required in these situations:

> *The issue for Western Australia in terms of access to care, is there isn't enough of them [GPs], they are not in the right location, and the workload and demand is extremely high. As a consequence, coordinated care directed by GP's is not possible in a lot of circumstances.*[427] [428]

The Inquiry considers it appropriate for the Commonwealth Government to examine what incentives it could offer GP's to enable them to spend longer with pregnant women explaining mental health issues and supports available. An incentive program – such as that implemented with the *Healthy Kids Check*[429] – could be one approach.

Recommendation 26: The Commonwealth Government provide for additional training to general practitioners and health professionals to assist in the early identification and treatment of mental health problems in pregnant women and children and young people.

Recommendation 27: The Commonwealth Government support incentives to ensure that general practitioners have longer consultations with pregnant women explaining mental health issues and supports.

Recommendation 28: Training be provided at university and TAFE as a part of relevant undergraduate and certificate courses (for example, for general practitioners, teachers, allied health professionals, youth workers and child care workers) to improve the understanding of the mental health needs of children and young people.

424 SANE Australia, 2011, SANE Research Bulletin 13: Parenting and mental illness: the early years, p. 1.
425 Ibid, p. 2.
426 Britt H, Miller GC, Charles J, Henderson J etal. 2010, General practice activity in Australia 2000–01 to 2009–10, General practice series no. 28, Australian Institute of Health and Welfare, Canberra.
427 Information provided to the Commissioner for Children and Young People from the Department of Health, 1 March 2011.
428 Lack of access to general practitioner services is illustrated by expenditure statistics for the Commonwealth Medical Benefits Scheme (MBS). For the 2009/10 financial year MBS per capita expenditure in WA was $545.94 and for Australia it was $691.00 – a difference of $145.06 per person. (Information provided to the Commissioner for Children and Young People from the Department of Health, 1 March 2011).
429 Department of Health and Ageing [website], viewed 3 March 2011, http://www.health.gov.au/internet/main/publishing.nsf/Content/Health_Kids_Check_Factsheet

The importance of comprehensive and culturally-responsive antenatal and perinatal care for Aboriginal parents and babies is also critical, particularly because of the ongoing and intergenerational disadvantage faced by Aboriginal people (see Chapter 5).

> *The health disparities between Australia's Indigenous and non-Indigenous mothers, infants and children are stark with most measures of morbidity and mortality at least two to three times worse. The consequences of this health burden over the life course and into successive generations are profound.*[430]

The Aboriginal Health Council of Western Australia (AHCWA) submitted to the Inquiry that Aboriginal Community Controlled Health Services (ACCHS) see approximately 50 per cent of Western Australian Aboriginal women who are pregnant.[431] [432] The submission stated that ACCHS offers an opportunity to improve the health of Aboriginal mothers, infants and children but that inadequate resourcing, breaks in continuity of care and a lack of national and State vision about the appropriate role of ACCHS are constraining service delivery.

> *What is clear is that Aboriginal children are almost certainly falling through service gaps, and greater capacity within ACCHS to address child health with a systematic and holistic model of care would probably result in healthier children.*[433]

A study by TICHR into antenatal services for Aboriginal women found that women were more likely to access services where culturally responsive processes were in place.[434]

Box 12: Aboriginal Maternity Group Practice, Midland Clinic

The Practice provides a free full antenatal service for pregnant Aboriginal women. The service is culturally safe and secure. It provides antenatal clinics in the community, support at hospital and specialist appointments, home visits, support to families, education and free pregnancy testing. The target group for the service is pregnant Aboriginal women 19 years and under. However, the service can accept Aboriginal women of any age if there are spaces available.[435]

A key part of ensuring a service is culturally safe is through the employment of Aboriginal maternal and/or child health workers.

> *The involvement of the AHW [Aboriginal Health Worker] in maternal and child health care enhances cultural security, provides parenting support and ensures use of well established health promotion and public health competencies.*[436]

Accordingly, the Inquiry supports the AHCWA being directly involved in all planning for child and maternal health services so that services, can be made culturally safe and progress can be made in improving outcomes for Aboriginal children and young people.

430 Aboriginal Maternal and Child Project Strengths and Needs Analysis, Submission No. 102 from Aboriginal Health Council of Western Australia, p. 5., supplementary information.
431 Ibid, p. 7.
432 ACCHS provides maternal child health service provision across a range of primary care settings across remote, rural and urban Western Australia (Maternal and Child Health Model of Care, Submission No. 102 from Aboriginal Health Council of Western Australia, p. 19., supplementary information.
433 Aboriginal Maternal and Child Project Strengths and Needs Analysis, Submission No. 102 from Aboriginal Health Council of Western Australia, p. 6., supplementary information.
434 Jackiewicz, 2008, cited in Reibel, T, & Walker, R, 2009, Overview and summary report of antenatal services audit for Aboriginal women and assessment of Aboriginal content in health education in Western Australia, Telethon Institute of Child Health Research, Western Australia, p. 5.
435 Australian Indigenous HealthInfonet, [website] viewed 21 March 2011, http://www.healthinfonet.ecu.edu.au/health-resources/programs-projects?pid=936
436 Maternal and Child Health Model of Care, Submission No. 102 from Aboriginal Health Council of Western Australia, p. 19., supplementary information.

Infant and child health

The first universal service that a child and mother will receive in Western Australia is a home visit from a community child health nurse, up to 10 days after the baby is born. All babies born in Western Australia are eligible to receive free Universal Child Health Checks, provided by DoH. DoH's policy is to provide seven checks in total up until school entry. After the first home visit the remaining checks take place at a child health clinic.[437]

In addition to providing an essential universal health service, community child health nurses act as a critical 'gateway' to the health system. Through regular contact with families they provide support in areas such as infant feeding, child development, injury prevention and child safety and protection. They also provide networks by linking new parents together and encouraging the development of social supports, as well as referring parents to specialist services where more support or intervention is required.[438] Aboriginal health workers may also assist with home visit services, acting as interpreters and educating families.[439]

One of the functions that the community child health nurses undertake is screening new mothers for postnatal depression using the Edinburgh Postnatal Depression Scale (EPDS) at the six to eight week and the three to four month checks.[440] This is the only universal screening for maternal mental health issues and, with an estimated 16 per cent of Australian mothers affected by postnatal depression,[441] it is a critical tool for early intervention for both the mother and the child.[442]

> *Early identification of the risk for or presence of perinatal mental health issues in the mother (or father) provides opportunities to intervene in the progression of a decline in the parent's mental state thereby potentially preventing mental health and wellbeing concerns in the infant. …Infants show very subtle but predictable signs of being affected by the mental health and wellbeing deficits in their caregivers (Guedeney, 2007). It could be said that infants are often the 'barometers' of how well a mother is doing psychologically.*[443]

However, even if a mother is accurately identified as needing further assistance at one of these checks (and the Inquiry notes the relatively lengthy timeframe between them), there are few services the child health nurse can refer the mother and baby to for more specialist support. This paucity of early intervention and treatment services for mild to moderate mental health problems was a recurring theme heard by the Inquiry, and applied to children and young people of all ages.

Between May 2009 and March 2010, three separate Western Australian Parliamentary Inquiries found that services for young children, particularly health services, are under-resourced and that early childhood services in the State lack integration, coordination and leadership.[444] [445] [446] All three reports confirmed that, despite the increases in Western Australia's population and number of births, community child health services have not received equivalent funding increases and are now significantly under-resourced. (The implications for the Child Development Services (CDS) follow).

437 Department of Health, Child and Adolescent Community Health: Our Services [website], viewed 10 February 2011, http://pmh.health.wa.gov.au/general/CACH/services.htm#cda
438 Senate Select Committee on Mental Health, 2006, A national approach to mental health - from crisis to community: First report, Parliament of Australia, Canberra. p. 114.
439 Submission No. 102 from Aboriginal Maternity Service Support Unit.
440 Submission No. 120 from Community Health Nurses WA, p. 6.
441 Beyond Blue, Types of Postnatal Depression, viewed 10 February 2011, http://www.beyondblue.org.au/index.aspx?link_id=94.600
442 National Scientific Council, Center on the Developing Child at Harvard University, 2007, The Science of Early Childhood Development: Closing the gap on what we know and what we do, p. 11 [website], viewed 10 February 2011, http://developingchild.harvard.edu/library/reports_and_working_papers/science_of_early_childhood_development
443 Submission No. 120 from Community Health Nurses WA, p. 6.
444 Community Development and Justice Standing Committee, 2009, Inquiry into the adequacy of services to meet the developmental needs of Western Australia's children, Legislative Assembly, Parliament of Western Australia, Western Australia. p. 62 & p. 165.
445 Education and Health Standing Committee, 2009, Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs, Legislative Assembly, Parliament of Western Australia, Western Australia.
446 Education and Health Standing Committee 2010, Invest now or pay later: Securing the future of Western Australia's children, Legislative Assembly, Western Australian Parliament, Western Australia.

Consequently, most of these services are now stretched, a situation which is increasingly manifesting in longer waiting lists and the reduced potential for families to access services. In all likelihood, this then results in poorer health and developmental outcomes for children and young people. The Mental Health Commission (MHC) has acknowledged that the '*majority of tier 1 and tier 2 mental health services for infants and their families are available in primary health care and the CACHS [Child and Adolescent Community Health Services]*'[447] yet the Inquiry found that CACHS is under-resourced and unable to provide an adequate and timely service. The Parliament's Community Development and Justice Committee found that:

> *There are significant issues of access and resourcing. Despite the increasing population and the changing complexity of families [sic] needs, there has been a per capita reduction in the resourcing of allied health services. This has led to a narrowing of eligibility criteria.*[448]

With regard to community child health nurses, the same Parliamentary Committee found that:

> *The child health nurses' visitation program is, in practice, no longer universal as the number of child health nurses has declined, on a per capita basis, across the State of Western Australia. The reduction in available support restricts access to this key link in early childhood health services. Given the child health nurse's role in our community, as 'an early warning and intervention system in identifying a wide range of early childhood disorders', this is a major shortcoming and indeed a regression in the provision of services to young children.*[449]

In 2010, the Parliament's Education and Health Standing Committee tabled its report *Invest now or pay later: Securing the future of WA's children.* The Committee found that Western Australia required an additional 105 community child health nurses, 135 school health nurses and 126 child development staff and that there should be *'no further attrition of community child health staff employed by the Department of Health'.*[450]

In November 2010, the Western Australian Auditor General released a report on the Universal Child Health Checks, which found the checks are important for detecting developmental problems at the right time. The Auditor General also found many children are missing out on health checks or not getting them at the right time because the Department of Health has prioritised the first four checks over later ones.[451]

Several submissions expressed the importance of the community child health nurses' role in monitoring the health of infants and parents, and raised concerns that more are needed to fulfil their role across the State. For example, NIFTeY's submission stated:

> *Community and Child Health Nurses have a major role in … preventive and supportive activity but need to be available and accessible. It is an ideal time to form partnerships that go beyond the pregnancy and delivery time - for support in breast feeding, nutrition, secure attachment, developmental and child rearing as well as child health advice - and the linking of new parents into community supports as required. …Many more Community Child Health Nurses need to be available in all areas and every day of the week to provide regular home visiting and developmental monitoring at least in the first three years of life…*[452]

There has now been extensive and thorough research into the state of Universal Child Checks in Western Australia and this Inquiry urges action on the various findings and recommendations of each. Primarily, the Inquiry recommends an

447 Submission No. 141 from Mental Health Commission, p. 101.
448 Community Development and Justice Standing Committee, 2009, Inquiry into the adequacy of services to meet the developmental needs of Western Australia's children, Legislative Assembly, Parliament of Western Australia, Western Australia. p. xviii.
449 Ibid. p. 92.
450 Education and Health Standing Committee, 2010, Invest now or pay later: Securing the future of Western Australia's children, Legislative Assembly, Parliament of Western Australia, Western Australia, p. xxxiv.
451 Auditor General for Western Australia, 2010, Universal Child Health Checks, Report No. 11, Office of the Auditor General, Perth. p. 7.
452 Submission No. 37 from National Investment for the Early Years (NIFTeY), p. 2.

urgent increase in the number of community child health nurses to provide for the increased number of infants and children in Western Australia, so as to provide them with optimum support and care in this crucial time of cognitive, emotional, and physical development.

Recommendation 29: The number of community child health nurses be increased to provide a comprehensive, universal health service to parents and children across Western Australia.

Universal services need to be strongly supported by targeted and specialist services so that a child identified as being in need can receive more comprehensive support. One of the strengths of effective home visiting programs is that they are able to link families into existing programs and supports that they might not otherwise have accessed. The quality and availability of these targeted services is therefore highly relevant to the success of the program, and they need to be offered in a variety of ways and a variety of places.

An effective example is in South Australia where the Family Home Visiting Service offers more intensive care and support for those parents who are considered to be more at-risk (see Box 13).

Box 13: South Australian Family Home Visiting Service[453] [454]

In South Australia almost all new mothers receive a universal contact from a child health nurse, usually between two and four weeks after delivery and most frequently in their own home. At that time they undergo a standardised assessment of needs and the nurse seeks to identify the most appropriate support services for the new mother.

The Family Home Visiting Service then offers more intensive care and support for parents who are considered to be more at-risk, for example:

- mother is less than 20 years of age;
- infant is identified as being of Aboriginal or Torres Strait Islander descent;
- mother is socially isolated;
- mother expresses poor attribution towards her infant;
- current or past treatment for a mental health issue;
- drug and alcohol related issues;
- domestic violence currently impacting on parenting;
- previous intervention from welfare services;
- child born with congenital abnormalities; and
- concern on the part of the assessing nurse.

These parents are then offered 34 home visits by a specially-trained nurse over the first two years of the infant's life. This model is based on the building of a relationship between the nurse home visitor and the family, and on the development of the infant and the parent-infant relationship. Flexibility is embedded in the program so that it suits the family and follows the parent's lead, addressing the issues they raise.

Parenting

One of the key concepts to emerge from child development research is that of the importance of 'attachment' of the infant with the caregiver. The importance of 'serve and return' relationships with carers – the intimate, loving and mutually rewarding one-to-one interaction – is an essential prerequisite for the development of the child's emotional,

453 Government of South Australia, 2005, Family Home Visiting: Service Outline, Children Youth and Women's Health Service, South Australia, p. 15-19.

454 Nossar, V, 2006, Family Home Visiting Service in South Australia -Translating the evidence into practice, presented at the Royal Australasian College of Physicians Congress 2006, Cairns, Queensland, 7-11 May [website], viewed, http://researchonline.nd.edu.au/cgi/viewcontent.cgi?article=1019&context=med_conference

physical and cognitive skills.[455] [456] [457] [458]

The research demonstrates that the importance of strong and loving parental and caregiver support in these early years cannot be overstated. The Inquiry notes the *Paid Parental Leave Act 2010* (Cwth) provides for Australia's first National Paid Parental Leave scheme which commenced on 1 January 2011.[459] The scheme enables carers to take time off work to care for their child after the child's birth or adoption. One of the objects of the Act is to enhance the health and development of birth mothers and their children in the crucial first 12 months of a child's life.

> *The quality and stability of a child's human relationships in the early years lay the foundation for a wide range of later developmental outcomes that really matter – self-confidence and sound mental health, motivation to learn, achievement in school and later in life, the ability to control aggressive impulses and resolve conflicts in nonviolent ways, knowing the difference between right and wrong, having the capacity to develop and sustain casual friendships and intimate relationships, and ultimately to be a successful parent oneself.*[460]

In the first years of life, with strong parenting, most infants develop an 'organised' attachment strategy to deal with stressful situations, separations, strange environments or illness.[461] A close, loving and encouraging childhood relationship with parents may also buffer young people from mental health problems.[462] Further, an untimely disruption of this bond between a child and its primary care giver can lead to anxiety, grief and depression in the infant.[463] [464] [465]

In the same way that positive parenting can lay the foundations for healthy development, young children are also highly vulnerable to adverse influences, such as parental mental health problems and family violence.[466] Poor parenting in itself can also be highly detrimental:

> *Hostile, non-affectionate and coercive parenting is related to high levels of problem behaviours. It was more than 4 times more likely that children would have conduct problems; emotional problems; and hyperactivity associated with hostile parenting. Children were twice as likely to have lower prosocial behaviours and were 1.5 times more likely to have peer relationship problems.*[467]

Many submissions and a vast range of research highlight the critical importance of consistent, quality parenting in the raising of healthy, competent and independent children. In her book *Children of the Lucky Country?* Professor Fiona Stanley AC responds to the question 'what kind of society is good for our children?':

> *Obviously our society would put the highest value on parenting. It would acknowledge that parents who*

455 National Scientific Council, Center on the Developing Child at Harvard University, 2007, The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do, p. 5–8. [website], http://www.developingchild.net
456 UNICEF, 2008, The childcare transition: A league table of early childhood education and care in economically advanced countries, Innocenti Report Card 8, UNICEF Innocenti Research Centre, Florence, p. 5-7.
457 Shonkoff, J.P., cited in Cooke, R, Early childhood stress affects developing brain: Impacts real and long lasting, Harvard Science [website], viewed 25 November 2010, http://news.harvard.edu/gazette/story/2008/02/early-childhood-stress-affects-developing-brain/
458 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth, p. 3.
459 Department of Families, Housing, Community Services and Indigenous Affairs, [website] viewed 22 March 2011, http://www.fahcsia.gov.au/sa/families/progserv/paid_parental/Pages/default.aspx
460 National Scientific Council on the Developing Child, 2004, Young children develop in an environment of relationships, Working Paper No.1, Harvard University, Massachusetts, p. 1.
461 Infant Mental Health Working Group, 2009, Infant mental health is everybody's business, [unpublished], Perth, p. 3.
462 Price-Robinson, R, Smart, D, Bromfield, L, 2010, Family is for life: Connections between adult family experiences and wellbeing in early adulthood, Family Matters, Australian Institute of Family Studies, Melbourne, p. 15.
463 National Scientific Council, Center on the Developing Child at Harvard University 2007, The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do, p. 5–8 [website], viewed, http://www.developingchild.net
464 UNICEF, 2008, The childcare transition: A league table of early childhood education and care in economically advanced countries, Innocenti Report Card 8, UNICEF Innocenti Research Centre, Florence. p. 5-7.
465 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth, p. 3.
466 National Scientific Council on the Developing Child, 2004, Young children develop in an environment of relationships, Working Paper No.1, Harvard University, Massachusetts p. 3.
467 Infant Mental Health Working Group 2009, Infant mental health is everybody's business, [unpublished], Perth, pp. 7-8.

> *are valued, supported and educated about child development, and enabled by their communities and workplaces to be good parents will be the backbone of our success for children and youth. Instead of valuing parents as economic contributors whose parenting might get in the way of financial productivity, our society would value parenting as a major productive activity, not to be squeezed into the other spaces in their lives.*[468]

Given the central role of parenting in the cognitive, language, social and emotional development of children, it is important that parenting programs and supports are available on a universal basis, with additional supports for those families with greater needs. The Australian Research Alliance for Children and Youth submitted to the Inquiry that:

> *…parent and community education relating to children's developmental needs should be universally provided in innovative ways, in various settings, as well as being non-labelling and non-stigmatising.*[469]

This includes providing parenting programs that recognise the very significant role of fathers in their child's development from the earliest days of their life. Parenting services such as Ngala's Hey Dad WA (see Box 14) are inclusive and responsive to fathers both in the type of information provided and the way it is delivered.

Box 14: Hey Dad WA[470]

A father-inclusive approach has now become a core component of Ngala's service delivery model and philosophy and is applied to all existing and new service designs and delivery modalities. Services offered by Hey Dad WA staff include:

- Dad's Time open fathers forum 48 weeks per year one evening per week;
- Skilled Dads Workshop three to five times per year for fathers of children 0 to six years;
- antenatal fathers sessions at King Edward Memorial Hospital and Osborne Park Hospital;
- the provision of telephone and in-person, short, solution-focused consultations with parents of children 0 to six years;
- partnering with Relationships Australia, Community Link and Network (CLAN WA) and Langford Aboriginal Association to provide father inclusive practice and early parenting support for Aboriginal fathers;
- the provision of a 'Meet and Greet' service for day and overnight stay families, offering encouragement to fathers' participation and information on how fathers can make a difference; and
- the provision of workshops as requested to parents and community groups on the role and benefits of fathers in early years, adjustment to parenting and other related issues in conjunction with Ngala parenting education team.

Parenting programs are also critical in breaking inter-generational cycles of disadvantage. Adults who have not experienced a loving, nurturing childhood are less likely to be able to create this experience for their own children.

> *Kids need to grow up in an environment that is loving, learning and nurturing; however, many parents have not themselves had these parenting behaviours role modelled for them by their own parents. This means that despite best intentions, the lack of opportunity to learn these behaviours can result in a perpetuating cycle of disadvantage and poor health and wellbeing outcomes.*[471]

Western Australia has a variety of parenting programs available, run by a range of government and non-government agencies.[472] Some of the evidence-based programs offered for young children aged from birth to five years are listed in Box 15.

468 Stanley, F, Richardson, S, & Prior, M, 2005, Children of the lucky country? How Australian society has turned its back on children and why children matter, Pan MacMillan, Sydney. p. 165.
469 Submission No. 133 from Australian Research Alliance for Children and Youth, p. 10.
470 Submission No. 117 from Ngala.
471 Submission No. 119 from The Smith Family, p. 4.
472 Submission No. 141 from Mental Health Commission.

Box 15: Example of evidence-based parenting programs offered in Western Australia

Triple P®

Triple P is a multi-level system of family intervention offered jointly by the Department of Health and the Department of Education, which provides five levels of intervention of increasing strength. These include a universal population-level media strategy targeting all parents, two levels of brief primary care consultations targeting mild behaviour problems and two more intensive parent training and family intervention programs for children at risk for more severe behavioural problems. The program aims to determine the minimally sufficient intervention a parent requires in order to deflect a child away from a trajectory towards more serious problems. The program offers flexible delivery options (including individual face-to-face, group, telephone assisted and self-directed programs) to tailor the strength and format of the intervention to the requirements of individual families.

The Telethon Institute for Child Health Research has evaluated *Triple P* and found improvements in parent-reported child behaviour and lower levels of parent-reported coercive parenting.[473]

Best Beginnings

Best Beginnings is a program run by the Department for Child Protection which provides a service to referred parents of infants aged 0 to two years. It aims to promote attachment and enhance infant and parental health and wellbeing, foster positive family functioning and increase social connectedness. It is available in 11 districts in metropolitan and regional areas. An evaluation by the Telethon Institute for Child Health Research in 2008 found four out of five clients believed that the program had a positive impact on how their child grew and developed, and that it improved aspects of life for them and their child.[474]

Positively, there is a range of parenting services available of which many are targeted to the early years of a child's life. However, there are difficulties for parents who may be seeking out parenting advice and support. Three levels of government (Commonwealth, State and Local) are responsible for various parenting programs, and further services are offered by the non-government and private sector. The services and service providers do not appear connected or integrated from a parent or user perspective. Further, the number and range of programs available to parents decreases as the child gets older – see Chapters 7 and 8 for more information.

Recently, the Department for Communities (DfC) undertook to create a 'parenting sector' in Western Australia and launched the *Parenting WA Strategic Framework* in order to pull together the various disparate parenting services offered. The Framework states that the DfC will be:

> *…working with other agencies to raise awareness of the importance of parenting services and education. The aim is to plan and coordinate services to improve parent access, creating economic and social benefit for the community.*[475]

The Inquiry supports this aim and the broader goal of streamlining information about parenting services in Western Australia so parents can find supports quickly and easily. This is also in line with the Economic Audit Committee's (EAC) focus on the need for improved collaboration and coordination.

The Inquiry considers that the DfC is best placed to have leadership in Western Australia for the provision of parenting programs and services.

473 Department for Communities 2010, Parenting WA Strategic Framework, Government of Western Australia, p. 16 [website], viewed, http://www.communities.wa.gov.au/childrenandfamilies/parentingwa/Documents/Parenting%20Wa%20Strategic%20Framework%20final%201.pdf; Zubrick, S, et al 2005, 'Prevention of child behavior problems through universal implementation of a group behavioral family intervention', Prevention Science Journal, Society for Prevention Research, Canada,

474 Submission No. 141 from Mental Health Commission, p. 43.

475 Department for Communities 2010, Parenting WA Strategic Framework, Government of Western Australia [website], viewed 3 March 2011, http://www.communities.wa.gov.au/childrenandfamilies/parentingwa/Documents/Parenting%20Wa%20Strategic%20Framework%20final%201.pdf

Recommendation 30: The Department for Communities establish a mechanism across government agencies – including the Departments of Education, Health and Child Protection – to coordinate, collaborate on and deliver effective parenting programs across Western Australia for parents of children and young people.

Recommendation 31: Significant funding be provided to increase the delivery of evidence-based parenting programs for parents of children and young people. Programs must be universal and targeted, accessible across the State, with some tailored to children and young people who have particular needs.

The fragmentation of parenting services is indicative of a broader issue for early childhood services in Western Australia, in that there is no central agency or a statewide plan. Consequently, the implementation of care, education, health and parenting services for children in their earliest years is relatively ad hoc – spread across the three Departments of Education, Health and Communities, with three different Ministers, and with input as required from other agencies and jurisdictions including the Deparment for Child Protection, Disability Services Commission, Drug and Alcohol Office and the Commonwealth Government.

In addition to being an inefficient model, the absence of structure or planning leads to a level of *'frustration for families and their children'*,[476] and limits strategic and long-term investment in the early childhood area. As one submission from people working in the area of early childhood stated:

> *In our experience, collaboration is working well at ground level but is lacking at departmental level. In fact we have voiced our concern at a seeming decline of services for families with young children aged 0-4… [Who] has responsibility for investing in school and community based programs for families with children aged 0-4? This lack of investment in the early years is disappointing in light of hard evidence that the first five years of a child's life are crucial.*[477]

The need to better integrate early childhood services was a finding of the Community Development and Justice Standing Committee's report:

> *There is a general consensus around the need to interlink early education, childcare, health and parenting support programs and services. The benefits of linking early child development services include improved access for parents and care givers to a range of support services, a more efficient use of resources, and, through information and skill sharing, more knowledge amongst the staff of providers of those services.*[478]

For several years now the Commissioner for Children and Young People (The Commissioner) has been calling for the establishment of a Western Australian Office of Early Childhood to become the central early childhood agency, responsible for this 'interlinking' and coordinating and managing a statewide plan for early childhood.[479]

Until there is a move towards a central early childhood agency, the needs of Western Australia families and children will continue to be compartmentalised rather than addressed and understood holistically. As TICHR stated in its submission, this risks missing '*…the whole for the parts. Children and families are living dynamic and complex entities and systems. We must do better in responding to this fact.*'[480]

The proposed central agency would work from the understanding that factors during pregnancy and early childhood can adversely affect a person's mental health and wellbeing in later life. Early interventions can

476 Community Development and Justice Standing Committee 2009, Inquiry into the adequacy of services to meet the developmental needs of Western Australia's children, Legislative Assembly, Parliament of Western Australia, Western Australia. p. xvii.
477 Submission No. 83 Confidential.
478 Community Development and Justice Standing Committee 2009, Inquiry into the adequacy of services to meet the developmental needs of Western Australia's children, Legislative Assembly, Parliament of Western Australia, Western Australia, p. xxix.
479 Commissioner for Children and Young People, 2009, Issues Paper 1, Early Childhood.
480 Submission No. 125 from Telethon Institute for Child Health Research, p. 6.

positively counteract those negative factors and bring about long-term benefits both to the individual's mental health and wellbeing and, as such more broadly, to society. The agency can then better coordinate services, focussing on monitoring the extent to which delivery occurs and addressing longer-term training and workforce challenges.

At a minimum, and in the absence of the recommended structural reform, significant government collaboration through the establishment of a governance arrangement is required to ensure coordination of early childhood services for this critical developmental period. The vision of the EAC supports such a move (see Chapter 4).

Recommendation 32: A central Office of Early Childhood be established and a statewide plan for early childhood be prepared.

Recommendation 33: Pending the establishment of the Office of Early Childhood, the Directors General of the Departments of Health, Education and Communities establish a working party mechanism to ensure collaboration and coordination in the important area of early childhood services.

6.2.2 Community

Child care, playgroups and community settings

Beyond the family context, there are a number of other settings where programs and services for young children's mental health can be delivered.

For a growing number of children, child care is an increasingly important influence outside of the family with more than half of 0 to four year olds in Western Australia attending child care of some kind.[481] This is in step with trends across developed nations, with this generation of young children the first in which *'a majority are spending a large part of their early childhoods not in their own homes with their own families, but in some form of childcare'*.[482]

The quality of care received in the child care environment is equally as important as that received in the family environment in terms of relationship building and attachment, especially if the child is spending a significant amount of time in child care and therefore in the care of adults other than their parents.

Child Australia's submission cited research demonstrating that poor quality child care can impact negatively on children's mental health and wellbeing, while high quality child care can be beneficial for children's mental health and wellbeing.[483]

There has been a high level of activity in the child care sector since the Council of Australian Governments introduced its *Early Childhood Reform Agenda* in 2009, including the introduction of the *Early Years Learning Framework* and the *National Quality Standards for Early Education and Care*.[484]

481 Department for Communities 2010, Strengthening Children and Families in the Community: Child and Family Service Locations, Government of Western Australia.

482 UNICEF 2008, The childcare transition: A league table of early childhood education and care in economically advanced countries, Innocenti Report Card 8, UNICEF Innocenti Research Centre, Florence, p. 3.

483 Sims, M, et al 2005, 'What cortisol levels tell us about quality in childcare centres', Australian Journal of Early Childhood, vol. 30, no. 2, pp. 29-39, cited in Submission No. 95 from Child Australia.

484 Kindergarten Parents Victoria Inc, 2009, Early Childhood Information Sheet: Overview of National Reform Agenda for Early Childhood, Victoria [website], viewed 14 February 2011, http://www.kpv.org.au/files/page/file/1%20Overview%20of%20National%20Reform%20Agenda%20for%20Early%20Childhood(1).pdf

The improvement agenda is welcome, particularly given the increasing importance of child care as a setting for early childhood development.

> *For too long, day care has been seen as a babysitting facility. Yet quality early childhood development is crucial in creating empathy, personal connection and establishing the foundations for effective lifelong learning.*[485]

It is important to recognise that there are many individuals and professionals who come into contact with children in these critical early years and who can have a positive influence on their mental health. Child care workers are a key example of a group of professionals who, if provided with adequate training and supported appropriately, could greatly assist in the delivery of mental health promotion and illness prevention programs (see Recommendation 28).

The Inquiry notes that *KidsMatter Early Childhood* is an initiative currently being piloted across the country in selected early childhood services (see Box 16). This initiative is showing encouraging results, and is based on its evaluated predecessors: *KidsMatter* and *MindMatters* (see Chapters 6 and 7).

Box 16: *KidsMatter Early Childhood*[486]

On 5 October 2009 the Minister for Health and Ageing, Hon Nicola Roxon MP, announced funding of $6.5 million over three years to develop *KidsMatter Early Childhood* and conduct an Australia-wide pilot.

KidsMatter Early Childhood is a national early childhood mental health promotion, prevention and early intervention initiative specifically developed for early childhood services, including preschools and long day care. It involves the people who have a significant influence on young children's lives – parents, carers, families and early childhood professionals, along with a range of community and health professionals – in making a positive difference to young children's mental health and wellbeing during this important developmental period.

Given the importance of a child's early years, and of equipping early childhood staff with increased knowledge of the importance of mental health in young children, the Inquiry recommends that consideration be given to rolling the *KidsMatter Early Childhood* initiative out to all early childhood services in Western Australia.

Recommendation 34: Consideration be given to rolling out *KidsMatter Early Childhood* to all early childhood services across Western Australia.

Another significant program that is delivered for young children and their families in the community setting is Playgroups WA – accessed by more than 17,000 families across the State.[487] Activities such as playgroups help to develop and strengthen the social and emotional skills of young children and equip them for ongoing development of these skills as they enter school (see Chapter 7). It would also be of benefit to enhance the mental health literacy of the adults involved in activities such as playgroups and develop their understanding of the mental health and wellbeing needs of young children.

On 15 December 2010 the Western Australian Premier, Hon Colin Barnett MLA, announced that schools would be receiving increases in resources to enable them to become one-stop-shops for a range of early childhood services including child care, playgroups, kindergarten for three-year-olds, child health services, health services for young mothers and parenting services.[488]

The Inquiry notes that co-location on school sites is just one model and others could include location with family centres, community houses and neighbourhood centres.

485 Stanley, F, & Gillespie, N, 2010, 'Disadvantaged children fall behind in the land of the fair go', The Age Newspaper, 6 December 2010.
486 Kids Matter [website], http://www.kidsmatter.edu.au/ec/, viewed 3 March 2011
487 Playgroup Australia [website], viewed 3 March 2011, http://www.playgroupaustralia.com.au/wa/go/our-services/about-playgroup-wa
488 Harvey, B 2010, 'Children the winners in State's mining boom', The West Australian, Wednesday 15 December, p. 1.

These early childhood 'hubs' would create another setting for the provision of mental health services for young children and their families and is strongly supported by the Inquiry (see Chapter 4). The hubs also present the opportunity for specialist mental health staff to work closely with other professionals (such as child care workers) to provide training and mental health literacy skills – thereby sharing their expertise, facilitating collaboration and strengthening their capacity to deliver promotion, prevention and early intervention strategies.[489]

Play and recreation

> *…the importance of physical activity in improving overall wellbeing should not be underestimated when considering a mentally healthy WA. Building in physical activity should be seen as integral to a holistic approach to mental health management.*[490]

The connection between play, recreation and mental health outcomes was an issue raised by several submissions to the Inquiry. It is discussed further in Chapters 7 and 8 but should be read as applying equally to very young children.

6.3 Early intervention and treatment

Early intervention and treatment services are an integral part of the intervention continuum, so that when a promotion or prevention service identifies a developmental need there are appropriate services and programs to refer for more specialist support.

All aspects of the intervention continuum need to function well if the whole system is to work effectively – if one part is missing, the pressure on the others mounts. For example, the presence of universal services coupled with the absence of early intervention or treatment services is *'a formula for frustration and serves to heighten the potential for emotionally isolating the identified child'.*[491] Conversely, specialist treatment services often need to refer to universal services. Children and their parents should be able to move easily between services as their mental health needs change, receiving a seamless service along the continuum of interventions.

The Inquiry has found that while there is a range of universal general services for new parents, newborns and young children, there are limited early intervention and specialist treatment services available at this stage to support those with greater mental health and wellbeing needs.

The following case study (drawn from a submission to the Inquiry) demonstrates how very young children can start to experience mental health problems and some of the challenges in accessing early intervention or treatment services, with the common response that the child will 'grow out of it'.

Box 17: Case study

"Whilst [I was] trying to survive the [abusive] marriage, my daughter T shut down and cocooned herself in order to stay safe. However, once I escaped the marriage the fourth and final time, my 14-month-old daughter fell to pieces. T was suddenly too scared to sleep, as every time she closed her eyes nightmares and night terrors would follow. She stopped eating. She stopped talking. She was terrified of all people and especially men. Every loud noise had her drop to the ground screaming. The only thing T wanted to do at this point was breastfeed from Mum and just hold onto Mum for dear life. She was an empty shell with no will to live…

489 Tolan & Dodge; Fonagy cited in Centre for Community Child Health 2006, Policy Brief 4: Services for young children and families: an integrated approach, The Royal Children's Hospital Melbourne, p. 4.
490 Submission No. 40 from Physical Activity Taskforce Secretariat, Department of Sport and Recreation, p. 1.
491 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., p. 232.

Initially I had a lot of difficulty in accessing help for my daughter. Everyone seemed to be of the opinion that T was young and would simply just 'grow out of it'. This included two child health nurses, a GP, plus the initial counselor I went to for help. Unfortunately though, trauma is not so easily forgotten, even when you are very young. My daughter needed assistance to stay safe, plus she needed Therapy to work through her traumatic past, and neither of these came easily for us…

…it wasn't until T entered into Play Therapy [through Relationships Australia] at the age of 2½ that her life really started to change for the better." [492]

The MHC has indicated that the specialist services that do exist *'are not comprehensive and service gaps for infants and their families still exists' [and that as] 'mental health issues become more complex services tend to divide infants from their families and there are few services that deal with infants and their families together'*.[493]

6.3.1 Child Development Services

Another service important for the healthy developmental trajectory of young children at the early intervention/treatment end of the continuum is the DoH's Child Development Services (CDS).[494] [495] [496]

These services, provided in the metropolitan areas by the CDS and in regional and remote areas by the WA Country Health Service, deal with the prevention, assessment and management of children's developmental disorder and delay. CDS are a critical referral point for universal health services, such as community child health nurses.

They also play a key role in health prevention and promotion through the delivery of community education, professional development and the delivery of universal prevention programs.

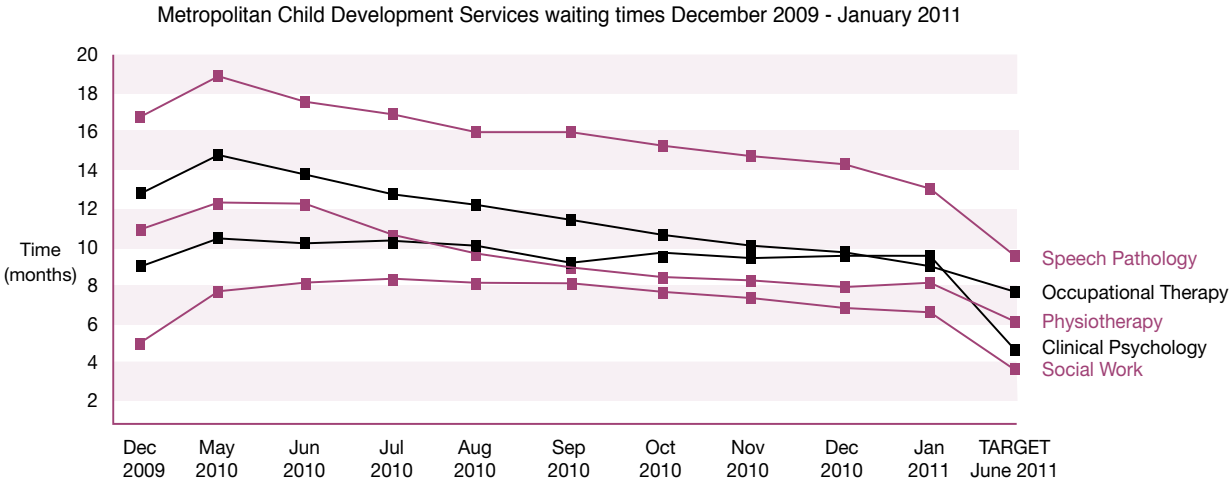
The CDS in Western Australia are important referral points from universal service providers, offering services from a range of health professionals. These include clinical psychologists, social workers, physiotherapists, occupational therapists, speech pathologists, podiatrists, dieticians, paediatricians and nurses.

Although CDS does not provide specialised mental health services, the services that are offered by the various disciplines can have a significant impact on a child's healthy development, and are therefore inextricably linked to mental health outcomes. For example, speech delays are one known causal factor for later emotional or behavioural difficulties.[497] It is not a big leap, therefore, to suggest that early identification and intervention in speech delays can have a significant impact on both the child's language development and their mental health and wellbeing. Unfortunately, years of under-investment in this area has left it struggling to service the needs of those children who most need it.

An increased budget allocation of $49.7 million in 2010 for speech pathology, occupational therapy and physiotherapy[498] has begun to reduce waitlists for the CDS. However, as at January 2011, waiting times for specific services at the metropolitan CDS were between seven and 13 months (as shown in Figure 5) and clinical psychology and social work are not making the same gains as the other CDS areas.[499]

492 Submission No. 94 Confidential.
493 Submission No. 141 from Mental Health Commission, p. 101.
494 Health Reform Implementation Taskforce 2005, Future Directions for Western Australian Child Development Services. Report of the review by the Health Reform Implementation Taskforce, Departmetn of Health, Perth, p. 5.
495 Government of Western Australia, Department of Health [website], viewed 3 March 2011, http://www.pmh.health.wa.gov.au/general/CACH/services.htm#cds
496 Advice received by the Commissioner for Children and Young People's from Department of Health, 24 July 2009.
497 Zubrick, S, et al 2005, The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, p. 64.
498 Hames, K 2010, State Budget 2010-11: More than 45 child health specialists to cut waiting times, Ministerial Media Statements [website], viewed 15 March 2011, http://www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=133493&minister=Hames&admin=Barnett&page=2
499 Information provided to the Commissioner for Children and Young People by the Department of Health, 1 March 2011.

Figure 5: Metropolitan Child Development Services average waiting times – May 2010 to January 2011



In the life of an 18 month-old learning to speak, a 13 month wait for a specialist speech service will mean that critical opportunities for early and effective intervention are lost.

The Education and Health Standing Committee's Inquiry in 2010 examined the CDS and other community child health services, and found that:

> *The situation for Western Australia's children is unacceptable and it will continue to deteriorate unless there is an immediate and significant increase in community child health resources. The current situation has developed over a number of years and there have been a range of contributing factors including:*
> - *Western Australia's strong population growth which has resulted in a significant increase in demand for services;*
> - *A chronic lack of investment in community child health services over the last two decades; and*
> - *The lack of an adequate resource allocation model for community child health services that reflects population growth and service demand.*[500]

Recommendation 35: The State Child Development Services receive significant investment to increase service to an appropriate level and reduce waiting times.

6.3.2 Infant, Child, Adolescent and Youth Mental Health Services (ICAYMHS)

The DoH's Infant, Child, Adolescent and Youth Mental Health Service (ICAYMHS) provides services to infants and young children who have severe, complex and persistent mental health disorders.[501] It is the primary, public deliverer of mental health services for children and young people in the State. However, the 2007 *Review of Child and Adolescent Mental Health Services in Western Australia* found that it was under-resourced and unable to meet the needs of its client group:

> *The failure to resource CAMHS adequately means that the staffing of individual CAMHS clinics is usually too sparse for the tasks that they are expected to address. If one or two staff are on leave, clinic capacity deteriorates further. Mental health promotion and prevention, early intervention, infant mental health, the adoption of new programs, outcome assessment, outreach, and collaboration with allied services is hampered or impossible. The clinic struggles to cope with urgent referrals, the*

500 Education and Health Standing Committee 2010, Invest now or pay later: Securing the future of Western Australia's children, Legislative Assembly, Western Australian Parliament, Perth, p. 46.

501 Information received from Department of Health, Child, Adolescent and Youth Mental Health Service, North Metropolitan Area Health Service, http://www.nmahsmh.health.wa.gov.au/about/

drawbridge is raised, and consumers and allied services begin to perceive CAMHS as inaccessible and, ultimately, irrelevant.[502]

It does not appear that the situation has improved since the Review's publication. Many submissions to the Inquiry referred to the under-resourcing of ICAYMHS and the particular impact this is having on services for infants and very young children. One submission from a specialist service provider stated that:

In my opinion, services for the mental health needs of 0-5 year sector within the north metro area have declined over the last 5-10 years. Over the last 5 years referrals for the 0-5's have declined significantly … [work with childcare, infant health and community groups] has no longer been possible due to the increased demands of crisis interventions for the adolescent sector.[503]

Another submission stated:

The overburdened ICAMHS services have been given the mandate to extend their services to children under 5 years – however, there has been only minimal and tokenistic infrastructure, training, and resources has been provided to support this… Long waitlists exist for ICAMHS services. There are strict criteria to access these services and priority is given to problems which present as urgent (e.g. suicidality, psychosis). In this context of overstretched and under resourced services for children 6-16, untrained staff do not recognise the distress or significance of distress in very young children and therefore such presentations are not prioritised.[504]

This issue is statewide, with another submission stating:

Mental health services for mothers and infants are at this stage non-existent in rural and remote WA…[505]

This statement about the dearth of services in regional and remote parts of the State was confirmed in information provided to the Inquiry by the DoH:

At present WACHS [WA Country Health Service] Mental Health Services are unable to provide a comprehensive infant mental health service, though this is a priority for the future at which point services will be rebadged as ICAYMHS.[506]

The inability of ICAYMHS to provide early intervention and treatment services for mild to moderate mental health problems for infants and young children is of particular concern as the only option without such a service is to wait until problems turn into severe disorders. This not only misses a critical window for the potential minimising of problems and reduction of child and family distress, but also places a larger burden on acute and specialist mental health services.

There are some additional specialist services for parents and infants, including the Mother and Baby Unit,[507] the Childbirth and Mental Illness Antenatal Clinic,[508] the Western Australian Perinatal Mental Health Unit[509] (all based at

502 Nurcombe, B, 2007, A Review of Child and Adolescent Mental Health Services in Western Australia, [unpublished], p. 22.
503 Submission No. 77 from Ms. Heath Townsend, Clinical Psychologist, p. 2
504 Submission No. 91 from Australian Association for Infant Mental Health WA Branch, p. 6-7.
505 Submission No. 15 from Dr. Prue Stone, p. 1.
506 Submission No. 141 from Mental Health Commission, p. 9.
507 Department of Health 2011, Western Australia, King Edward Memorial Hospital, Mother Baby Unit, http://www.kemh.health.wa.gov.au/services/mbu/index.htm
508 Department of Health 2010, Western Australia, King Edward Memorial Hospital Childbirth and Mental Illness Antenatal Clinic (CAMI): Pregnancy support for women with serious mental illness [website], viewed 14 February 2011, http://kemh.health.wa.gov.au/brochures/consumers/cami.pdf
509 Department of Health 2010, Western Australia King Edward Memorial Hospital: WA Perinatal Mental Health Unit [website], viewed 14 February 2011, http://www.kemh.health.wa.gov.au/health_professionals/WA_perinatal_mental_health_unit/index.php

King Edward Memorial Hospital), and the infant mental health service provided by the Raphael Centre, St John of God Hospital (a fee-paying service). None of these, however, comprise an extensive, comprehensive, statewide service.

This is a significant gap in the mental health service environment of Western Australia. The MHC has recognised this as a need, stating that a service gap in the area for infants is a *'comprehensive specialist infant mental health service'*.[510] The Inquiry found that this should be progressed as a matter of priority.

> *…there is very good evidence that we are intervening in mental illness at the wrong stage in life. There is really good evidence now that we should be concentrating mostly on infants – not even children; on infants. The kinds of traumas they may suffer – broken families, and sexual, physical and emotional abuse – leave a very deep mark on the psyche at an early stage.*[511]

The essential ingredients of specialist infant mental health teams are a capacity to liaise and join with other infant and family-centred services and to provide specialist consultation, assessment and treatment in communities. Ideally, they should also have the capacity to provide education and training and establish joint programs as infant mental health problems often co-occur with developmental difficulties.

Many of the families who attend a specialist service would then be able to return to other universal and targeted support services provided by the health and NGO sector, with a new ability to use these services confidently and effectively.

Recommendation 36: A comprehensive, specialist infant mental health service be developed that can provide early intervention and treatment services for very young children and their parents.

510 Submission No. 141 from Mental Health Commission, p. 101.

511 Dr Steven Patchett (then Executive Director, Mental Health, Department of Health), Education & Health Standing Committee, 2009, Review of WA's current and future hospital and community health care services, transcript of evidence taken 25 August 2009, session three [website], viewed 14 February 2011, http://www.parliament.wa.gov.au/parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/06A667FB0BC3DDD448257831003C116F/$file/educ&health090825.3.pdf

Children aged between four and 12 years comprise 50 per cent of all Western Australian children and young people under 18 years.[512] From 2006 to 2010 the estimated population of this age group increased by more than five per cent.[513]

7.1 Introduction

This chapter considers the mental health and wellbeing of children, defined loosely in this chapter as being of primary school age (between four and 12 years). Children in this age group begin to move out of the relatively narrow contextual experiences of infancy and early childhood and into broader experiences such as formal schooling (in most instances) and wider community involvement in sports, clubs and other social and recreational activities.

This chapter explores the new social and environmental contexts within which children are situated, how mental health promotion and illness prevention can be provided in these contexts, and the opportunities that are available for early intervention in mental health problems as they begin to emerge.

The importance of mental health and wellbeing in childhood

The developmental tasks in childhood are many and varied. During these years children learn to read, write, think mathematically, follow the rules of home, school and the community, develop empathy, accept others' emotions and develop social problem-solving skills.[514]

Of these skills, the latter three are all aspects of social and emotional development. This strand of development is significant for mental health and wellbeing – with one of the consequences of poor social and emotional development being mental health problems.[515] In its report, *A Picture of Australia's Children 2009,* the Australian Institute of Health and Welfare (AIHW) describes social and emotional development as:

> *[Encompassing] a number of skills that children need to develop and succeed at school and in life in general. These include the ability to identify and understand one's feelings, accurately read and comprehend emotional states in others, manage strong emotions and their expression, regulate one's behaviour, develop empathy for other, establish and sustain relationships. These skills form the basis for self-regulation, enabling children to withstand impulses, maintain focus and undertake tasks regardless of competing interests.*[516]

The AIHW identifies early childhood as a crucial time for social and emotional development but also emphasises how this development continues throughout later childhood and adolescence, resulting in *'the strength and capacity to lead a full and productive life, and having the resilience to deal with change and unpredictability'.*[517]

Recent work by Australian Research Alliance for Children and Youth (ARACY) around the 'middle years' (nine to 14 years) also identifies social and emotional development as critical for children transitioning into adolescence, being identified as only second to physical development in importance (and followed by peer relationships, self esteem/body image and transition to independence).[518]

512 Australian Bureau of Statistics 2006, Census of Population and Housing, 'Age (Full Classification List) by Sex - Place of Usual Residence', cat. no. 2068.0, Canberra.
513 Australian Bureau of Statistics 2010, Population by Age and Sex, Australian States & Territories, 'Table 5, Estimated Resident Population By Single Year of Age, Western Australia', cat. no. 3201.0, viewed, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3201.0Jun%202010?OpenDocument
514 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and promising interventions, National Academies Press, Washington D.C., pp. 77-79.
515 Australian Institute for Health and Welfare 2009, A Picture of Australia's Children 2009, Canberra, p. 60.
516 Ibid.
517 Ibid.
518 [Results of a survey of ARACY members working in service provision, research or policy] Australian Research Alliance for Children and Youth (ARACY) 2011, 'betwixt and between': A Report on ARACY's Middle Years Project, ARACY, p. 12.

ARACY describes the period from nine to 14 years as being associated with:

- major physiological, neurological, cognitive and psychosocial changes;
- changing relationships with parents and families (as children seek greater autonomy and independence from parental oversight and control of their lives); and
- an increase in the importance and influence of peer relationships (as children seek to establish their own personal and social identity).[519]

Being aware of deviations from healthy developmental trajectories throughout this childhood period, particularly social and emotional development, is critically important as it presents the opportunity for prevention and early intervention activities. These deviations often represent warning signs of problems that can be addressed if attended to early enough, and may not indicate the presence of an established mental health disorder. As the Telethon Institute for Child Health Research (TICHR) points out:

> *Mental health problems are just one of several possible negative outcomes for children and young people where key developmental tasks are delayed or problematic.*[520]

As discussed in Chapter 6, in some cases the foundations for poor mental health have been laid in infancy and early childhood and it is often in this later period of childhood – and before adolescence – when established symptoms of mental health disorders do begin to emerge. This is particularly true for conduct and anxiety disorders.[521] [522] [523] It is known that the first symptoms of most mental health disorders precede the full onset of the illness by several years,[524] which establishes childhood as a key period for treatment opportunities.

> *Research demonstrates that first symptoms of behavioural problems typically precede a mental, emotional or behavioural disorder by two to four years and that early therapeutic intervention can be highly effective at limiting the severity and/or progression of problems.*[525]

Despite the multiple changes occurring in the lives of children and the important 'windows' for prevention and intervention offered in these years, the Inquiry concurs with ARACY that the developmental needs of primary school aged children *'appear to be relatively neglected in Australian policy and practice'.*[526] [527]

Many submissions were concerned about the increasing number of children experiencing problems in this age group.[528] Research shows that approximately one in six children and one in four Aboriginal children of primary school

519 Ibid, p. 5.
520 Submission No. 125 from Telethon Institute for Child Health Research, p. 5.
521 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., p. 50.
522 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 18.
523 World Health Organisation Department of Mental Health and Substance Abuse: in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options - summary report, World Health Organisation, Geneva., p. 37.
524 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., p. 50.
525 O'Connell et al, 2009, and Hazell P. 2000, cited in Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 4.
526 ARACY makes this remark regarding children in their middle years (9-14) but the Inquiry's impression is that in Western Australia this statement is true for all primary school aged children.
527 ARACY 'betwix and between, focusing on the social and emotional development and wellbeing of Australian children aged 9-14', Symposium flyer [website], viewed 28 February 2011, http://www.aracy.org.au/publicationDocuments/Middle%20Years%20Info_Flyer(1).pdf
528 Submission No. 3 Confidential; Submission No. 20 from Catholic Education Office; Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch (Submission No. 37, 39, 48, 63, 65, 66, 96, 99, 128 also referenced).

age can be identified as being at significant risk of, or having, mental health problems.[529] [530]

The Western Australian Primary Principals' Association submitted to the Inquiry that:

> *Primary Principals report an increase in the numbers of students experiencing problems with stress, anxiety, aggression, alienation and resilience… incidences of poverty, social isolation, family breakdown, domestic violence, physical and sexual abuse, insecure attachment and substance abuse are increasing… there is an increase in bullying and other behavioural issues in schools… an increase in the numbers of students diagnosed with autism, attention deficit disorders and other disabilities with significant behavioural side affects [sic].*[531]

This Chapter examines what is and what needs to be offered to ensure that as a child emerges from early childhood their mental health and wellbeing is as strong as possible and that they are equipped for the challenges of adolescence.

7.2 Promotion and prevention

7.2.1 Family

> *Friends and family encourage us to do the right thing. They also help you with all your problems big or small. They are people you can talk to about your feelings or problems. (Girl, 10)*[532]

The critical role of families – particularly parents – continues for children as they move out of infancy and early childhood and into childhood. Children of this age look to their parents as role models and as guides on how to be an adult in the world. Strong parenting is known to be a key protective factor for mental health issues.[533] [534]

These findings echo those of the Commissioner for Children and Young People's (The Commissioner) wellbeing research *Speaking out about wellbeing* which found from consulting with 1,000 Western Australian children and young people, that:

- they value a loving and supportive family and believe this is essential to their wellbeing;
- on the whole, they enjoy being with their families and want to spend more time with them;
- they want to have a good relationship with and be able to talk with their parents and to be treated fairly; and
- family conflict and alcohol misuse within the family is a major source of stress for some children and young people.[535]

In a consultation for the Inquiry, the Halo Leadership Development Agency spoke with a group of Aboriginal boys of primary school age. Six of the nine boys did not have a father figure in their life because of jail, death, or because their father was absent or unknown. The boys expressed a deep sadness about this and a keen desire for male role models in their lives.[536]

529 Zubrick, S, et al 1995, The Western Australian Child Health Survey: Developing Health and Well-being in the Nineties, Australian Bureau of Statistics and the Institute for Child Health Research, Perth, vol 1, p. 37.
530 Zubrick, S, et al 2005, The Western Australian Aboriginal Child Health Survey: The social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth, vol 2. p. 31.
531 Submission No. 39 from WA Primary School Principals Association, p. 1.
532 Taken from an entry to Commissioner for Children and Young People's Commissioner for a Day Challenge.
533 Mental Health and Special Programs Branch 2000, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Health and Aged Care, Canberra.
534 North Metropolitan Area Health Service Child and Adolescent Mental Health Services 2008, Infant, Child, Adolescent and Youth Mental Health Services Strategic Directions 2008-2013, Department of Health, Perth
535 Commissioner for Children and Young People 2010, Speaking out about wellbeing: The views of Western Australian children and young people, p. 6.
536 Submission No. 136 from Halo Leadership Development Agency, p. 21.

In another consultation with young boys in the Banksia Hill Juvenile Detention Centre, the absence of parental role models (again, particularly fathers), no support at home, or a violent/dysfunctional family life were recurring themes that the boys identified about their younger lives. One young man, when asked what would make him happy, expressed his hope to create a better family life for himself one day: *"Get my own good family and do them good and give them a good life."*[537]

Parenting

Providing supports for Western Australian parents and building their skills, particular to the developmental needs of their children, are crucial if the mental health of children and young people is to be strengthened and supported.

Although some targeted parenting programs exist that address the needs of specific groups of children (for example, those provided by the Department for Child Protection, Disability Services Commission,[538] Wanslea Family Services[539] and Ngala[540]), an environmental scan of parenting supports in Western Australia reveals a substantial gap for services for primary school aged children (and adolescents – discussed further in Chapter 8).

This unmet need was identified in several submissions, including the Department of Education which noted the high demand for parenting services in schools:

> *Primary schools are often the first point of contact for parents requiring targeted, individualised support with parenting. Schools are not currently resourced or have staff trained to deliver services.*[541]

Although Parenting WA offers telephone support to parents of children up to age 18 years, most of the evidence-based parenting programs that are offered and to which parents can be referred, such as *Triple-P®* and *Circle of Security™*, are primarily delivered for parents of children aged between 0 to five years.[542] For reasons discussed in Chapter 6, parenting programs for early childhood years are critical and it is imperative that supports are available for these years. However, this should not be at the exclusion of the older age groups, as the importance and challenges of parenting do not stop once a child enters school.

See Recommendation 31 in Chapter 6 regarding expanded parenting programs for children.

Box 18: The impact of media and the sexualisation of children

Several submissions raised concerns regarding the negative impact of media, including violence and the sexualisation of children, on the mental health and wellbeing of children and young people.[543] A number of Australian organisations have developed position and policy papers on these topics.[544] Media violence and the sexualisation of children have been the subject of several recent Commonwealth Government inquiries and reviews[545] including the Senate Standing Committee on Environment, Communications and the Arts' Inquiry into the sexualisation of children in the contemporary media.[546]

537 Submission No. 136 from Halo Leadership Development Agency, p. 19.
538 Submission No. 141 from Mental Health Commission p. 45, 56.
539 Submission No. 44 from Wanslea.
540 Submission No. 117 from Ngala.
541 Submission No. 16 from Department of Education, p. 14.
542 Department for Communities 2010, Parenting WA Strategic Framework, Government of Western Australia, p. 5 [website], viewed http://www.communities.wa.gov.au/childrenandfamilies/parentingwa/Documents/Parenting%20Wa%20Strategic%20Framework%20final%201.pdf
543 Submission No. 62 from Hon Nick Goiran MLC; Submission No. 121 from Australian Council on Children & the Media; Submission No. 123 from The Australian Psychological Society Limited (Submission No. 132 also referenced).
544 For example, Australian Psychological Society, the Royal Australasian College of Physicians, The Centre for Community Child Health, Australian Council on Children and the Media.
545 For example, Australian Parliament Joint Select Committee on Cyber-Safety, Inquiry into Cyber Safety; Attorney General's Department, R18+ Classification for Computer Games; House Standing Committee on Family Community Housing and Youth, Inquiry into the Impact of Violence on Young Australians.
546 Standing Committee on Environment, Communications and the Arts, 2008, Sexualisation of children in the contemporary media [website], viewed 16 February, http://www.aph.gov.au/senate/committee/eca_ctte/sexualisation_of_children/report/report.pdf

The Senate Committee's recommendations acknowledged the increasing concern about the sexualisation of children and the significant cultural challenge it presented. The Committee also made a number of recommendations about the role of the Advertising Standards Board and the Australian Communications and Media Authority and a review of the Association of National Advertisers' Code for Advertising and Marketing Communications to Children.[547] These recommendations are applicable to other aspects of media including violent games and advertising.

This issue illustrates the need for whole-of-community engagement in promoting positive mental health in children and young people. A collaborative approach between parents, legislators, marketers, advertisers, the media, and children and young people is needed that will ensure the healthy and positive development of children in the contemporary media environment.

7.2.2 School

Perhaps second only to home-life, the school-life of children is extremely significant. Children spend approximately 32 hours of their week in primary school (up from 15 hours per week in kindergarten), making it a setting where many different experiences and interactions occur. School is also arguably the most significant place for friendship and social development. Many submissions referred to the mental health and wellbeing of children in the primary school context.[548] Children consulted for this Inquiry spoke about how good they feel when they achieve at their homework or learning. Some of them said they did not like school holidays because they missed school.[549] Others spoke about the importance of school not only for learning but for being with friends.[550]

A positive, rewarding school environment and a child's sense of connectedness to the school are protective against mental health problems and enhance children's mental health and wellbeing.[551] [552] Conversely, experiencing school failure, isolation or bullying, or poor attachment to school puts a child at greater risk of mental health problems.[553] For Aboriginal children and children from culturally and linguistically diverse backgrounds, tolerant and culturally inclusive schools free from social exclusion, racism and bullying are essential for a positive school environment.[554] [555] Therefore, how a school attends to the promotion of mental health – at both an individual and a whole-of-school level – can have significant impacts on its students' mental health and wellbeing.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) argues that, for school age children, formal schooling becomes relevant to prevention and early intervention of mental illness, as well as relevant to detecting and improving behavioural and emotional problems:[556]

> *School based initiatives can aim to improve self-esteem and life skills through school-based curricula of pro-social behaviour and by creating a positive and safe school environment. Resilience building*

547 Ibid.
548 Submission No. 39 from Western Australian Primary Principals' Association; Submission No. 65 from Mandurah Area Public School Principals; Submission No. 66 from Atwell Primary School (Submission No. 16, 20, 25, 32, 118, 47, 52, 53, 57, 76, 85, 99, 116, 136 also referenced).
549 Submission No. 136 from Halo Leadership Development Agency.
550 Submission No. 30 from Indigenous Youth Council – Geraldton Streetwork Aboriginal Corporation.
551 Commonwealth of Australia 2000, National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, Commonwealth of Australia, p. 28.
552 Raphael, B 2000, Promoting the Mental Health and Wellbeing of Children and Young People. Discussion Paper: Key Principles and Directions, National Mental health Working Group, Commonwealth Department of Health and Aged Care, Canberra, p. 17.
553 Mental Health and Special Programs Branch 2000, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Health and Aged Care, Canberra, p. 16.
554 Zubrick, S, et al 2007, Vol 3, Improving the Educational Experiences of Aboriginal Children and Young People, Western Australian Aboriginal Child Health Survey, p. 512, viewed, http://www.ichr.uwa.edu.au/waachs/publications/volume_three
555 Malin, M 2003, Is Schooling Good for Aboriginal Children's Health, Cooperative Research Centre for Aboriginal and Tropical Health [website], viewed, http://www.crcah.org.au/publications/downloads/Is_Schooling_good_for_Aboriginal_Children.pdf; Early Childhood Strategy Division 2009, Transition: A Positive Start to School Resource Kit, Office of Children and Portfolio Coordination, Department of Education and Early Childhood Development, Victoria, p. 6:1 [website], viewed 3 March 2011, http://www.eduweb.vic.gov.au/edulibrary/public/earlychildhood/learning/trkall.pdf
556 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 11.

and proactive teaching of cognitive techniques, for example enhancing individual coping skills and promoting social competence, are important tools for preventing and reducing mental health problems.[557]

The World Health Organisation (WHO) also acknowledges the role of schools in influencing positive mental health outcomes and notes that universal programs provided to groups of students can assist in *'achieving improved competence and self-worth, as well as decreasing emotional and behavioural problems'.* [558]

Several submissions to the Inquiry supported the *KidsMatter* program in primary schools as an evidence-based way to work with children, parents and the whole school community to strengthen mental health. The *KidsMatter* program, outlined in Box 19, has been evaluated by Flinders University in South Australia[559] and found to have *'a positive impact on schools, children, parents and carers'*.[560] In Western Australia, *KidsMatter* is currently implemented in 65 primary schools[561] (there are 691 primary schools in Western Australia[562]) and is funded by the Commonwealth Government's Department of Health and Ageing.

Box 19: *KidsMatter*

The *KidsMatter* initiatives provide a framework for mental health promotion, prevention and early intervention that is specifically designed for early childhood services through to primary schools. *KidsMatter Primary* focuses on children aged five to 13 years in primary school. The foundation of the *KidsMatter* initiatives is a comprehensive approach to mental health and wellbeing that addresses the mental health of all children. The initiatives also assist schools and early childhood services to better address the needs of children experiencing mental health difficulties, including through facilitating early intervention. By adopting a holistic, whole-of-setting approach, *KidsMatter* aims to:

1. Improve the mental health and wellbeing of children;
2. Reduce mental health problems amongst children; and
3. Achieve greater support for children experiencing mental health problems.

The *KidsMatter* initiatives emphasise a sense of shared responsibility for children's wellbeing amongst the people who have a significant influence on their lives – parents, carers, families, early childhood service staff, teachers, professional and community services and the broader community. The *KidsMatter* initiatives provide a comprehensive framework for addressing mental health and wellbeing that focuses on four key areas:

Component 1: Building a positive community;
Component 2: Social and emotional learning;
Component 3: Working with parents and carers; and
Component 4: Early intervention for children experiencing mental health difficulties.[563]

In its submission to the Inquiry, *KidsMatter* called for an increased number of Western Australian schools to access the *KidsMatter* initiative and suggested this could be achieved by:

…allocating staffing resources within education, particularly the school psychology services, and within mental health services, to support schools to implement the initiative by providing professional learning

557 Ibid.
558 Lahtinen et al 1999, cited in World Health Organisation, Victorian Health Promotion Foundation, & University of Melbourne 2005, Promoting mental health; concepts, emerging evidence, practice, WHO Press, Geneva, p. 176.
559 Slee, PT, Lawson, MJ, Russell, A, Askell-Williams, H, Dix, KL, Owens, L, Skrzypiec, G, Spears, B 2009, Executive Summary, Evaluation Final Report, KidsMatter, Centre for Analysis of Educational Futures, Flinders University, viewed, http://www.kidsmatter.edu.au/uploads/2009/10/kidsmatter-exec-summary-report-web.pdf
560 KidsMatter[website], viewed, http://www.kidsmatter.edu.au/
561 Information provided to Commissioner for Children and Young People's office from WA KidsMatter Primary Coordinator, 11 February 2011 [by telephone].
562 Department of Education WA, School Statistical Reports 2010 [website], viewed 1 Mar 2011, http://www.det.wa.edu.au/education/schoolinfo/estat/Latest/t101ads.html
563 Submission No. 57 from KidsMatter, pp. 11-12.

> *on mental health and facilitating school change processes. KidsMatter will provide access to training and resources to enable this to occur. Investment in KidsMatter Primary by education and health in WA to form a strong partnership would enable more schools to become part of the initiative, which in turn has demonstrated benefits to more children and families and the wider community.*[564]

This is in keeping with WHO's conclusion that the most effective mental health promotion and prevention programs in schools are those that address a number of factors at different levels, including changing the school environment.[565]

As *KidsMatter* provides an evidence-based, whole-school framework for the strengthening of children's mental health and wellbeing (using evidence-based programs to develop children's social and emotional skills – see Box 22[566]) the Inquiry supports the allocation of resources to facilitate the expansion of *KidsMatter* into all Western Australian primary schools.

Recommendation 37: Funding be provided to *KidsMatter* and all primary schools in Western Australia to enable the implementation of social and emotional learning programs within the *KidsMatter* framework.

School transitions

Beginning kindergarten and primary school and moving from primary school to secondary school are major transitions for children. These transition points have been identified as a time of particular vulnerability and a risk factor for mental health issues, especially when the needed supports are not available.[567] [568] [569]

> *Commencing school presents children and their families with both opportunities and challenges. It requires them to negotiate many changes - in identity, relationships, physical environment, social environment status, learning environment, and rules.*[570]

An increasing awareness of the importance of a smooth transition to school has led to the development of some innovative programs, such as Linking Education and Families (LEAF) outlined in Box 20, to assist a child's movement into kindergarten.

Box 20: *Linking Education and Families*

Linking Education and Families (LEAF) is a school-based program, coordinated by a trained kindergarten teacher that targets families with children aged 0 to four years. LEAF has been piloted in several schools in the South West Region (including in Bunbury) and provides a mechanism by which schools can make contact with families with young children before they attend kindergarten.

The program involves several key elements including:

- training for project coordinators;
- family visits (home visiting);

564 Submission No. 57 from KidsMatter, p. 21.
565 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options - summary report, World Health Organisation, Geneva, pp. 30, 31.
566 KidsMatter Program Guide [website], viewed 28 February 2011, http://www.kidsmatter.edu.au/content/uploads/2009/09/Component-2-general-table-08.12.2010.pdf
567 Mental Health and Special Programs Branch 2000, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Health and Aged Care, Canberra, pp. 15, 16.
568 Centre for Community Child Health 2008, Policy Brief 11: Rethinking the Transition to School: Linking schools and early years services, The Royal Children's Hospital Melbourne, p. 1.
569 Submission No. 7 from Richard Waddy.
570 Centre for Community Child Health 2008, Policy Brief 11: Rethinking the Transition to School: Linking schools and early years services, The Royal Children's Hospital Melbourne, p. 1.

- *Play Cafés* for families of 0 to four year olds;
- collaborative transition plan for kindergarten children in the year prior to school; and
- access to health staff and specialist services.

Both *Play Cafés* and family visiting provide a framework for schools to actively support the transition to school, and an opportunity to get to know children and their particular learning and social needs before they commence school. In short, the LEAF program provides an opportunity for health and education to work collaboratively to improve outcomes for very young children and their families.[571] [572]

One of the key reasons why supporting the transition to kindergarten and primary school is so important is to ensure children manage the demands of the new environment and engage with the school's processes and activities:

> *As the early years of school are now recognised as being critical for later school success, both attendance and engagement are vital to establishing the attitudes, behaviours and competencies crucial to ongoing achievement… A successful transition to school results in children who like school, look forward to going regularly, and show steady growth in academic and social skills. Successful transitions are also more likely to lead to families being actively involved in their children's education, and in teachers and families valuing each other.*[573]

A smooth transition from primary to secondary school is just as crucial, requiring a period of adjustment to cope with the many changes. For many children this transition occurs at the same time as other major adjustments including puberty. This is significant because not only is there stress associated with the transition to secondary school, but the more adjustments occurring at any one time, the greater the likelihood of negative consequences.[574]

Research commissioned by the Ministry of Education in New Zealand showed the extent to which students experienced difficulty following transition was strongly correlated with their likelihood of school dropout, regardless of the age at which the transition occurs.[575]

Submissions raised concern about the impact of these transitions on children[576] and, in particular, the transition to secondary school for Aboriginal children, who continue to achieve poorer academic outcomes than non-Aboriginal children.[577]

> *…transitional programs for Aboriginal young people are imperative for any form of success with educational processes.*[578]

In summary, successful transitions are vital in securing ongoing engagement with school, academic achievement, and as a protective factor against mental health and wellbeing concerns.

571 Gregg, C, 2009 The Linking Education and Families Program Evaluation Report 2008, Investing in Our Youth Inc, Bunbury Western Australia.
572 Submission No. 13 from Bunbury Early Years Network.
573 NICHD Early Childcare Research Network, 2004; Pianta & Cox, 1999, 2002, Centre for Community Child Health 2008, Policy Brief 11: Rethinking the Transition to School: Linking schools and early years services, The Royal Children's Hospital Melbourne, [website] http://www.rch.org.au/emplibrary/ccch/PB11_Transition_to_school.pdf
574 Simmons, et al 1987, cited in McGee, C, et al, 2004, Transition to Secondary School: A Literature Review, Ministry of Education, NZ, pp. 14-15 [website], viewed 28 February 2011, http://www.educationcounts.govt.nz/__data/assets/pdf_file/0018/7560/transition.pdf
575 McGee, C, et al 2004, Transition to Secondary School: A Literature Review, Ministry of Education, NZ, p. 9 [website], viewed 28 February 2011, http://www.educationcounts.govt.nz/__data/assets/pdf_file/0018/7560/transition.pdf
576 Submission No. 6 from Samaritans Crisis Line, p. 1; Submission No. 101 from South West Aboriginal Medical Service, p. 2.
577 National Assessment Program Literacy and Numeracy (NAPLAN) 2009, Achievement in Reading, Writing, Language Conventions and Numeracy, Ministerial Council on Education, Early Childhood Development and Youth Affairs.
578 Submission No. 101 from South West Aboriginal Medical Service

Further, academic achievement and positive mental health are themselves inter-related given that children with mental health problems are less likely to perform as well in school. Many submissions to the Inquiry made this point.[579] *The Western Australian Child Health Survey* found *'a five-fold increase in the likelihood of below age academic competence in students with an identified mental health problem'* and that *'mental health problems in students were associated with higher rates of school absenteeism, suspension/exclusion, truancy and school alienation'*.[580]

The *Western Australian Aboriginal Child Health Survey* concluded that the high proportion of Aboriginal students at risk of emotional or behavioural difficulties is one of the main factors contributing to poor academic performance among Aboriginal students.[581]

The Inquiry agrees that the relationship between mental health problems and a lower level of success for children in school is of particular concern and is of considerable concern for Aboriginal children.

Bullying

Bullying is a whole-of-community issue, and addressing it is not the sole responsibility of schools. However, it is known that bullying peaks twice in childhood: once in primary school and then again on transition to secondary school,[582] making primary school a key setting for implementing programs that address the issue.

Unfortunately, bullying is a reality for many children in Western Australia.[583] Extensive research by the Child Health Promotion Research Centre (CHPRC) has found that one in four children report being bullied every few weeks or more.[584] Recent research by Girl Guides Australia found that more than two-thirds of girls under ten years of age have been bullied.[585]

The Commissioner's wellbeing research *Speaking out about wellbeing* found that bullying at school was an issue of significant concern for children and young people, with 60 per cent of respondents to the survey stating they had been bullied and 44 per cent agreeing they had bullied someone else.[586]

> *"I got bullied earlier in the year and that put a really bad perspective on my life. I didn't see things as funny anymore."* (Girl, 14)[587]

In its submission to the Inquiry, the CHPRC described the impact of bullying on children and young people's mental health, indicating its links with anxiety, depression, suicidality, psychiatric disorders, poor academic achievement, poor relationships with peers, increased loneliness, low self-esteem and increased alcohol and substance use.[588] Bullying and the effects of bullying are, of course, not exclusive to children of primary school age, but can also commence in and have longer term impacts into adolescence.

579 Submission No. 20 from Catholic Education Office; Submission No. 39 from WA Primary Principals Association; Submission No. 65 from Mandurah Area Public School Principals (Submissions No. 66, 85 also referenced).
580 Zubrick, S, et al 1995, The Western Australian Child Health Survey: Education, Health & Competence, Australian Bureau of Statistics and the Telethon Institute for Child Health Research, Perth. p. 35.
581 Zubrick, S, et al 2005 Western Australian Aboriginal Child Health Survey, Volume 3: Improving the educational experiences of aboriginal children and young people, p. 506, viewed 28 February 2011, http://www.ichr.uwa.edu.au/waachs/publications/volume_three
582 Submission No. 99 from Child Health Promotion Research Centre, Edith Cowan University, p. 6.
583 Submission No. 59 from Esteem Plus: Counselling, Training & Education; Submission No. 54 Confidential.
584 Submission No. 99 from Child Health Promotion Research Centre, Edith Cowan University, p. 4
585 Girl Guides Australia 2010, Australian Guides Say...2010: An insight into the minds of girls and young women in Australia today, p. 23 [website], viewed 28 February 2010, http://www.girlguides.org.au/attach/Guides%20Say%20Report%20FIN.pdf
586 Commissioner for Children and Young People, 2010, Speaking out about wellbeing: The views of Western Australian children and young people, p. 17 [website], viewed 28 February 2011, http://www.ccyp.wa.gov.au/files/Wellbeing%20research%20report%202010/wellbeing-report[1].pdf
587 Ibid.
588 Submission No. 99 from Child Health Promotion Research Centre, Edith Cowan University, p. 3.

> *Evidence from longitudinal data indicates that bullying has a tendency to result in increasing social maladjustment and withdrawal from society in adolescence, including depression, anxiety and suicidal ideation.*[589]

The CHPRC has developed evidence-based, whole school, multi-level interventions for primary school aged children and those transitioning to secondary school. The programs are aimed at addressing most of the risk and protective factors which contribute to bullying at individual, family, peer and school levels and have resulted in significant reductions in bullying.[590]

Box 21: *Solid Kids, Solid Schools*[591]

Responding to the *'…general lack of understanding and appropriate management of bullying for Aboriginal young people in schools and other community settings, and poor acknowledgement of how culture impacts upon these bullying behaviours'*, the CHPRC, in partnership with the Combined Universities Centre for Rural Health (CUCRH) and TICHR, developed the *Solid Kids, Solid Schools* program addressing bullying among Aboriginal children.

From 2006–2009 the *Solid Kids, Solid Schools* project worked with Yamaji communities in the Mid-West, Murchison region of Western Australia to find out about childhood bullying experiences.

Specific school-based programs targeting bullying are important to equip children with better understanding and skills, but also to assist teachers in prevention strategies. The CHPRC reports that almost 50 per cent of teachers say they do not know how to effectively help students who have been bullied and feel even less capable of helping students who bully others to stop.

> *Learning effective strategies to respond to a range of student behaviours that impede student academic success and wellbeing are relevant for all teachers. However, teachers report they have had virtually no pre-service education and cannot access effective in-service processional learning to more effectively address student behaviour.*[592]

As noted, bullying is not solely a school-based issue. Bullying occurs in a variety of settings, including sporting and social clubs and requires a whole-of-community response to address it.

The Inquiry notes the strong focus on anti-bullying measures currently in place with the Commonwealth and State Governments and the school sector – for example through the *Bullying No Way!* campaign,[593] and the productive partnership between the Western Australian Department of Education and the CHPRC. The Inquiry supports these activities and encourages an ongoing focus on this important issue.

Recommendation 38: The current focus on bullying be maintained and enhanced by the continued development and implementation of evidence-based anti-bullying programs involving the Commonwealth and State Governments, non-government agencies, community, parents, and children and young people.

589 Ibid.
590 Ibid, pp. 4-7.
591 Ibid, p. 11.
592 Ibid, p. 10.
593 Bullying No Way! [website], viewed 28 February 2011, http://www.bullyingnoway.com.au/issues/implications.shtml

Social and emotional skills in schools

Programs which strengthen social and emotional skills have been found to be effective mental health promotion and prevention interventions.[594] These skills include social problem-solving, self-management, good self-esteem, optimism, communication skills, coping behaviour/skills and life skills and are widely accepted to be protective of mental health and crucial for developing resilience.[595] [596] [597] [598] [599] Promotion and prevention programs to develop these skills are often implemented in primary schools based on the premise that such skills are modifiable in children and can be explicitly taught and learnt.[600] [601]

Although these skills develop throughout a child and young person's life,[602] it is in the childhood years when social and peer interactions begin to play a prominent role and independence starts to emerge that social and emotional competence becomes increasingly important.

Box 22: Selection of evidence-based social and emotional skills programs for primary schools

Aussie Optimism Program

The *Aussie Optimism Program* is an evidence-based intervention program for upper primary school children (Years 4 to 8) that enhances mental health and prevents depression and anxiety. *Aussie Optimism* provides teachers, practitioners and parents with practical strategies for developing children's social competence, self-management, and positive thinking.[603]

PATHS (Promoting Alternative Thinking Strategies)

The PATHS program teaches primary school children how to change behaviours and attitudes that contribute to violence and bullying, how to express and control their emotions, and how to develop effective conflict-resolution strategies. PATHS covers five conceptual domains, including self-control, emotional understanding, positive self-esteem, relationships and interpersonal problem-solving skills.[604]

FRIENDS for Life

The *FRIENDS for Life* program is a cognitive-behavioural therapy program designed to be used in the classroom that aims to increase the resilience and happiness of children. The FRIENDS program teaches children and families cognitive, emotional and behavioural skills for managing feelings and coping with life challenges with a positive and resilient attitude. It promotes important personal development concepts such as identity, self-esteem, problem-solving, self-expression and building positive relationships.[605]

594 WHO 2005, Promoting mental health: concepts, emerging practice, evidence, p. 176; Prevention of Mental Disorders: Effective Interventions and Policy Options, p. 30 [website], viewed 2 March 2011, http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf; Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne / [editors: Helen Herrman, Shekhar Saxena, Rob Moodie].

595 Aussie Optimism, Social Life Skills Teaching Resource, p. vi [website], viewed 28 February 2011, http://www.kidsmatter.edu.au/programs-guide/aussie-optimism-program/

596 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options - summary report, World Health Organisation, Geneva, p. 21.

597 Submission No. 125 from Telethon Institute for Child Health Research, p. 9.

598 Ibid.

599 Greenberg, MT, et al 2000, Preventing Mental Disorders in School-Age Children: A review of the effectiveness of prevention programs, Prevention Research Center for the Promotion of Human Development, College of Health and Human Development, Pennsylvania State University, p. 5 [website], viewed 28 February 2011, http://prevention.psu.edu/pubs/documents/MentalDisordersfullreport.pdf

600 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options - summary report, World Health Organisation, Geneva, p. 14.

601 Submission No. 57 from KidsMatter, p. 6.

602 Submission No. 85 from School Psychologists' Association of Western Australia Inc, p. 2.

603 Roberts, C., Ho, M, School of Psychology, Curtin University of Technology, Aussie Optimism Dissemination Project Report for the Office of Mental Health, WA Department of Health and WA Department of Education & Training [website], viewed 28 February 2011, http://psych.curtin.edu.au/local/docs/docs_aussieoptimism/office_mental_health_report_june09.pdf; Curtin University School of Psychology and Speech Pathology, Aussie Optimism [website], viewed 28 February 2011, http://psych.curtin.edu.au/research/aussieoptimism/index.cfm

604 Department of Education and Training (Queensland), PATHS Curriculum [website], viewed 28 February 2011, http://education.qld.gov.au/studentservices/protection/sel/paths-curriculum.html

605 KidsMatter, Friends for Life, Program Overview [website], viewed 28 February, 2011, http://www.kidsmatter.edu.au/programs-guide/friends/

7.2.3 Community

Play, sport and recreation

Opportunities for play and recreation are increasingly being linked to improved mental and physical health outcomes for children and young people[606] and are enshrined in the United Nations' *Convention on the Rights of the Child.*[607]

In his book, *Last Child in the Woods: Saving Our Children from Nature Deficit Disorder,* Richard Louv also describes the health benefits of increasing children's access to the natural environment:

> *…a growing body of research links our mental, physical and spiritual health directly to our association with nature—in positive ways. Several of these studies suggest that thoughtful exposure of youngsters to nature can even be a powerful form of therapy for attention-deficit disorder and other maladies.*[608]

Providing appropriate spaces, places and opportunities for children and young people to engage in play and recreation is therefore an important component in the promotion of their mental health and was the subject of several submissions to the Inquiry.[609]

The importance of the built environment in facilitating the recreation of children and young people was also raised. The Centre for Built Environment and Health at the University of Western Australia submitted that this is an area requiring increased focus and that there is a need to ensure children and young people are involved in planning and design so that not all spaces are designed 'by adults for adults'.[610]

> *From a broader child development perspective, providing opportunities for creative play, exploring, make-believe, contact with different textures and exposure to nature is crucial, yet often missing in the more typical 'plastic fantastic' traditional playgrounds found in many parks… there is strong support among children and parents for areas within the urban landscape that can reconnect children with nature and promote physical activity and creative, social and imaginative play.*[611]

The Inquiry encourages further work in this area to ensure urban design in Western Australia considers the needs of children and young people and the benefits of creative play, recreation and natural play spaces to their mental health.

7.3 Early intervention and treatment

Having looked at the primary settings of family and schools as places where effective mental health promotion and illness prevention programs can be implemented for children, the Inquiry examined what services exist for children who need additional supports. This included assessment, early intervention or treatment for mental health problems and disorders. See Box 23 for specialist mental health public services available to children.

The Inquiry found that not only is there a lack of systematic identification and assessment processes, but there is also a significant lack of resources. This was particularly in the form of mental health professionals or other trained staff to

606 Submission No. 127 from Centre for the Built Environment & Health, University of Western Australia.
607 [Article 31] Office of the United Nations High Commissioner on Human Rights [website], Convention on the Rights of the Child, viewed 16 March 2011, http://www2.ohchr.org/english/law/crc.htm
608 Louv, R 2005, Last Child in the Woods: Saving Our Children from Nature Deficit Disorder, Atlantic Books, London, p. 3.
609 Submission No. 127 from Centre for the Built Environment & Health, University of Western Australia; Submission No. 40 from Physical Activity Taskforce Secretariat, Department of Sport & Recreation; Submission No. 111 from Youth Activity Participation Study, Murdoch University.
610 Submission No. 127 from Centre for the Built Environment & Health, University of Western Australia, p. 4.
611 Ibid, p. 10.

implement early intervention and treatment programs when children in need are identified.[612]

The Inquiry found that once mild to moderate mental health problems have been identified in a child in Western Australia it is very difficult to obtain timely access to early intervention or treatment services. This applied to children and young people of all ages. This was one of the most significant gaps noted, with virtually no information being provided on services in this area.

A gap in the early intervention and treatment service area results in children having to wait until their condition deteriorates to an acute stage, or they hit crisis point, before any assistance can be accessed.

Further, the Inquiry learnt that the provision of specialist treatment services for children with mental illnesses is not comprehensive, integrated or coordinated.

Box 23: Specialist mental health public services available to eligible children[613] [614]

The following is a list of the specialist public mental health services offered to eligible children in Western Australia:

- Infant Child Adolescent Youth Mental Health Service (ICAYMHS);
- Complex Attention and Hyperactivity Service (CAHDS);
- Multi-Systemic Therapy;
- Ward 4H Princess Margaret Hospital (PMH);
- Bentley Adolescent Unit and Bentley Transition Unit;
- Eating Disorders Program;
- Paediatric Consultation Liaison Program;
- Assertive Community Intervention Team (ACIT);
- Families at Work; and
- Family Pathways.

7.3.1 Schools

The Inquiry acknowledges it is not the role of schools to assess or treat mental health problems. However, given schools are the settings where most children spend considerable amounts of their time, many submissions made to the Inquiry felt that schools have a pivotal role as being the place where identification, assessment, referral and early intervention for mental health problems can and should occur.[615]

The Department of Education acknowledged the broad identification role schools play *'Schools may identify a child at risk by way of information of [sic] school records, by observation of behaviour, anecdotal records or parent/carer report.'* [616] However, the Department then described the constraints they face in providing more comprehensive, or specialist, identification and assessment services.

In regard to school health nurses (employed by the Department of Health) and school psychologists, the Department of Education informed the Inquiry:

> *It is not the role of school psychologists to diagnose mental health disorders in students they may however use tools to identify difficulties… School Health Nurses can offer an initial point of contact for students with mental health problems. Limited resources means that nurses can play a minimal role in addressing student*

612 Submission No. 20 from Catholic Education Office; Submission No. 123 from The Australian Psychological Society Limited.
613 Submission No. 141 from Mental Health Commission, pp. 25-37.
614 Submission No. 97 from South Metropolitan Area Health Service.
615 Submission No. 39 from Western Australian Primary School Principals' Association; Submission No. 118 from Association of Independent Schools of Western Australia Inc; Submission No. 132 from State School Teachers Union of Western Australia (Submission No. 133, 134, 47 also referenced).
616 Submission No. 16 from Department of Education, p. 22.

mental health problems. This role may include targeted psychosocial assessments for students referred by school staff or parents and subsequent referral to appropriate services.[617]

Behaviour Centres in primary schools (referred to as Primary Behaviour Centres or PBCs) are located in five metropolitan school districts and three regional areas.[618] They provide specialist services to assist Government primary schools to manage and engage students with severely challenging behaviours.[619] However, the Department of Education also made it clear that the role of PBCs does not include the provision of mental health services:

The Department of Education's Behaviour Centres are not a provision for the support of students with mental health problems. Where students in the Centres have diagnosed mental health problems across agency collaboration is strongly pursued.[620]

On the face of it, it would be logical to put programs and services in schools to assist with the early identification of mental health problems (for example screening or training for teachers). However, identifying children with problems without providing the specialist services to meet their needs would do nothing to address their mental health problems.

Treatment services must complement the identification of mental health problems. For example:

Teachers can be trained to increase detection of problems and facilitate interventions or referrals to mental health professionals. However, early identification of individuals will only be successful in reducing the number and severity of mental health problems in the community if backed with easily accessible and high quality professional assistance.[621]

Box 24: Attention Deficit Hyperactivity Disorder (ADHD)

Several submissions raised issues regarding the identification and treatment of children and young people with Attention Deficit Hyperactivity Disorder (ADHD).[622] In particular, submissions focussed on the need for multi-disciplinary services.

A strong illustration, provided by people working in the area, of why a multi-disciplinary approach is needed for children and young people with ADHD specifically is as follows:

Twenty five percent of children diagnosed with a primary hyperactivity disorder will have a specific developmental disorder (specific learning disability) affecting reading, spelling, motor function, language or arithmetic. In a number of cases there will be coexisting general learning disability, which may have gone unsuspected because poor achievement has wrongly been attributed to hyperactivity. It is also likely that these same children may have coexisting difficulties such as family relationship difficulties, peer difficulties, sleeping difficulties, poor self-esteem and decreased academic performance. Children diagnosed with ADHD usually have other comorbid difficulties such as oppositional behaviour, depressive mood, anxiety, autistic features, developmental coordination disorder and speech and language problems.[623]

617 Ibid, pp. 22-26.
618 There are also Behaviour Centres in the secondary school system and the same applies to them.
619 Submission No. 16 from Department of Education, p. 23.
620 Ibid, p. 22.
621 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 11.
622 Submission No. 16 from Department of Education; Submission No. 18 from Office of Health Review; Submission No 50 from Mental Health Law Commission of Western Australia (Submission No. 64, 66, 86 also referenced).
623 Submission No. 64 Confidential.

Professionals including (but not limited to) psychiatrists, paediatricians, clinical psychologists, occupational therapists, social workers, school psychologists, mental health workers and teachers will have expertise in different aspects of the difficulties facing these children and young people.

> *An appropriate Mental Wellbeing system will see universal access on an as needed basis to services like speech therapy, occupational therapy, dieticians, school based nurses, child health nurses, family counselling, new mother and parent mentoring, sports and recreational activities, youth workers, social workers, opticians, audiologists, excellent teaching and schools etc.*[624]

The Education and Health Standing Committee (the Committee) report on the *Inquiry into Attention Deficit Hyperactivity Disorder in Western Australia* found:

> *There is widespread recognition of the need for a multidisciplinary approach in diagnosis and treatment of ADHD.*[625]

The Committee found that in ADHD where behavioural symptoms are a key factor and diagnosis involves behavioural observations, comorbidities and co-existing conditions may be misdiagnosed.[626] As a consequence of the Committee's Inquiry, CAHDS were developed and commenced in Joondalup (2009) and Murdoch (2010), and provide:

> *…multidisciplinary assessment, treatment and management for severely impaired tier four children with significant ADHD and complex co-morbid behavioural syndromes.*[627]

Limiting these services to children assessed as 'Tier 4' (see Figure 2 in Chapter 2) means that only the most severely impaired are included. Comprehensive multi-disciplinary assessment and treatment should not be limited to the most severely impaired children and young people but rather be available at the earliest signs and symptoms of problems.

Integrated services on school sites

As described in Chapter 4, the Western Australian Premier has made a commitment to establishing integrated early childhood services on school sites in recognition of the benefits that 'hubs' can bring in terms of service provision and support for children and families.

There is no reason that this model of service integration cannot be extended to primary and secondary schools. This was a proposal presented by several submissions, including the submission from the Department of Education. The Department of Education called for the establishment of a number of wrap-around[628] services in schools, whereby mental health staff and specialists work on school sites:

> *Increased "wrap around" services located in schools would be beneficial. Evidence states that mental disorder in schools could be more effectively managed if specialist mental health consultation liaison and assessment services were available within the school setting.*[629]

624 Submission No. 86 from Martin Whitely MLA, Member for Bassendean.
625 Education and Health Standing Committee 2004, Attention Deficit Hyperactivity Disorder in Western Australia, p. xxiii [website], viewed 16 January 2011, http://www.parliament.wa.gov.au/Parliament/commit.nsf/(Report+Lookup+by+Com+ID)/A8838813E981CEE948257831003E9611/$file/ADD+final+report+pdf+version.pdf
626 Ibid.
627 Western Australian Attention Deficit Hyperactivity Disorder Clinical Reference Committee 2009, Complex Attention and Hyperactivity Disorder Service: Clinical Model, Department of Health, Western Australia [website], viewed 15 February 2011, http://www.nmahsmh.health.wa.gov.au/services/docs/CAHDS_Clinical_Model_June09.pdf
628 'Wrap around' services is also referred to as 'extended service', 'full service' and 'integrated service'. The Inquiry uses the term 'integrated service' as a broad definition capturing the above terminology.
629 Submission No. 16 from Department of Education, p. 14.

This model of wrap-around (or integrated) services in schools is supported for many reasons, including that it provides easy access to services, allows treatment to occur in a familiar location and, importantly enables children to move in a coordinated and seamless way between services on the continuum of intervention. This transition is currently a challenging one – largely due to the dearth of early intervention services as described previously.

Integrated services in schools is not limited to mental health services however, and can be extended to accommodate a variety of services – such as Aboriginal health workers, youth workers, social workers, speech therapists, community child health nurses etc – as required by the children, their families and the communities.

A literature review by the Foundation for Young Australians described the benefits of this type of service provision:

> *[Schools] provide easy access to a range of services for children or young people and their families in a convenient location that is familiar to students and represents a visible and usually non-threatening first point of contact for community-based or social care agencies. Basing extended services on school sites is often more acceptable to parents, who may be hesitant for their children to use services located in unfamiliar settings. For some young people and their families – although not for all – accessing services within a school setting is considered to carry less of a stigma than accessing services within social care settings. Locating services on the school site also has the benefit of transforming the school into a community facility, which in turn expands the benefit derived from the considerable investment that rests in school sites.*[630]

Bringing early intervention and treatment services for mental illness into schools is a strategy strongly supported by the Inquiry and by many schools. Most submissions from the school sector acknowledged the need for a holistic approach to students' wellbeing, with some schools developing their own way of working to bring more services to the schools. For example, Atwell Primary School, having experienced the lengthy waitlists for specialist mental health services, sought a more active approach:

> *We are very proactive in supporting students and we see a definite need for faster, intervention and we have seen the benefits of students and families accessing support on school premises. Often families have difficulty getting to appointments and we offer opportunities for therapists, etc, to come to Atwell PS.*[631]

Providing mental health services on primary school sites is being trialled on a small scale with the ICAYMHS in Primary Schools Pilot (CAPS)[632] (see Box 25 below) and the Inquiry heard anecdotally that this was being well received by schools, parents and children.

Box 25: ICAYMHS in Primary Schools (CAPS)[633]

CAPS is a collaborative program between the Department of Education, Hospital School Services, Child Adolescent Mental Health Services (CAMHS) and selected Department of Education primary schools.
CAPS aims to:

- help schools identify and support students with social and emotional difficulties, or who are at risk because of mental health problems;
- support students, families, class teachers and pastoral care teams to intervene with these students at risk; and
- work with school communities to support holistic care systems for these students at risk.

630 Wilkin et al 2008, and Grossman et al 2001 cited in Black, R., Lemon, B., & Walsh, L., The Foundation for Young Australians, Literature review and background research for the National Collaboration Project, Extended Service School Model, Final Report, p. 7.
631 Submission No. 66 from Atwell Primary School, p. 2.
632 Submission No. 141 from Mental Health Commission, p. 31.
633 Department of Education, Statewide Specialist Services, Supporting students with disabilities and diverse learning needs, North Metropolitan CAHMS in Schools [website], viewed 28 February 2011, http://det.wa.edu.au/studentsupport/statewidespecialistservices/detcms/school-support-programs/statewide-specialist-services/hospital-school-services/north-metroplitan-camhs-in-schools-program.en?oid=MultiPartArticle-id-8026471

Although in its comments regarding the PBCs, the Department of Education appears to be drawing a distinction between behaviour or conduct issues and mental health problems, evidence to the Inquiry would suggest that this distinction is not always clear. As discussed previously, it is in the primary school years when behavioural problems are most likely to begin to manifest and, if left unaddressed, these problems can typically precede a mental health problem.[634]

Research from the Institute of Psychiatry at Kings College found that:

> *…childhood conduct and/or oppositional defiant disorder was a part of the developmental history of every adult disorder… this study suggests that juvenile conduct disorder cases constitute a vital prevention opportunity for reducing the burden associated with many major adult psychiatric disorders.*[635]

The linked nature of childhood behavioural issues and later onset of mental health problems provides a further reason for delivering the integrated services discussed previously.

Recommendation 39: The model of integrated services on school sites be established as pilots in a number of primary and secondary schools in Western Australia. These integrated services to include comprehensive mental health services.

7.3.2 Infant, Child, Adolescent and Youth Mental Health Services (ICAYMHS)

As noted in Chapter 4 and elsewhere in the Report, the under-resourced and stretched nature of the key child and adolescent mental illness treatment service – ICAYMHS – was the focus of many submissions. The RANZCP (WA Branch) expressed the situation as follows:

> *Currently the system of care for children and adolescents with mental health problems is fragmented and complex… Limited CAMHS resources result in time delays in children or adolescents with high risk conditions accessing appropriate services in a timely way. This includes the high risk time between a child or adolescent's discharge from hospital and follow-up community care. Best practice is for these children and adolescents to be accessing and gaining acceptance into a local CAMHS within a 24 to 48 hour period. Currently CAMHS capacity means that in some instances children and adolescents discharged from a tertiary service are experiencing long waiting times (months not days in many cases) to access CAMHS.*[636]

In an unpublished *Strategic Directions* document provided to the Inquiry, ICAYMHS estimates that it is currently only funded to provide a service to 20 per cent of the children and young people who require it.[637] ICAYMHS also states that:

> *There are poor backfill arrangements for staff on leave so services flounder and across the state there is difficulty in attracting staff to key positions. There are limited staff to undertake early intervention and infant mental health programs and nor is there opportunity to adopt specialty programs, including outreach programs, or to develop collaborative relationships with key agencies. Clinics instead focus on urgent referrals only and in some areas have lost standing in the broader community as a result.*[638]

As the quote describes, it appears that ICAYMHS has been required to restrict its service to such a point that it will only see children and young people with the most severe, complex and persistent mental disorders.

634 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 4.
635 Kim-Cohen et al 2003, 'Prior Juvenile Diagnoses in Adults With Mental Disorder, Developmental Follow-Back of a Prospective-Longitudinal Cohort', Archives of General Psychiatry/Vol 60, pp. 713-715.
636 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch.
637 Infant Child and Youth Mental Health Executive Group 2009, New Strategic Directions for Child and Adolescent Mental Health Services 2010-2020 [Draft], p. 10.
638 Ibid, p. 20.

Due to ongoing under-funding, ICAYMHS has been forced to tighten its eligibility criteria to such an extent that any collaborative work, training of other disciplines or outreach has been forgone. The frustration at this tightly restricted service was echoed in many submissions received by the Inquiry and needs to be addressed as a matter of urgency (see Recommendation 14 in Chapter 4).

7.3.3 Emergency assistance

Western Australia provides two key services for emergency response for mental health issues in the community, the Mental Health Emergency Response Line (MHERL) and the Community Emergency Response Teams (CERT). MHERL is a specialist psychiatric triage, advice and referral telephone service, and CERT responds to mental health emergencies or crises within the local community.[639]

Although nominally these services exist for 'persons of all ages',[640] the Inquiry learnt that these services have extremely low usage by children and young people.

Without adequate community emergency response, PMH's emergency department becomes the default admission point for children and young people in need of emergency mental health assistance.

PMH has partly addressed this need by establishing a Psychiatric Liaison Nursing Service (PLNs) which conducts psychiatric assessment within the emergency department environment. From there, children and young people may be referred to one of several acute options including Ward 4H, ACIT, or ICAYMHS.[641]

It is positive that the PLNs have been established within PMH, but there is a need for emergency assistance for children and young people to be provided in the community.

For example, a school dealing with a child experiencing a significant mental health problem would be best served by an emergency phone line and a mobile team of experts who could attend the school and provide assessment and/or treatment. In the absence of such a team, often the Western Australia Police (WAPOL) is called to assist in these circumstances – a response which WAPOL and the Inquiry both agree is often inappropriate and can exacerbate the situation. WAPOL submitted to the Inquiry that:

> *People with a mental illness have the right to dignity, privacy and treatment by the most appropriate, trained professionals. At times the presence of police escalates patients' behaviour, resulting in police using the highest degree of non-lethal force, a situation that is distressing to patients, their families and police.*[642]

WAPOL described its 'major concern' about the inability of the current mental health system to respond and provide assessment and treatment to children and young people. It described situations that, because of inappropriate response, escalate to become criminal justice matters.

> *Police officers report being repeatedly called to the same addresses and conveying the same young people to hospital for a mental health assessment, treatment and/or admission. Often children and young people are assessed as not requiring admission and they return home to be followed up by a mental health professional. However when police again attend after behaviour has escalated, family members report there has been no contact from the mental health system. This pattern continues until a crisis occurs, often involving criminal behaviour (and ultimately arrest) and entry into the formal criminal justice system.*

639 Submission No. 141 from Mental Health Commission, pp. 38-39.
640 Ibid, p. 38.
641 Submission No. 141 from Mental Health Commission.
642 Submission No. 24 from Western Australia Police, p. 6.

Innovative mental health service delivery is required to stop this cycle and actually improve the lives of mental health consumers.[643]

The implications of this are profound. That children with a mental illness needing specialist support should instead find themselves within the criminal justice system demonstrates that the response being offered is totally inadequate.

The Department of Corrective Services also identified this as an area of need, stating:

There does not appear to be a comparable level of emergency service provision available for young people presenting as acutely suicidal that is available to adults such as the Psychiatric Emergency Team.[644]

With appropriate specialist staffing and adequate resources, an expansion of either MHERL and CERT or ACIT could undertake the critical role of providing assistance in the community to children and young people experiencing mental health crises, thereby avoiding situations such as those described by WAPOL.

Recommendation 40: A specialised, statewide, 24-hour emergency service be developed for children and young people experiencing a mental health crisis.

643 Ibid, p. 6.
644 Submission No. 141 from Mental Health Commission, supplementary information from Department of Corrective Services.

In 2006, young people aged 12 to 17 years made up 35.1 per cent of all children and young people in Western Australia. Aboriginal young people in this age group comprised 32.2 per cent of the total Aboriginal 0 to 17 year old population (5.2 per cent of the total population of young people).[645]

8.1 Introduction

> *The mental health of young people is of growing concern within developed countries and has become the major threat to health during adolescence and early adult life… Early, effective intervention during [these periods] is essential if we wish to reduce the risk of ongoing impairment or disability associated with mental health and related substance use disorders.*[646]

This chapter examines the period of adolescence which, for the purposes of this Inquiry, is loosely defined as the ages of 13 to 17 years; from when a young person[647] moves into secondary education until they are 17 years, a period when they are in education, training or employment (or a combination).[648] [649]

Ongoing brain development, the transition from primary to secondary school, the increasing importance of peer and social relationships, and the tendency to engage in risky behaviours are just some of the elements that make the adolescent period a critical one for the prevention of and intervention for mental illness and disorders. This chapter explores these opportunities, as well as the key settings in which supports and programs can be implemented to strengthen young people's mental health.

The importance of mental health and wellbeing in adolescence

Adolescence is characterised by the growth of the child towards cognitive and physical maturity.[650] Throughout the adolescent years, the brain is still in the process of developing (a process that continues into the 20s[651]) and this affects how young people:

- think and feel – including how they respond to stress, regulate emotions, interpret others' emotions, as well as increase their capacity to use abstract thought;[652]
- behave – young people are more likely to experiment or engage in risky behaviours;[653] and
- respond to environmental influences.[654]

645 Australian Bureau of Statistics 2006, Census of Population and Housing, cat. no. 2068.0, 'Age by Indigenous Status by Sex'; Australian Bureau of Statistics 2006, Census of Population and Housing, cat. no. 2068.0, 'Age (Full Classification List) by Sex - Place of Usual Residence'.

646 McGorry, P, et al, 'Youth mental health services' [website], viewed 3 February 2011, http://www.psychology.org.au/publications/inpsych/youth_mental_health/

647 The terms 'adolescents' and 'young people' are used interchangeably.

648 Department of Education, Schools and You [website], viewed 28 February 2011, http://www.det.wa.edu.au/schoolsandyou/detcms/navigation/parents-and-community/schooling/?page=1

649 Chapter 9 of this Report deals with the transition to adult services.

650 Sawyer, M, et al, 2000, Mental Health of Young People in Australia: Child and Adolescent Component of the National Survey of Mental Health and Well-Being, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 12.

651 Bennet, D 2007, Adolescent Development and Risk-taking, Youth Action and Policy Association NSW [website], viewed 28 February 2011, http://www.yapa.org.au/youth/facts/devrisk.php>.

652 California Department of Education, Adolescent Characteristics [website], viewed 28 February 2011, http://pubs.cde.ca.gov/tcsii/ch4/adlescntcharactr.aspx

653 Bennet, D 2007, Adolescent Development and Risk-taking, Youth Action and Policy Association NSW, [website], viewed 28 February 2011, http://www.yapa.org.au/youth/facts/devrisk.php

654 Australian Research Alliance for Children and Youth, Youth Violence in Australia: A project of the Australian Research Alliance for Children and Youth (ARACY) aimed at reducing the level of violent and antisocial behaviour among young people in Australia [website], viewed 2 March 2011, http://www.aracy.org.au/cmsdocuments/Preventing_Youth_Violence_Rationale_180809.pdf

This period of physical, social and emotional growth, coupled with the transition from primary to secondary school, can be a difficult time – presenting challenges for both the young person and their families/carers.[655] [656]

Although it does not inevitably follow that the young person will experience mental health problems (and most do not), it is unquestionably a period of vulnerability[657] [658] and is the peak time for the manifestation of mental illness. Half of all serious mental health and substance use disorders commence by the age of 14 years and three-quarters before the age of 25 years.[659] In 2009, three out of four young Western Australians who contacted Kids Helpline with mental illness concerns were aged 15 to 18 years.[660]

Knowing this, and knowing that mental illness is also the most common health issue affecting young people in Australia (accounting for 61 per cent of the non-fatal burden of disease for young people[661]), it is of critical importance to explore the opportunities for mental health promotion and illness prevention and intervention in this developmental stage.

To do so it is then appropriate to consider the settings in young people's lives, to examine 'where they are' and 'who they are with' in order to implement programs and supports to strengthen their mental health.[662]

This examination, as with primary school aged children, leads us once again to families, schools and the wider community context.[663] It is in these settings that protective factors such as strong parental support, success at school and access to support services become key in the mental health of young people (see Chapter 2 for the full list of risk and protective factors).

8.2 Promotion and prevention

8.2.1 Family and trusted adults

> *Young people need a sense of belonging, connectedness to their family (whatever they say!), friends and community, and to make a meaningful contribution.*[664]

The importance of strong family or carer support as a key protective factor continues through infancy, early childhood, childhood, and into adolescence. In 2010, Mission Australia's annual *Youth Survey* revealed, consistent with previous years, that young people place great emphasis on the importance of family relationships, with almost 80 per cent of young people ranking it as the issue of most importance to them.[665] [666] Further, around 75 per cent of the young people surveyed identified parents as major sources of advice and support.[667]

655 Commonwealth of Australia 2009, Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014, ACT, p. 22.
656 Submission No. 69 from headspace National, p. 5.
657 Commonwealth of Australia 2009, Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014, ACT, p. 22.
658 Submission No. 69 from headspace National, p. 2.
659 Kessler, et al, cited in Access Economics Pty Ltd 2009, The economic impact of youth mental illness and the cost effectiveness of early intervention, Access Economics Pty Ltd., p. iv.
660 Submission No. 82 from BoysTown, p. 8.
661 [for 15-24 year olds] Australian Institute of Health and Welfare, 2007, Young Australians: their health and wellbeing 2007, p. 19., Australian Government, Canberra [website], viewed 28 February 2011, http://www.aihw.gov.au/publication-detail/?id=6442467991&libID=6442467989
662 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., p. 20.
663 Ibid, p. 20.
664 headspace, Fact sheet 13, Information for Parents and Carers [website], viewed 28 February 2011, http://www.headspace.org.au/_uploads/documents/Fact%20sheets/Parents_web.pdf
665 Mission Australia Youth Survey, 2010, National Survey of Young Australians, key and emerging issues, Mission Australia, p. 8.
666 Submission No. 81 from Mission Australia, p.5
667 Mission Australia Youth Survey, 2010, National Survey of Young Australians, key and emerging issues, Mission Australia, p. 4.

> *The findings from the Youth Survey … highlight the importance of healthy, functioning families in offering support to young people.*[668]

The findings of the *Youth Survey* were reinforced in the consultation with high school students undertaken by Regional Development Australia (RDA) for the Inquiry. The consultation found that the young people believed 'older' people will be able to help them if they experience any problems.[669]

Although some young people in the consultation listed *'Granny, Nan and Pop, Mum and Dad, aunty, uncle, cousins, any family members'* as people they would speak to if they needed mental health support, the consultation also found that *'most teenagers are uncomfortable talking to parents – embarrassment, too close to home, isolation, don't want to disappoint…'*[670]

The *National Survey of Mental Health Literacy* found that young people prefer to seek help from informal sources such as family and friends.[671]

Overall, the clear implication from the research and the consultation is that trusted adults – parents, family and others – are a key source of support for young people. This is noteworthy as it contradicts common assumptions that young people will always prefer to access supports from their peers or other young people.

It is therefore important to facilitate young people's access to a range of people and information sources, and to provide mental health skills and training for those who work with and have frequent interactions with young people.

Parenting

Given the importance of parents as sources of support and advice for young people, the availability of services that assist them in their role is pivotal to improving the long-term wellbeing and mental health of young people.[672]

In Western Australia, as discussed in previous chapters, parenting supports are offered by a range of agencies however there is no clear coordination and many of the supports offered are for parents of very young children. There is a lack of programs available to assist parents of adolescents. Parenting WA, run by the Department for Communities, offers advice to parents of children up to 18 years but there are limited other services or programs available. (See Recommendation 31 in Chapter 6 regarding an increase in parenting programs).

Trusted adults, other than parents, are often located in schools, youth centres or youth-friendly agencies (discussed further in the following sections).

8.2.2 Schools

Many submissions to the Inquiry, and many young people consulted during the Inquiry, spoke of the critical role that schools have as a setting for programs that promote mental health and prevent mental health problems. There are many benefits of recognising schools as an important setting for mental health intervention, some of which are listed below.

1. As young people are mandated to attend school, schools can provide a key 'community' place or setting where mental health promotion and prevention can occur.

668 Submission No. 81 from Mission Australia, p. 5.
669 Submission No. 113 from Regional Development Australia Wheatbelt, p. 15.
670 Ibid, pp. 14-16.
671 Orygen Youth Health Research Centre, National survey of mental health literacy in young people [website], viewed 28 February 2011, http://rc.oyh.org.au/ResearchAreas/mentalhealthliteracy/nationalsurvey
672 Submission No. 81 from Mission Australia, p. 5; Submission No. 54 Confidential.

> *"There is so much mental illness, suicides, drug and alcohol issues! If they brought in a subject that was taught every day and mandatory in all schools, based on building self-esteem, how to redirect thoughts in a positive way, taking responsibility for your life, how to make choices that are best for your own life and goal setting. These factors are such a big part of how we live our life. This could work, and would change the life of millions."*[673]

> *Behaviour management policies, whole-school approaches, bullying policies and values education are all ways that schools develop an environment that promotes positive mental health and prevents mental health problems from developing.*[674]

2. Schools are well-placed to identify young people with mental health problems and refer them to additional support services or specialist/treatment services (arguably most teachers understand which young people require additional supports).

> *Schools are an obvious point through which to assist in facilitating and/or providing additional supports required by children and young people facing mental health [problems].*[675]

> *…schools are often the first to identify child and adolescent mental health problems and can also be the first point of contact for parents with concerns about their children.*[676]

3. Schools are a place where adults such as teachers, school psychologists, and chaplains, as well as peers, are accessible to young people for advice and support.

> *"Schools that are a calm environment and teachers that are prepared to be there for us, and give us advice when needed. I think that if teenagers at school feel like the whole school (teachers, friends) are there and know how to deal with melt downs, panic attacks etc… this will prevent problems."* (Girl, 14)[677]

However, submissions to the Inquiry and young people themselves also described many barriers that currently exist to prevent schools from operating in a way that would optimise the mental health of the students. The issues raised are outlined below.

Teacher training and resourcing

Several submissions raised concerns about the overwhelming load already experienced by teachers and schools. While the benefits of strong mental health in their students are understood, the extreme pressure on their time and resources is a barrier to taking on a bigger role in this area. The State School Teachers' Union of Western Australia (SSTUWA) submitted:

> *Schools are time and resource poor, causing 'conflicts' in juggling the area of focus and prioritising of what can be managed… In theory we know and understand the connectedness between mental health and wellbeing and a student's ability to engage effectively, but the complexities and pressures of teaching, the lack of timely and effective interventions and an individual teacher's ability to compensate for that lack of appropriate intervention… do not help either the student or the teacher.*[678]

Submissions from schools advised the Inquiry that mental health problems in their students are a significant issue that presents many challenges and stressors on the teachers, many of whom are untrained to deal with the presenting

673 Submission No. 90 from Inspire Foundation.
674 Submission No. 16 from Department of Education, p. 3.
675 Submission No. 132 from State School Teachers Union of Western Australia, p. 6.
676 Submission No. 90 from Inspire Foundation, p. 7.
677 Submission No. 110 Confidential.
678 Submission No. 132 from State School Teachers Union of Western Australia, pp. 5-9.

behaviours. Additionally, teachers become anxious about their inability to assist to the required level which, in turn, affects staff morale.

Ballajura Community College described this issue clearly, advising the Inquiry that:

> *…conservatively, staff are dealing with some 300-320 plus adolescents with a mental illness of one kind or another. These are large numbers and the ability of the college staff to respond to all at the desired and, more importantly, appropriate level of support and follow up required is proving to be a near impossible task within current school resource parameters… Mental health issues are now significantly impacting on class sizes, curriculum offering, staff morale, resources available and most importantly on teacher and support staff time…*[679]

It is clear that schools are confronted with a number of mental health problems in young people and they understand the ongoing implications of leaving these problems unaddressed (including sub-optimal academic achievement).[680] However, it is unreasonable to expect schools (and teachers) to provide mental health services without adequate resourcing and training.[681]

In considering the role of schools and teachers in providing mental health services, the Inquiry examined the tiered system of care described in the existing mental health policy for children and young people (see Chapter 2).[682] [683] In the current Government policy the importance of schools providing primary mental health services for children and young people is clearly articulated. This indicates health services' reliance on schools and teachers to implement programs and interventions because of their universal role.

However, the Inquiry is unaware of any universal training provided to teachers on mental health, and the SSTUWA told the Inquiry that funding to support professional development in schools is limited. This is likely to be no more than two days per year and this time is dominated by curriculum associated training, leaving little focus or time for mental health and wellbeing issues.[684] It also noted that:

> *For staff taking on specific roles in schools which have a pastoral care aspect such as year level coordinator or counsellor, no guaranteed and targeted professional learning is provided to support them. The pressure on staff in such positions is enormous.*[685]

It would be unrealistic to expect that all teachers receive 'on-the-job' training in mental health matters, but it is reasonable to expect that appropriate mental health training be provided to school staff taking on pastoral care roles. It could also be a more comprehensive component of undergraduate training so graduate teachers were better equipped to deal with students with mental health problems.

Recommendation 41: Additional resourcing be provided to schools so that appropriate mental health training can be provided to school staff with pastoral care roles.

679 Submission No. 87 from Ballajura Community College, p. 1.
680 Submission No. 16 from Department of Education, p. 21.
681 Submission No. 87 from Ballajura Community College, p. 1; Submission No. 132 from State School Teachers Union, p. 5.
682 Mental Health Division, Department of Health 2001, Infancy to Young Adulthood: A Mental Health Policy for Western Australia, Government of Western Australia, p. 9.
683 Western Australian Mental Health Commission 2010, WA Mental Health Towards 2020: Consultation Paper, Government of Western Australia, Perth, p. 109.
684 Submission No. 132 from State School Teachers Union, p. 8.
685 Ibid.

School psychologists

Many submissions talked of the importance of school psychologists but highlighted the limitations of the role due to a lack of resources. The Department of Education advised the Inquiry that every public school has access to the specialist services of a school psychologist from the School Psychology Service.[686] [687] However, several submissions noted that the School Psychology Service is stretched and the ratio of psychologists to students is not high enough, meaning that:

> *Assessments and diagnosis can be frustratingly slow and cause significant delays in responding specifically to individual student needs.*[688]

In its submission, the Catholic Education Office called for a higher level of resourcing in the non-government sector to be able to provide an increased level of school psychology staff, particularly in areas of high need (including regional and remote schools).[689]

In the consultations for the Inquiry, most young people were aware of the pastoral care supports available at schools, but many were unclear about how to access their services.

> *Importantly, a significant number of students were unsure of or unfamiliar with the referral process to speak with a School Chaplain / School Psychiatrist / School Nurse / Community Health Nurse. Others stated that they were aware of the frequency of visits, but had to be referred - "can't just ask to see her". Comments made in relation to this were - "needs to be more frequent", "only come when they are asked", "concerned about privacy issues", "the service is not promoted", and "some issues are not realised by kids and / or administration".*[690]

Several submissions to the Inquiry and young people themselves called for an increased focus on mental health and wellbeing in the school curriculum, as well as increased support staff in schools.[691]

Recommendation 42: The Department of Education increase the number of school psychologists to enable the expansion of the services and programs they currently provide, for children and young people with mild to moderate mental health problems and to promote mental health and wellbeing.

School-based promotion and prevention programs

Young people identified schools as an ideal place for non-judgmental education on mental health (including around reducing discrimination and stigma) and were enthusiastic about workshops in school to discuss mental health issues.[692]

> *"[We should] Help young people in self-discovery, that it's ok to share stories with school mates, not keep it a secret that we go through stuff. Empower that it's ok to talk about it – have school curriculum on topics like self-care, challenges of teens even at primary school. Help us to empathise and have compassion for each other rather than compare one's situation to another and judge." (Male, 17)*[693]

686 As of August 2010 there were 231 School Psychologists servicing public schools in 14 Districts across the State.
687 Submission No. 16 from Department of Education, p. 25.
688 Submission No.132 from State School Teachers Union of Western Australia, p. 7.
689 Submission No. 20 from Catholic Education Office, p. 3.
690 Submission No. 113 from Regional Development Australia Wheatbelt, p. 19.
691 Submission No. 20 from Catholic Education Office; Submission No. 23 from Western Australian Secondary School Executives Association; Submission No. 65 from Mandurah Area Public School Principals (Submission No. 88, 123 also referenced).
692 Submission No. 113 from Regional Development Australia Wheatbelt, p. 21; Submission No. 114 from WA AIDS Council's Freedom Centre, p. 13.
693 Submission No. 104 from Relationships Australia, p. 11.

Many schools already run mental health literacy programs and, where they do there are positive results. *MindMatters* is a program that was mentioned by several submissions[694] as an effective resource and professional development program supporting secondary schools in promoting and protecting the mental health and social and emotional wellbeing of all members of school communities (see Box 26).[695]

Box 26: *MindMatters*

MindMatters is a national mental health initiative for secondary school staff funded by the Commonwealth Department of Health and Ageing and implemented by Principals Australia. *MindMatters* uses a whole-school approach to mental health promotion and aims to:

- embed promotion, prevention and early intervention activities for mental health and wellbeing in Australian secondary schools;
- enhance the development of school environments where young people feel safe, valued, engaged and purposeful;
- develop the social and emotional skills required to meet life's challenges;
- help school communities create a climate of positive mental health and wellbeing;
- develop strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing; and
- enable schools to better collaborate with families and the health sector.[696]

An evaluation of *MindMatters* by the Australian Council for Educational Research found that, in schools that used *MindMatters* as a key resource, the view that mental health and wellbeing was an integral part of the school ethos and culture was greater than in other schools.[697]

As with *KidsMatter* and *KidsMatter Early Childhood,* the Inquiry considers the comprehensive rollout of *MindMatters* to be a valuable strategy in encouraging social and emotional learning in schools and reducing the prevalence and impact of mental health problems among young people.

Recommendation 43: Funding be provided to *MindMatters* and all secondary schools in Western Australia to enable the implementation of social and emotional learning programs within the *MindMatters* framework.

An additional benefit of implementing mental health literacy programs in schools is that it challenges the ongoing stigma around mental health issues.[698] [699] This is discussed further below.

8.2.3 Community

Due to their increasing independence, young people are more likely than younger children to access supports that are available outside of their family and school. Mental health services and programs that are available in the wider community context therefore become more important for this group.

694 Submission No. 23 from Western Australian Secondary School Executives Association; Submission No. 65 from Mandurah Area Public School Principals; Submission No. 69 from headspace National (Submission No. 133 also referenced).
695 Mind Matters [website], viewed 28 February, http://www.mindmatters.edu.au/default.asp
696 Ibid.
697 Ainley, J, Withers, G, Underwood, C, Frigo, T 2006, Report to the Australian Principals' Associations Professional Development Council, National Survey of Health and Well-being Promotion Policies and Practices in Secondary Schools, Australian Council for Educational Research, p. vii [website], viewed 28 February 2011, http://www.mindmatters.edu.au/verve/_resources/acer_mm_evaluation.pdf
698 Barney. LJ, Griffiths, KM, Jorm. AF, Christensen. H, Stigma about depression and its impact on help-seeking intentions, Centre for Mental Health Research, Australian National University, Canberra, Australia [website], viewed 28 February 2011, http://www.ncbi.nlm.nih.gov/pubmed/16403038
699 Submission No. 69 from headspace National, pp. 1-3; Submission No. 57 from KidsMatter, p. 3.

Stigma and help-seeking

Young people raised ongoing stigma around mental health problems as an issue – because it prevents them from seeking help if required and because it leads to general misunderstandings in the community about mental health issues. They said they would like to see more awareness in the school and broader community about the signs, symptoms and services for mental illness:

> *"There needs to be a lot more education around mental health and a promotion of the fact that mental health does not just mean having issues such as psychosis, but also just feeling under pressure and needing to talk. Mental health wellbeing, and mental health in general, is an unclear topic with a lot of young people and most young people seem to think that having a mental health issue is for 'crazy people'. They struggle to identify themselves when it comes to mental health issues."* (Youth Engagement Officer)[700]

> *"I believe that there should be adverts on the TV and radio and magazines informing people about the terrible thing that is mental illness, the symptoms, and what can be done about it." (Girl, 15)*[701]

Other strategies for overcoming stigma and highlighting the importance of mental health include community or media-based campaigns.[702] These can normalise help-seeking behaviour as well as promoting a community dialogue about mental health.

> *Community strategies aimed at reducing societal stigma, combined with interventions to reduce self-stigma and perceived stigma together have the potential to improve help seeking behaviour in young people.*[703]

Increasing the acceptability of young people's help-seeking is an important goal and was supported by several submissions to the Inquiry.[704] It is known that young people are less likely than other age groups to seek professional help for mental health problems.[705] Further, of all young people, young males are less likely than females to seek help or support. This was demonstrated in BoysTown's submission to the Inquiry which highlighted that:

> *Young males made 16% and young females 84% of mental health counselling contacts for Western Australia in 2009. This gender breakdown is consistent with help-seeking trends for other counselling services and for Kids Helpline nationally…*[706]

Aboriginal young people appear even less likely to actively seek help. Only one per cent of the young Western Australians calling Kids Helpline with mental health concerns in 2009 were Aboriginal.[707]

The Commissioner for Children and Young People's (The Commissioner) research *Speaking out about wellbeing* found that almost 40 per cent of children and young people stated they did not have anyone to talk to or would prefer to keep problems to themselves. This response was considerably higher among boys and Aboriginal young people.[708]

In most cases, a failure to seek help in the early days of a mental health problem, as with a physical health problem, simply results in a worsening of symptoms and a need for specialist or acute treatment down the track.

700 Submission No. 28 from City of Melville, p. 2.
701 Submission No. 49 from Ellie, p. 1.
702 Submission No. 123 from The Australian Psychological Society Limited, p. 10.
703 Submission No. 90 from Inspire Foundation, p. 7.
704 Submission No. 69 from headspace National; Submission No. 134 from Youth Affairs Council of Western Australia; Submission No. 90 from Inspire Foundation.
705 Submission No. 69 from headspace National, p. 3. [Refers to young people 16 to 24 years]; Submission No. 90 from Inspire Foundation.
706 Submission No. 82 from BoysTown, pp. 8-9.
707 Ibid, p. 10.
708 Commissioner for Children and Young People 2010, Speaking out about wellbeing: The views of Western Australian children and young people, p. 22.

Raising community awareness is particularly important. The Inquiry found that there is a general lack of understanding in the community that children (particularly infants and young children) can experience significant mental health problems. Recent research in America found that people surveyed often reasoned that children do not 'have' mental health:

> *Informants often reasoned that children don't have mental health because children have undeveloped emotional capacities and limited memories. Their minds work in such fundamentally different ways than those of adults that they simply cannot experience mental health.*[709]

Further, if there was an awareness that children can, and do, experience mental health, any problems were often considered to be less complicated than adult mental health issues with fewer variables or factors at play.[710]

Although the Inquiry is not aware of similar research in Australia, it seems reasonable to assume the general findings would be the same in the broader Australian community.

To this end, the Inquiry considers improved awareness by the Western Australian community about the reality, impact and prevalence of mental illness in children and young people to be an essential component of mental health reform. One of the Mental Health Commission's (MHC) functions is to promote *'social inclusion, public awareness and understanding of matters relating to the wellbeing of people with mental illness to address stigma and discrimination'*.[711] The Inquiry believes that a community education campaign about the importance of children and young people's mental health would be a critical part of this role – in that it would raise awareness, help address stigma and encourage help-seeking by young people.

Recommendation 44: A community education campaign about the importance of children and young people's mental health be led by the Mental Health Commission.

Information and communication technology

Linked to encouraging help-seeking is the value of information and communication technology (ICT) and, more specifically, the internet. Community research conducted by the Australian Communications and Media Authority in 2008 found that 74 per cent of young people (aged between eight and 17 years) used the internet over the three days the survey took place.[712]

Young people are avid users of the internet and, after family and friends, it is where young people turn for advice and support in difficult times.[713] [714] It offers opportunities to increase help-seeking for mental health problems and engage those least likely to seek professional help (such as young males).[715]

> *With its unique ability to connect people to information and each other, the Internet offers opportunities to engage the 71% of young people experiencing mental health problems who are not currently seeking professional help.*[716]

709 Davey, L 2010, FrameWorks Institute, How to Talk About Children's Mental Health: A Frameworks Message Memo, p. 5.
710 Ibid, p. 5.
711 Submission No. 141 from Mental Health Commission, supplementary information.
712 Australian Communications and Media Authority, Internet use and social networking by young people, No.1., Media and Communications in Australian Families series, p. 4. [website], viewed 28 February 2011, http://www.acma.gov.au/webwr/_assets/main/lib310665/no1_internet_use_social_networking_young_people.pdf
713 Mission Australia 2010, National Survey of Young Australians 2010: key and emerging issues, Mission Australia, p. 14.
714 Submission No. 134 from Youth Affairs Council of Western Australia, p. 7.
715 Reavley NJ, Cvetkovski S, Jorm, AF, Sources of information about mental health and links to help seeking: findings from the 2007 Australian National Survey of Mental Health and Wellbeing, U.S. National Library of Medicine, National Institutes of Health [website], viewed 28 February 2011, http://www.ncbi.nlm.nih.gov/pubmed/20978883
716 Sawyer, MG et al, cited in Submission No. 90 from Inspire Foundation, p. 8.

Young people themselves identify the many benefits of having access to information on the internet (and phone helplines) including that it is accessible, anonymous, engaging and informative:[717]

> *"It will be hard [for young people] to find face-to-face help, for the first time especially, because it can be really nerve-racking and cause a lot of anxiety to reach out for help for that first time so… stuff like telephone counselling or kids helpline chat online can be really good to reach out for the first time because it can be a lot less intimidating to seek help online rather than face-to-face."* (Young girl)[718]

The benefits of ICT are of course doubly true for young people in regional and remote areas where isolation and being unable to access services are significant barriers.[719]

However, the Inquiry acknowledges that not all young people have access to the internet (including those living in regional and remote areas). For example young people who are highly disadvantaged, homeless, or struggling with poverty are unlikely to have regular access.[720] Many young people would also prefer to access a face-to-face service or speak with a trusted adult. ICT solutions cannot therefore be seen as the panacea in the place of face-to-face services or youth centres, such as those described previously, but they are an important way to reach children and young people and provide a range of mental health services.

Box 27: ReachOut.com

ReachOut is a web-based service that supports young people to help themselves through tough times, find ways to boost their own mental health and wellbeing and seek the help they need.

The aim is to improve young people's mental health and wellbeing by building skills and providing information, support and referrals in ways known to work for young people. Reach Out is run by the Inspire Foundation.[721]

"I think ReachOut is a really good place for someone who's just kind of thinking, 'hmm, not really sure if there's something going on here, I don't feel quite right…' or, 'my friends don't seem to be experiencing this…' they can jump onto Reach Out and look at the blog posts or the fact sheets – they can find out information via videos as well and the YouTube links, so they can kind of explore for themselves what it means to have a mental health issue. And then on the forums they can meet other people online who are either going through it, have been through an acute stage who are managing it, or who might be at the same stage as them: just finding their feet and finding out what it means to be going through something like them." (Young girl)[722]

The majority of respondents to the ReachOut.com National Survey scored in the high (19.4 per cent) or very high (51.8 per cent) range of psychological distress. However, only 53 per cent of young people scoring in these high ranges reported visiting the site because they were going through a tough time and looking for help. This suggests that ReachOut.com is reaching a significant subsection of young people who do not yet recognise their need for support.[723]

Recommendation 45: Information and communication technology be an integral part of any comprehensive mental health plan for children and young people.

717 Submission No. 90 from Inspire Foundation, p. 6.
718 Ibid, supplementary information.
719 Submission No. 83 Confidential, p. 2.
720 Wyn, J, Cuervo, H, Woodman, D, & Stokes, H 2005, Young people, wellbeing and communication technologies, VicHealth, Melbourne, p. 5.
721 ReachOut.com, What is ReachOut? [website], viewed 28 February 2011, http://au.reachout.com/about/faqs/whatisro
722 Submission No. 90 from Inspire Foundation, supplementary information.
723 Metcalf, A, et al 2010, ReachOut.com National Survey 2010, Inspire Foundation, p. 3.

Sport and recreation

Increasingly, evidence is showing that adolescents' participation in extracurricular activities is linked to a range of positive outcomes and that young people who participate in activities appear to have a more positive sense of self.[724] In practice, however, it appears that many children and young people in Western Australia do not feel they have adequate access to these important sport and recreation opportunities.

The Commissioner has travelled extensively across Western Australia and in virtually every community she has visited she has been told of the lack of recreational activities for young people. This has been particularly true for regional and remote areas and has been directly linked by community members and children and young people themselves to young people experiencing mental health problems, engaging in substance abuse, anti-social behaviour and entering the youth justice system.

This was reinforced by a submission from the Centre for the Built Environment and Health at the University of Western Australia:

> *A lack of 'things for young people to do' is a frequent lament of parents and young people themselves, particularly for teenagers, and in newer or lower SES suburbs where there is less community infrastructure and facilities. This is of relevance to mental health, as it impedes the opportunities for young people to interact and socialise with other young people, and to spend their 'free time' in positive ways.*[725]

In its consultation for the Inquiry, Regional Development Australia (Wheatbelt) (RDA) found that:

> *The majority of students who participated believe that being involved in sport and other activities and having more of these opportunities available would make a significant difference to the mental health and wellbeing of young people, particularly high school / adolescent aged students.*[726]

This finding followed the young people's comments about the limited recreational opportunities in their area.

> *There is a lack of adequate sporting and playground facilities for high school students on school sites e.g. fitness tracks, playground equipment, basketball courts, lawn area. Generally, they are unable to utilise primary school facilities in co-located schools, and there is limited or no funding available for their own facilities. For various reasons, there is also a lack of sporting equipment to use e.g. basketballs, cricket bats and wickets and so on unless students bring their own from home. On some sites the Gymnasium is not open at recess and lunch breaks for physical activity.*[727]

Other submissions strongly supported the call for increased sport and recreation facilities and opportunities for young people, including low cost gymnasiums, combined sport centres with youth/drop-in services and mentoring/peer support and cheap, organised activities.[728] [729] [730] [731]

The importance of providing affordable activities was made in several submissions, as cost can be a prohibitive factor for many children and young people wanting to access services.[732] The City of Swan highlighted that access

724 Blomfield, CJ, Barber, BL 2010, 'Developmental Experiences During Extracurricular Activities and Australian Adolescents' Self-Concept: Particularly Important for Youth in Disadvantaged Schools', Journal of Youth Adolescence, School of Psychology, Murdoch University, Western Australia.
725 Submission No. 127 from Centre for Built Environment & Health, University of Western Australia, p. 3.
726 Submission No. 113 from Regional Development Australia Wheatbelt, p. 1.
727 Ibid, p. 26.
728 Submission No. 111 from Youth Activity Participation Study, Murdoch University, p. 4.
729 Submission No. 70 from Swan and Surrounding Suburbs Youth Networks, p. 2.
730 Submission No. 119 from The Smith Family, p. 12; Submission No. 26 from Town of Mosman Park, p. 2; Submission No. 134 from Youth Affairs Council WA, p. 4.
731 Submission No. 71 from Outcare, p. 4.
732 Submission No. 26 from Town of Mosman Park, p. 2.

to recreation in the local area is largely limited to the young people whose parents have the money and the time to transport them to the different locations.[733] The Smith Family noted:

> *Young people in lower income families are less likely to have participated in organised activities with a focus on sports, music, arts and social activity clubs than those in the higher income families. It is likely that these personal development opportunities are seen as 'extra-curricular' and therefore associated with a financial cost beyond the reach of many disadvantaged families. We already know that disadvantaged children and young people are particularly at risk of having low emotional literacy levels.*[734]

In Western Australia, the Department of Sport and Recreation (DSR) takes primary responsibility for this area and acknowledges the important role of sport and recreation in strengthening mental health.

> *…people who participate in sports clubs and organised recreational activity enjoy better mental health, are more alert, and more resilient against the stresses of modern living. Participation in recreational groups and socially supported physical activity is shown to reduce stress, anxiety and depression…*[735]

The DSR's submission to the Inquiry stated that there is *'significant opportunity to boost programs and initiatives that can target building resilience and provide positive experiences for children and young people'.*[736] Given many young people across the State are also asking for this, the Inquiry strongly supports further work in this area.

Box 28 highlights the Swim for Life (SFL) program operating in the Town of Port Hedland (Hedland). It is an example of where locally developed sport and recreation activities can lead to training and employment opportunities and substantial improvement in the lives of young people.

Box 28: Swim for Life Program

Swim for Life (SFL) commenced in 2008–2009 as a training and employment program in Hedland. It was initiated by the YMCA and funded by the Commonwealth's Department of Education, Employment and Workplace Relations (DEEWR). After the 2008/09 summer season SFL won accolades and awards from across Western Australia and the nation as a leading exponent of youth development qualifying young Aboriginal people as lifeguards who achieved first-time employment.

The Hedland pools now possess a depth of expertise and enjoy an availability of staff rarely achieved in rural and remote pool centres. SFL is highly regarded by experts in the aquatic industry for the skills and achievements demonstrated by the Aboriginal lifeguards. The Hedland pools are viewed with respect and affection by the local Aboriginal community who are proud to see their young people succeed in positions of authority and responsibility.

The SFL model has achieved effective training and employment outcomes for Aboriginal youth through good planning, community engagement, and the development of solid partnerships. This model is applicable to other towns and communities who could achieve this success in addressing the needs of its youth.[737]

In order to cater for the diverse needs of children and young people, recreation opportunities must not simply be defined as 'sport'. The benefits of activities such as art, drama, dance, cultural activities and a wide range of physical

733 Submission No, 96 from City of Swan, p. 3.
734 Submission No. 119 from The Smith Family, p. 12.
735 Street, G, & James, R, The relationship between organised recreational activity and mental health [website], viewed 28 February 2011, http://www.dsr.wa.gov.au/the-relationship-between-organised-recreational-activity-and-mental-health
736 Submission No. 141 from Mental Health Commission, p. 107.
737 Submission No. 130 from Swim for Life.

activities[738] must be included as part of any holistic program of recreation. As the Department of Culture and the Arts (DCA) submitted to the Inquiry:

> *The arts can be a powerful tool in developing and maintaining positive mental health and wellbeing in children and young people, as well as their parents and carers. Whilst the arts are often used as a therapy tool, it's important to look at the role that they can play in preventing mental ill-health and promoting wellbeing in children and young people.*[739]

The need for activities other than sport was highlighted by the Peel Development Commission which described the success of the *Restart* program run in the region:

> *Boddington Youth Arts 'Restart': The Boddington Old School (similar to a Community Centre) piloted this program to provide youth with an alternative to sporting outlets. It was recognised that as a country town children had access to many sporting activities but few other outlets. This was seen as an opportunity for other youth in the area to develop a different range of skills and to provide a form of release and social participation. The art project was successful and has been modelled to develop a Junior Arts Program.*[740]

DSR submitted to the Inquiry that it has:

> *…opportunities to drive or contribute to a partnership with other relevant agencies across government and community to make some significant headway into the mental wellbeing of children and young people, particularly at a localised level.*[741]

The Inquiry commends DSR for its willingness to explore new opportunities and partnerships in this area and recommends that this work commence as a matter of priority with the MHC and the DCA in the first instance.

Recommendation 46: The Department of Sport and Recreation, the Department of Culture and the Arts and the Mental Health Commission work to increase arts, cultural, sport and recreation opportunities for young people – particularly in regional and remote areas.

8.3 Early intervention and treatment

> *"I am a single parent of two daughters, aged 18 and 17, the eldest of whom has suffered from mental health issues for about 18 months now, including bulimia and self-harm, which has resulted in three hospitalisations. Our experience, hers and mine, of the mental health system has been one of frustration and disillusionment."*[742]

This frustration and disillusionment felt towards the mental health system was reflected in many submissions to the Inquiry. As previous chapters have shown, this experience is not exclusive to services for young people but is similar across the age continuum from birth to 18 years (and beyond). However, many submissions focused on the challenges of receiving early intervention and treatment services for adolescents, including the lengthy delays for referrals and subsequent delays on waiting lists.[743]

738 Submission No. 127 from Centre for Built Environment & Health, University of Western Australia, p. 6.
739 Submission No. 41 from Department of Culture and the Arts, p. 1.
740 Submission No. 11 from Peel Development Commission, p. 2.
741 Submission No. 141 from Mental Health Commission, p. 107.
742 Submission No. 9 Confidential, p. 1.
743 Submission No.16 from Department of Education; Submission No. 23 from Western Australian Secondary School Executives Association; Submission No. 49 from Ellie (Submission No. 70, 98, 118, 132 also referenced).

Box 29: Case study

The Health and Disability Services Complaints Office submitted the following case study to the Inquiry:

A mother called us concerned that her teenage son had been waiting over a year to receive a written referral to a specialist. The specialist was to assess his mental health concerns related to learning difficulties, anxiety and depression. She expected that once she received the referral she would then have to wait another period of time for the appointment and was concerned with the ongoing delays… [Eventually] the mother called to withdraw the complaint. She had grown frustrated dealing with the health services involved and did not trust that what they could offer her son would be comparable with other States. She made the decision to relocate interstate in the hope that she could access better mental health services for her son.[744]

8.3.1 Youth centres and youth-friendly agencies

Several submissions discussed the nature of a 'youth-friendly' service, with most of them describing a centre that provides a single point of access that builds solid relationships with the young person and facilitates a holistic and responsive plan for (and with) the young person.[745] Youth-friendly services provide direct service provision such as treatment, support, group work, referrals and rehabilitation, as well as working towards the prevention of ill-health.[746] Effective youth services are also often characterised by using a co-location model, integrating a number of different services and achieving marked results as a consequence:

> *Some youth health services have developed co-location models with youth centres so that youth worker run recreation programs can run concurrently with health activities. This has been particularly useful for marginalised young people who may access a particular youth centre because they trust the resident youth worker but are unwilling to go elsewhere. In such a situation, young people have an opportunity to observe and assess the health service without committing themselves to anything. Co-location has meant that health and youth workers can see and understand the nature of each other's work. Communication and trust can develop and workers feel confident about referring to the other service.*[747]

The City of Swan described the need for confidential services accessible to young people without parental consent:

> *The ideal environment for young people to access services is in an informal, youth-friendly environment that combines passive recreation or "hang out space" with easily accessible, confidential health and support services. Services MUST be accessible by public transport to allow independent access by young people, and must provide a non-judgemental service that is focused on informing and supporting young people rather than directing them.*[748]

Many submissions supported the headspace model (see Box 30) as a positive example of an effective youth-friendly mental health service that provides support and advice to young people, and also to parents, carers, and workers. There are currently three headspace sites in Western Australia (Broome, Fremantle and Albany) with funding provided by the Commonwealth Government for an additional centre in Perth to open in the near future.[749]

744 Submission No. 18 from Health and Disability Services Complaints Office (formerly Office of Health Review), pp. 1-2.
745 Submission No. 69 from headspace National; Submission No. 70 from Swan and Surrounding Suburbs Youth Network; Submission No. 73 from West Australian Coalition for Youth Mental Health (Submission Nos. 96 and 88 also referenced).
746 New South Wales Association for Adolescent Health 2005, Getting it Right, A Background Paper, Models of Better Practice in Youth Health, p. 62 [website], viewed 28 February 2011, http://www.nayh.org.au/documents/GIR%20Full%20Report%202005.pdf
747 Ibid.
748 Submission No. 96 from City of Swan, p. 4.
749 Roxon, N 2011, Ten new headspace youth mental health facilities, Federal Government Media Statement [website], viewed 28 February 2011, http://www.alp.org.au/federal-government/news/ten-new-headspace-youth-mental-health-facilities/

Box 30: headspace

The headspace model was launched in 2006 and is currently funded by the Commonwealth's Department of Health and Ageing under the *Youth Mental Health Initiative* program. A headspace centre, of which there are 30 across the country, is a youth-friendly community-based provider of services to young people aged 12 to 25. Provided at a community level by a consortium of services, all headspace centres have at their core a primary care component that includes general practitioners, allied health staff, drug and alcohol workers, and mental health practitioners. The array of services is diverse and multidisciplinary, ensuring centres can address a wide range of concerns affecting young people.[750]

The headspace co-location model was supported by a range of agencies including the Australian Psychological Society, the Youth Affairs Council of Western Australia and the City of Swan.[751]

The headspace centres provide a useful model for expansion in Western Australia. The co-location of services for young people enhances opportunities for various supports to be accessed and minimises any sense of judgement or stigma (the importance of which is discussed further below). However, with only three centres operating in a state as geographically vast as Western Australia, there is an obvious need for similar services to be established in many other areas. Once again, it is important for the centres' success that they have clear pathways and access to well-resourced specialist services so that young people can be referred where necessary.

Recommendation 47: The Mental Health Commission coordinate the establishment of co-located 'youth service centres' across the State.

Integrated services in schools (see Chapter 7) are also an entirely appropriate model for high schools and their benefits would equally apply for this older age group – see Recommendation 39.

8.3.2 Confidentiality

Agencies that represent young people describe concern about confidentiality as a significant barrier that prevents young people from accessing supports. Young people are extremely reluctant to seek help on a mental health matter if they believe their action will be reported or discussed by their confidant.

> *Young people are very aware than any information shared on school grounds is not regarded by staff as confidential, and this has a very real impact on their willingness to seek help within school.*[752]

This presents a significant challenge for schools, which are unable to guarantee confidentiality to students because of some reporting requirements and their duty of care. The Western Australian Secondary School Executives' Association described how this means other services from outside agencies must be sourced for a young person in need:

> *Sometimes young people are reluctant to speak with school staff because of their reporting requirements. These requirements are necessary but this often means that unless we find a worker from an outside agency for them to talk to, they are often not talking to anyone.*[753]

Young people reinforced this point to the Inquiry. Privacy and confidentiality concerns were paramount in their decision when considering with whom they should talk:[754]

750 Submission No. 69 from headspace National.
751 Submission No. 123 from The Australian Psychological Society Limited; Submission No. 134 from Youth Affairs Council of Western Australia; Submission No. 96 from City of Swan, p. 5.
752 Submission No. 96 from City of Swan, p. 4.
753 Submission No. 23 from Western Australian Secondary School Executives Association, p. 3.
754 Submission No. 26 from Town of Mosman Park, p. 2; Submission No. 124 from headspace Kimberley – Youth Advisory Crew.

> *"I want somewhere/someone that is empathetic, will listen, help me work through my problems and keep it to themselves."* (Young person)[755]

In the RDA's consultation, the young people were asked how adults could better support them with their mental health problems. The young people listed characteristics including: *'Keep things between you and them (confidential); respect their privacy; keep secrets confidential.'* [756]

Given that early help-seeking and early intervention is key to making an impact on young people's mental health and wellbeing,[757] unnecessary barriers that prevent young people from accessing assistance should be removed. To this end, and wherever possible, services for young people seeking help for mental health issues should ensure confidentiality to the young person seeking help.

Recommendation 48: Confidentiality, wherever possible, should be a critical consideration in the design and operation of services and programs, to encourage young people to seek help with issues concerning their mental health and wellbeing.

8.3.3 School psychologists

The Inquiry believes that, with adequate resourcing, school psychologists could play a stronger role in providing early intervention services for young people. In its submission, the Australian Psychological Society agreed with this position, arguing for increased comprehensive psychological supports in schools:

> *The APS believes that there has never been a greater need than now for a nationwide system of comprehensive psychological supports services for Australian children and young people… The APS believes that psychologists are one of the most qualified professional groups to provide early intervention services to students who are experiencing poor psychological health or who are coping with difficult personal or family issues. School psychologists also work collaboratively with school staff, families and external health and welfare services.*[758]

See Recommendation 42.

8.3.4 Infant, Child, Adolescent and Youth Mental Health Service (ICAYMHS)

> *Accessing resources BEFORE crisis point is very hard for many reasons one of the biggest being lack of resources for agencies such as CAHMS.*[759]

As with the younger age groups, the under-resourced nature of ICAYMHS was raised as a primary concern. The consequent inability for a young person to access specialist treatment unless in severe crisis was a repeated theme.

In an article for the Australian Psychological Society Ltd, Professor Patrick McGorry et al describe the consequences of a mental health system constrained to emergency and crisis management:

> *Without access to appropriate treatment, many young people present in repeated crisis to over-stretched hospital emergency departments, or their parents and carers are left to try and cope alone. In far too many cases their difficulties eventually become chronic and disabling. A more substantial focus on the needs of*

755 Submission No. 114 from WA AIDS Council's Freedom Centre, p. 10.
756 Submission No. 113 from Regional Development Australia Wheatbelt, p. 14.
757 Submission No. 69 from headspace National, p. 10.
758 Submission No. 123 from The Australian Psychological Society Limited, p. 6.
759 Submission No. 23 from Western Australian Secondary School Executives Association, p. 4.

young people and how a service should orient itself towards this population is critical.[760]

It was acknowledged in various forums (in submissions, meeting with stakeholders and at the information sessions) that when young people can access ICAYMHS, the staff provide a highly valued service. However, access is so limited and restricted that the criteria have the effect of exclusion rather than inclusion.

Further, given the reluctance of young people to seek help for a mental health issue, there is often only a limited opportunity to assist if help is sought.

The waiting lists for CAMHS are often long… There is often only a small window of opportunity where a young person may accept help, with increased waiting lists sometimes the window closes before the person is able to access any help.[761]

The concern about waiting lists was not exclusive to ICAYMHS, with similar comments made about accessing a range of other mental health services:

The waiting lists however are extremely long not only at CAMHS, but also at Princess Margaret Hospital for children and the Bentley Health Campus for adolescents, as well as through the Non Government School Psychology Service due to the demand on these services. Many schools and families attempt to access private therapy in order to access services at the point of need, however cost is prohibitive and thus many children and young people forgo support in circumstances when support is vital.[762]

The Coroner's Court of Western Australia raised concerns to the Inquiry about the continuing challenges faced in securing appropriate discharge back into the community from mental health facilities, including Princess Margaret Hospital (PMH). The Coroner's Court also noted the link to suicide if this seamless care is not provided in acute cases.[763]

The MHC acknowledged in its submission to the Inquiry that the treatment and specialist services that exist for young people *'do not constitute a comprehensive youth mental health service'*.[764]

Box 31: Eating Disorders

There are several types of Eating Disorders including anorexia nervosa, bulimia nervosa, and a group of disorders classed as 'Eating Disorders Not Otherwise Specified', which includes binge eating disorder. Eating Disorders are serious illnesses which involve considerable psychological distress as well as major physical dangers – potentially affecting every major organ in the body.[765] [766]

Eating Disorders are particularly prevalent in young people relative to the rest of the population, with the two peak risk periods for onset being early adolescence and in the late teenage years.[767] [768] Eating disorders represent the third

760 McGorry,P, Parker, A, Purcell, R, The University of Melbourne and ORYGEN Research Centre, Youth Mental Health Services, The Australian Psychological Society [website], viewed 28 February 2011, http://www.psychology.org.au/publications/inpsych/youth_mental_health/
761 Submission No. 70 from Swan and Surrounding Suburbs Youth Network, pp. 2-3.
762 Submission No. 118 from Association of Independent Schools of Western Australia, p. 5; Submission No. 132 from State School Teachers Union of Western Australia, p. 4.
763 Submission No. 1 from Coroner's Court of Western Australia, p. 1.
764 Submission No. 141 from Mental Health Commission, p. 100.
765 National Eating Disorders Collaboration 2010, Eating Disorders Prevention Treatment & Management: An Evidence Review, Prepared for the Commonwealth Department of Health and Ageing, Canberra, p. ix.
766 Submission No. 74 from Bridge Eating Disorders Reference Group, p. 2.
767 National Eating Disorders Collaboration 2010, Eating Disorders Prevention Treatment & Management: An Evidence Review, Prepared for the Commonwealth Department of Health and Ageing, Canberra, p. ix.
768 Submission No. 74 from Bridge Eating Disorders Reference Group of Western Australia, p. 2.

most common chronic illness (after asthma and obesity) in adolescent females[769] and the Bridge Eating Disorders Reference Group of Western Australia described children and young people from regional and remote areas as being particularly at risk:

> *Children and adolescents from regional Western Australia represent a particularly severe subgroup of patients. A recent study… found of those who present with Anorexia Nervosa or Eating Disorders with severe dietary restriction are significantly more underweight at presentation compared to their metropolitan counterparts. Rural and remote youth with Eating Disorders lack access to specialist care, which translates to greater severity and duration of illness. This inequality is unsettling because youth with a longer duration of illness do not respond as well to conventional treatment and are at far greater risk of non-recovery.*[770]

The prevalence and costs of Eating Disorders are high, and they are associated with substantial economic and social burden. Figures cited in a recently released Evidence Review from the National Eating Disorders Collaboration show that:

- [bulimia nervosa and anorexia nervosa] are the 8th and 10th leading causes, respectively, of burden of disease and injury in females aged 15 to 24 years in Australia, as measured by disability-adjusted life years;
- Eating Disorders are the 12th leading cause of hospitalisation costs due to mental health within Australia; and
- the expense of treatment of an episode of [anorexia nervosa] has been reported to come second only to the cost of cardiac artery bypass surgery in the private hospital sector in Australia.[771]

Eating Disorders (and body image) are also a considerable concern to children and young people themselves. In Mission Australia's 2010 *Youth Survey*, more than 30 percent of children and young people ranked 'body image' as their number one area of concern.[772] The Freedom Centre's submission to the Inquiry included comments from young people who had had negative experiences with receiving treatment for their Eating Disorders:

> *"Many psychs refuse to see someone if they have even the slightest sign of something they didn't specialize in. I couldn't be seen for depression by a psych because I was also displaying symptoms of EDNOS [Eating Disorder Not Otherwise Specified]"* (Male, 18)[773]

As with other mental illnesses, the approach to treating Eating Disorders must be holistic – spanning the full intervention continuum of promotion, prevention, early intervention and treatment. It is believed that initiatives aimed at preventing Eating Disorders could potentially translate to significant savings (both economic and social) and research is also showing the benefits of early intervention in Eating Disorders, with significantly improved outcomes for individuals who are identified and treated early in the course of illness.[774]

With Eating Disorders often affecting young people in later adolescence, appropriate transition to adult services is also of crucial importance so as to ensure continuity of care and effective treatment (see Chapter 9).[775]

In March 2011, the Minister for Mental Health, Hon Helen Morton MLC announced the Western Australian commitment to a nationwide framework for people dealing with negative body image issues and eating disorders.[776] The Inquiry supports

769 The Royal Australian College of General Practitioners, Australian Physicians, Eating disorders – early identification in general practice, p. 108 [website], viewed 15 March 2011, http://www.racgp.org.au/afp/201103/41502
770 Submission No. 74 from Bridge Eating Disorders Reference Group of Western Australia, p. 4.
771 Australian Institute of Health and Welfare; Mathers, C. et al; Pratt, B. M., & Woolfenden, S. R., cited in National Eating Disorders Collaboration 2010, Eating Disorders Prevention Treatment & Management: An Evidence Review, Prepared for the Commonwealth Department of Health and Ageing, Canberra, p. 8.
772 Mission Australia 2010, National Survey of Young Australians 2010: key and emerging issues, Mission Australia, p. 10.
773 Submission No. 114 from WA Aids Council's Freedom Centre, p. 12.
774 Australian Institute of Health and Welfare; Mathers, C. et al; Pratt, B. M., & Woolfenden, S. R., cited in National Eating Disorders Collaboration 2010, Eating Disorders Prevention Treatment & Management: An Evidence Review, Prepared for the Commonwealth Department of Health and Ageing, Canberra, pp. x-xi.
775 Submission No. 74 from Bridge Eating Disorders Reference Group of Western Australia, p. 5.
776 Morton, H 2011, Minister announces National Framework for Eating Disorders, Ministerial Media Statements [website], viewed 14 March 2011, http://www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=137482

this action, and encourages further work in this area to ensure supports are available across the intervention continuum.

The Inquiry received several submissions highlighting issues around Eating Disorders.[777] One personal story was recounted by a young woman who had struggled with anorexia nervosa and depression throughout her adolescence:

> *"…After a number of admissions at 4H [eight bed acute ward located at PMH], I felt so low that I stopped eating and consumed minimal liquid. My physical health severely deteriorated and I lost weight quite fast. I finally felt back in control of something and losing weight gave me a sense of this as well as achievement, I couldn't control my thoughts and my life but one thing I could control was what I could put in my mouth. It was making me happy and also provided a distraction as I now focused on losing weight.*
>
> *Having the [nasal-gastric] tube made me feel out of control again as I couldn't 'control' what I was having via the tube. [I] removed the tube and refused to have it replaced or consume anything orally. My case team made the decision to move me to an involuntary ward as they did not want my medical status to decline.*
>
> *I was put into a 4-bed adolescent psych ward involuntarily at Bentley hospital [Bentley Adolescent Unit] for approximately four months, meaning I didn't have a choice in the treatment I was given. I was held down by nurses and forced-fed via NG tube because I couldn't fight my head to have it orally. I was never sedated there and had nurses shove a tube up my nose to feed me liquid nutrition… I eventually did eat but I had no psychological support (I probably saw a psych 4-5 times in the four months I was there. I was surrounded by walls and didn't go outside (not that I wanted to anyway because all it was, was a high wall and pavement.) I was isolated and with severely mentally ill boys for the majority of admissions.*
>
> *I eventually got up to the weight for discharge but as soon as I got out went to what I knew best so I was back there after two weeks and then the turmoil started again…"* [778]

8.3.5 Bentley Adolescent Unit

The Bentley Adolescent Unit (BAU) is a 12-bed inpatient unit that admits young people from the age of 12 to 18 years. For many years, the BAU has been criticised by the Council of Official Visitors which states that it:

> *…looks and feels like a prison, has insufficient outdoor area and inappropriately houses children ranging in age from 9 to 17 years old (the day they turn 18 they are moved to an adult ward). Although the BAU is a children's ward, its consumers receive none of the extra attention and support that children with a physical illness in Princess Margaret Hospital receive via the PMH Foundation.*[779]

The Western Australian Association for Mental Health also expressed concern at the inadequate inpatient facilities available for young people most in need:

> *…specialised care for these children and young people, is significantly inadequate, considerably underfunded and needs urgent attention.*[780]

Not only is the BAU inadequate in terms of age-appropriate care and facilities, but it is also unable to meet service demand. It is known that over the six-month period from September 2010 to February 2011, 30 children were

777 Submission No. 34 Confidential; Submission No. 74 from Bridge Eating Disorders Reference Group; Submission No. 114 from WA Aids Council's Freedom Centre.
778 Submission No. 34 Confidential.
779 Council of Official Visitors, Annual Report 2008-09, p. 19 [website], viewed 28 February 2011, http://coov.org/publications/
780 Submission No. 137 from State School Teachers Union of Western Australia, p. 5.

unable to be admitted to the BAU and were redirected to alternative services.[781] The Minister for Mental Health has expressed her concern about this situation in Parliament[782] and the Inquiry notes that funding has been provided for improvements to the BAU (see Chapter 4).

The Inquiry also acknowledges the Government's medium-term plan to move six beds from the BAU to the new Children's Hospital, making a total of 20 inpatient beds.[783]

These are positive developments to help overcome the extremely inadequate service currently provided for these children and young people. The new Children's Hospital presents an important opportunity to provide a new, greatly enhanced therapeutic environment and the opportunity to design it in consultation with children and young people.

The need for more appropriate acute care is required urgently but the new Children's Hospital is not scheduled for completion until 2015.[784]

In addition, the proposed beds are for children and young people under 16 years of age[785] whereas there is a need for an acute care facility to accommodate up to 25 year olds, where developmentally appropriate (see Chapter 9).

Recommendation 49: As a matter of urgency, the Bentley Adolescent Unit be upgraded to provide a more therapeutic service for children and young people.

Recommendation 50: Planning for the new Children's Hospital should include comprehensive therapeutic services for children and young people with mental illness, and be able to accommodate and support young people up to 25 years of age where developmentally and clinically appropriate.

Recommendation 51: The planning and design of the mental health facilities in the new Children's Hospital should occur with the direct involvement of children and young people.

8.3.6 Homelessness

Mental health issues are more prevalent among homeless young people than the broad population of young people in Australia.[786] Across Australia, just over one-third of the clients of agencies providing assistance to homeless people are aged between 12 to 24 years.[787] Further, in Western Australia, approximately 38 per cent of these young people had some form of mental illness.[788]

Accommodation and homelessness were issues raised with the Inquiry as having significant impact on the mental health of young people. Conversely, young people with mental health issues are often at high risk of homelessness and:

781 Hon Helen Morton MLA, Minister for Mental Health, Legislative Council, Thursday 17 February 2011, Hansard – Daily Transcripts, p . 596 [website], viewed 17 February 2011, http://www.parliament.wa.gov.au/web/newwebparl.nsf/iframewebpages/hansard+-+daily+transcripts

782 Ibid.

783 Jacobs, G 2010, Mental health inpatient services for new children's hospital, Ministerial Media Statements [website], viewed 20 November 2010, http://www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=134329

784 Barnett, C and Hames, K 2011, Planning for WA's new children's hospital begins, Ministerial Media Statements [website], viewed 28 February 2011, http://www.mediastatements.wa.gov.au/Pages/ByPortfolio.aspx?ItemId=133153&search=&admin=&minister=&portfolio=Health&region=&page=2

785 Jacobs, G 2010, Mental health inpatient services for new children's hospital, Ministerial Media Statements [website], viewed 20 November 2010, http://www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=134329

786 National Youth Commission 2008, Australia's Homeless Youth, Project Summary, p. 143. [website], viewed http://www.abc.net.au/tv/oasis/report/report.htm

787 [2004-05 data] Australian Institute of Health and Welfare 2007, Young Australians: Their Health and Wellbeing 2007, Canberra [website], viewed 2 March 2011, http://www.aihw.gov.au/publications/aus/yathaw07/yathaw07.pdf

788 Australian Institute for Health & Welfare 2007, Homeless SAAP Clients with mental health and substance use problems 2004-05, Supplementary Statistical Tables: Western Australia, p. 1.

…do a lot of 'couch surfing'. Sometimes they need access to long term stable housing and other times they may need a place to stay to give them and their families some respite… Young people can't work on their mental health improving if they don't know where they will be sleeping from night to night.[789]

The Inquiry heard that the general challenges faced in accessing mental health services are compounded for young people who are transient.

For young people who are homeless this service [ICAYMHS] is difficult for the young people to maintain appointments as it is their responsibility to go to the appointments rather than having a worker come to visit them.[790]

Receiving ongoing through-care, consistent care and follow-up were also raised as challenges faced by young people who are homeless. One implication of this is the difficulty of managing and monitoring the medication received by these young people.[791]

In 2010, an accommodation facility opened in Fremantle for young people aged 17 to 22 years. It caters for people in the early stages of mental illness who are unable to live in their existing setting without support. It is designed to be homelike and provide stable accommodation for up to 12 months.[792]

YouthLink and YouthReach South are specifically mandated to provide services to young people experiencing primary and secondary homelessness and offer flexible models of care (such as outreach). They provide a range of direct clinical services to at-risk and marginalised young people including, assessment, individual and group counselling and therapy, and case management.[793]

Youthlink and YouthReach South were described positively by submissions to the Inquiry[794] and were noted as being effective in their ability to meet the needs of transient young people. Once again, however, the issue of waiting times for services was presented as a significant barrier:

…the assessment procedures to be linked in with Youthlink are often long. The young person has to speak with the triage nurse and then the referral is taken to the intake meetings for a decision. That small window of opportunity has often vanished by the time the referral has been accepted. A lot of young people do not have the capacity to understand why procedures take as long as they do. Most often if a young person wants help they want it now.[795]

8.3.7 Supported accommodation

Supported accommodation is also a significant issue for young people with a mental illness who are being discharged from acute in-patient care. There is currently no such accommodation, and therefore no 'step-down' or respite service for children and young people with a mental illness. This is a critical area of need.

The Western Australian Branch of the Royal Australian and New Zealand College of Psychiatrists recommended to the Inquiry that:

…significant priority be given to ensure that any future expansion of community supported accommodation programs allocate resources to target young people proportionate to population need and morbidity. These programs should aim to develop a range of developmentally appropriate designed facilities and

789 Submission No. 23 from Western Australian Secondary School Executives Association, p. 3.
790 Submission No. 70 from Swan and Surrounding Suburbs Youth Network, p. 2.
791 Submission No. 70 from Swan and Surrounding Suburbs Youth Network, p. 3.
792 Submission No. 141 from Mental Health Commission, p. 83.
793 Ibid, pp. 31 & 83.
794 Submission No. 70 from Swan and Surrounding Suburbs Youth Network, p. 3; and Submission No. 140 from Anglicare, p. 4.
795 Submission No. 70 from Swan and Surrounding Suburbs Youth Network, p. 1.

accommodation support programs to service varying levels of need and complexity, to facilitate early and safe discharge from hospital and to act as an alternative to hospital admission. This may include safe and secure therapeutic communities with collaborative and joint responsibility across relevant agencies.[796]

Recommendation 52: A short-term residential facility for young people being discharged from acute in-patient care be made available as a 'step-down' from hospital care when appropriate.

Box 32: Suicide and self-harm

Youth suicide is a tragedy that affects the lives of many. In particular, the death of a young person can have a devastating impact on the lives of families left to cope with the loss of loved ones. The financial and psychological cost of suicide across Australia is immense, with estimates of the economic costs being in the billions every year.[797]

In Western Australia the number of suicides among the 15 to 19 years age group has remained almost unchanged for the past decade. The Australian Bureau of Statistics (ABS) has recorded an average of 14.4 deaths per annum through suicide in that age group for the period 1999 to 2008.[798]

On a national level the ABS found there was an average of 10.5 suicide deaths per year of children under 15 years of age between 1995 and 2005.[799] Suicide deaths comprise a large proportion of deaths in younger age groups and the proportion of male deaths is significantly higher than female deaths.[800]

Although the research on Aboriginal suicide is lacking, it is considered probable that young Aboriginal males have greatly elevated suicide rates.[801] Considerable concern was expressed to the Inquiry by the Kimberley Aboriginal Law and Culture Centre about the continuing high number of suicides in the Kimberley, including of young people.[802] This is likely to be an issue for a number of Aboriginal communities throughout Western Australia as according to the *Overcoming Indigenous Disadvantage Report 2009* Aboriginal people are twice as likely to die from suicide as non-Aboriginal people.[803]

There is consistent evidence to suggest that young people who are exposed to a range of life stressors, and drug and alcohol use are at increased risk of suicidal behaviour. There is also strong evidence of a link between mental health problems in adolescence, physical illnesses or disabilities and suicidal behaviour in young people.[804]

Prevention of suicide, self-harm and the promotion of wellbeing require a whole-of-community response and a number of submissions to the Inquiry highlighted the need for increased funding for universal, targeted and diverse long-term strategies to address risk factors and to support individuals, parents, families and carers from the point of assessment, admission and continuity of care in the community.[805]

796 Submission No. 27 from The Royal Australian & New Zealand College of Psychiatrists WA Branch, p.10.
797 Senate Community Affairs References Committee 2010, The Hidden Toll: Suicide in Australia, Parliament of Australia, Canberra.
798 Australian Bureau of Statistics 2010, Causes of Death 2008, cat. no. 3303.0, Canberra [website], www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/E8510D1C8DC1AE1CCA2576F600139288/$File/33030_2008.pdf [WA data available upon request].
799 Ibid.
800 Ibid.
801 Department of Health and Aged Care 1999, National Youth Suicide Prevention Strategy: Setting the evidence-based research agenda for Australia (A literature review) [website], viewed 16 February 2011, http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/mh12.pdf
802 Submission No. 4 from Kimberley Aboriginal Law and Culture Centre.
803 Steering Committee for the Review of Government Service Provision 2009, Overcoming Indigenous Disadvantage: Key Indicators 2009, Productivity Commission, Canberra, p. 46. [website], viewed 2 March 2011, http://www.pc.gov.au/gsp/reports/indigenous/keyindicators2009
804 Department of Health and Aged Care 1999, National Youth Suicide Prevention Strategy: Setting the evidence-based research agenda for Australia (A literature review) [website], viewed 16 February 2011, http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/mh12.pdf
805 Submission No. 1 from Coroner's Court of Western Australia; Submission No. 4 from Kimberley Aboriginal Law and Cultural Centre; Submission No. 16 from Department of Education.

Submissions also drew to the Inquiry's attention the extensive and significant recommendations made in a number of recent reports about preventing and treating suicide: the Auditor General of Western Australia's *2001 Performance Examination* into the management of deliberate self-harm of young people,[806] the Western Australian Coroner's 2008 *Report into the Deaths of Aboriginal People in the Kimberley*,[807] the Deputy State Coroner's *General Comments* of April 2008,[808] the Telethon Institute for Child Health Research 2010 review *Who Cares: A Review of the Services Provided to Young People who Attend Emergency Department with Deliberate Self Harm, Suicide Ideation, or a Suicide Attempt in the Perth Metropolitan Area* [809] and most recently the 2010 Senate Community Affairs Reference Committee report *The Hidden Toll: Suicide in Australia.*[810]

Both the State and Commonwealth Governments have developed suicide prevention strategies.[811] [812] In Western Australia the *Suicide Prevention Strategy 2009-2013 One Life Strategy* is the responsibility of the Minister for Mental Health. The Ministerial Council for Suicide Prevention (the Council) will lead and oversee the implementation of the initiatives of the *One Life Strategy* and Centrecare has been appointed to work with the Council and other stakeholders to implement the strategy.[813]

The Inquiry welcomes the dedicated approach of State and Commonwealth Governments to suicide prevention and interventions and stresses the importance of keeping the community informed of the progress of the actions to implement the national and State strategies.

Recommendation 53: The previous reports by the Western Australian Coroner, Deputy Coroner, Telethon Institute for Child Health Research and the Senate Community Affairs Reference Committee be taken into account by the Mental Health Commission to inform a comprehensive approach to suicide and suicide prevention in WA.

806 Auditor General for Western Australia 2001, Life Matters: Management of Deliberate Self Harm in Young People, Report 11 – November 2001 [website], viewed 3 March 2011, http://www.audit.wa.gov.au/reports/pdfreports/2001%20Insert%20LifeMatters.pdf
807 Hope, A 2008, Report into the deaths of 22 Aboriginal people in the Kimberley, Coroner's Court of Western Australia.
808 Submission No. 1 from Coroner's Court of Western Australia.
809 Submission No. 125 from the Telethon Institute for Child Health Research, Appendix 3.
810 Senate Community Affairs References Committee 2010, The Hidden Toll: Suicide in Australia [website], viewed 16 February 2011, http://www.aph.gov/senate/committee/inquiries
811 Auditor General for Western Australia 2001, Performance Examination, Life Matters:Management of Deliberate Self-Harm in Young People Report No. 11 [website], viewed 28 February 2011, http://www.audit.wa.gov.au/reports/pdfreports/report2001_11.pdf
812 Centrecare, One Life Strategy [website], viewed 28 February 2011, http://www.onelifewa.com.au
813 Ibid.

The *National Survey of Mental Health and Wellbeing 2007* found that more than one in four young people aged 16 to 24 years experienced a mental disorder in the previous 12 months. This is a higher prevalence than in any other age group.[814]

9.1 Introduction

This chapter considers the issues for young people with mental health problems and disorders as they transition to adulthood. The chapter is deliberately brief, as the Commissioner for Children and Young People's statutory responsibility does not extend to young people beyond 18 years of age. However, the issues were considered important to acknowledge as several submissions raised this transitional period as critical in the effective delivery of mental health services for young people. The chapter should be considered in the context of the discussion and recommendations of the previous chapter on adolescence.

9.2 Transition to adult services

As discussed in Chapter 2, periods of transition are a known risk factor for mental health problems and can bring about periods of vulnerability. For young people with mental illness who are already receiving the support of a mental health service, it is critical that any transition from a child-focused service to an adult-focused service is smooth and consistent.

Effective transition to an adult health service can give a young person a sense of maturity and hope for the future,[815] providing continuity of care into adulthood:

> *The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood.*[816]

Unfortunately, submissions to the Inquiry indicated that the transitional processes in place in Western Australian mental health services are often inadequate and not meeting the needs of young people. The Inquiry heard concerns from several submissions that the transition from adolescent to adult health care is often abrupt,[817] particularly when services have geared their treatment cut-off point around age rather than a young person's development or readiness.

> *As early as 16 years old people are having to transition into an adult service and by 18 years old it is a requirement. There is a high risk of withdrawal from services for the above age group and current transitioning does not promote continuity of care.*[818]

Table 3, while not comprehensive, illustrates the ages at which young people are required to attend or transition to an adult service for treatment from various mental health services in Western Australia.

814 Slade, T, et al. 2009, The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing, Department of Health and Ageing, Canberra, p. xii.

815 Conway SP, cited in Bennet, D, et al 2005, 'Smoothing the transition to adult care', Medical Journal of Australia [website], viewed 1 March 2011, http://www.mja.com.au/public/issues/182_08_180405/ben10158_fm.html#i1085723

816 American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians-American Society of Internal Medicine 2002, 'A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs', Pediatrics, Vol. 110, No. 6, p. 1304. [website], viewed 1 March 2011, http://www.aucd.org/docs/transitions/Consensus_Statement_on_Health_Care_Transitions_for_Young_Adults_With_Special_Health_Care_Needs.pdf

817 Submission No. 75 from Bridges Eating Disorders Reference Group for Western Australia; Submission No. 67 from South Metropolitan Mental Health Advisory Group (SuMMaT); Submission No. 90 from Inspire Foundation.

818 Submission No. 67 from South Metropolitan Mental Health Advisory Group (SuMMaT).

Table 3: Eligibility for mental health services according to age[819]

Service	Age
Infant, Child, Adolescent and Youth Mental Health Service	In most cases to 18 years
Complex Attention and Hyperactivity Disorder Service	To 18 years
Bentley Adolescent Inpatient Unit and Transition Unit	To 18 years
Ward 4H Princess Margaret Hospital	To 16 years
Assertive Community Intervention Team	To 16 years
Eating Disorders Program PMH (Outpatient and Inpatient)	To 16 years

The move to an adult health service because of a person's birthday, rather than their readiness for a planned and assisted transition, does not take into account the particular developmental needs of the young person. Instead current practice means young people move to an adult service whether they are ready or not. This Report calls for a stronger focus on developmental pathways across the age continuum and the transition from adolescent to adult health service is no exception.

> *Transition proceeds at different rates for different individuals and families. Most developmental transitions create anxiety… timing of the transition will depend on developmental readiness, complexity of the health problems, characteristics of the adolescent and family, and the availability of skilled adult health providers.*[820]

The consequences of failing to achieve successful transition in this period can be significant. Submissions to the Inquiry spoke particularly of concerns in relation to continuity of care and disengagement of the young person from mental health services.[821] In addition, other implications of 'failed transition' for young people include a reliance on crisis services and a subsequent 'falling through the gap' that may lead to significant adverse health consequences.[822] [823]

The MHC's consultation paper made similar findings, hearing that:

> *[There] should be youth services to ease the transition into Adult Mental Health. The current transition or lack thereof interrupts recovery and means no continuity of treatment models. . .The transition from ICAYMHS to adult mental health services at 18 is very frightening as a consumer.*[824]

The 2006 Senate Select Committee on Mental Health found an absence of transition frameworks for young people moving out of adolescent services into adult services was creating service gaps for young people with complex needs, and co-morbid disorders including drug and alcohol problems.[825] Smooth transitional processes are therefore particularly important for children and young people with complex needs, or those who are vulnerable and who do not have strong family supports, such as children in the care of the Department for Child Protection who have mental health issues.

819 Submission No. 141 from Mental Health Commission, p. 31., supplemented by Mental Health Commission [website], viewed 1 March 2011, http://www.mentalhealth.wa.gov.au/Homepage.aspx

820 Reiss, J., & Gibson, R. 2002, 'Health care transition: destinations unknown', Pediatrics, Vol. 110 No. 6, American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians-American Society of Internal Medicine [website], viewed 1 March 2011, http://www.ncbi.nlm.nih.gov/pubmed/12456950

821 Submission No. 67 from South Metropolitan Mental Health Advisory (SuMMaT) Group; Submission No. 93 from Hon Alison Xamon MLC.

822 Conway SP, cited in Bennet, D., et al 2005, 'Smoothing the transition to adult care', Medical Journal of Australia [website], viewed 1 March 2011, http://www.mja.com.au/public/issues/182_08_180405/ben10158_fm.html#i1085723

823 Mental Health Commission, 2010, WA Mental Health Towards 2020: Consultation Paper, Government of Western Australia, p. 15.

824 Ibid, p. 111.

825 Senate Select Committee on Mental Health 2006, A national approach to mental health - from crisis to community, Final Report, Parliament of Australia, Canberra [website], viewed 1 March 2011, http://www.aph.gov.au/senate/committee/mentalhealth_ctte/report/c15.htm

In its submission to the Inquiry, the MHC shared these concerns, particularly with regard to inappropriate service delivery for this age group:

> *The majority of mental health services for young people 16 years and over are provided by adult mental health services which are not youth friendly or suitable for young people with acquired brain injuries and developmental delays.*[826]

9.3 Transition services for young people

Submissions expressed the view that improved services for this transitional period should reflect the latest developmental evidence and take account of the life changes young people are experiencing. Improved services should support young people through these changes, rather than adding further complexity and discontinuity.

> *… Particularly between the ages of 17 and 21 young people can require support as they negotiate the transition from secondary education to employment and training or from living at home to living independently. Providing consistent and specialist mental health support across this age group is crucial.*[827]

The provision of 'youth-friendly' mental health services (as discussed in Chapter 8) was one solution presented by submissions as a way of meeting the transitional needs of young people. A key characteristic of these mental health services is that they extend their services to young people in their 20s:

> *Youth specific services are required for the 18-25 age group to reduce the trauma of admissions and service delivery in inappropriate settings such as public adult mental health wards.*[828]

Examples provided to the Inquiry of services representing best practice in delivering services for young people as they moved through adolescence and into adulthood, included:

- headspace;
- ReachOut.com (Inspire Foundation);
- YouthLink and YouthReach South; and
- Orygen Youth Health (Victoria) (see Box 33).[829]

In addition to being accessible, flexible and focussed on individual needs a key feature of these services is that eligibility extends beyond 18 years.

Box 33: Orygen Youth Health Clinical program (OYH-CP) Victoria

Orygen Youth Health Clinical Program provides mental health assessment and treatment to 15 to 24 year olds who live in the Western and North Western areas of Melbourne. At any one time approximately 900 young people from a catchment population of 960,000 are being treated within the service for serious emerging mental health and substance use issues.

OYH-CP aims to provide accessible, timely, flexible and effective clinical treatment that encourages further help seeking in young people. Most importantly OYH-CP endeavours to offer a service that young people experience as responsive and respectful. OYH-CP has a range of specialist teams that provide clinical services.[830]

826 Submission No. 141 from Mental Health Commission, p. 100.
827 Submission No. 90 from Inspire Foundation, p. 3.
828 Submission No. 75 from Bridges Eating Disorders Reference Group for Western Australia, p. 3.
829 Submission No. 28 from City of Melville; Submission No. 69 from headspace National; Submission No. 81 from Mission Australia (Submission No. 90, 42 also referenced).
830 Orygen Youth Health Clinical Program [website], viewed 1 March 2011, http://cp.oyh.org.au/

There is also a need, however, for existing adolescent mental health services to be provided with the resources and opportunities to assist the transitional process, so they can be more flexible in their approach to developmental readiness. Services need to be less attached to an age cut-off and more willing to engage with the young person (and the adult health sector as required) to ensure their ongoing health care needs are met.

> *Adolescent transition is a major milestone in the life of the young person and their family. As with other transitions in life, such as from high school, it should be coordinated and planned well in advance, in close consultation with the young person. This will serve to minimise unnecessary upheaval for the young person and ensure their participation and engagement with adult health care providers.*[831]

A literature review conducted for the Victorian Government summarised the requirements for successful transition as follows:

- the timing of transition must be appropriate;
- transition should involve a period of preparation and education;
- young people and their families and/or carers should be involved in the transition process;
- the transition process should be co-ordinated and continuous;
- the transition process should meet the needs of a wide-range of young people;
- transition needs to incorporate the common concerns of all young people;
- transition should be supported by effective communication channels and information flow; and
- transition should have appropriate managerial and administrative support.[832]

The Inquiry acknowledges that early intervention for young people aged 15 to 24 years is a Ministerial priority.[833] The MHC advised the Inquiry that it aims to develop a *'comprehensive youth mental health service'*[834] (although the details of such a service are yet to be announced).

The Inquiry welcomes these developments and encourages all future planning for the provision of services for young people to include consideration of the principles outlined above.

Recommendation 54: Transition strategies for young people moving into adult services be developed and implemented between services to ensure the individual is supported and continuity of care is maintained.

831 The Royal Children's Hospital Melbourne, Transition @ RCH, What is Adolescent Transition? [website], viewed 1 March 2011, http://www.rch.org.au/transition/index.cfm?doc_id=8143>.

832 Collis, F, Finger, E, Owens, K 2008, Review of Transitions to Young Adult Clinics, Final Report – Attachment 6: Literature Review, Ipsos-Eureka Social Research Institute [website], viewed 1 March 2011, http://www.health.vic.gov.au/subacute/literature-review.pdf

833 Morton, H 2011, The next step towards mental health reform, Ministerial Media Statements [website], viewed 1 March 2011, http://www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=136261&

834 Submission No. 141 from Mental Health Commission, p. 100; Mental Health Commission, 2010, WA Mental Health Towards 2020: Consultation Paper, Government of Western Australia.

Inquiry into the mental health and wellbeing of children and young people

A guide to making a submission

Introduction

The Commissioner for Children and Young People WA is inquiring into the mental health and wellbeing of children and young people in Western Australia.

The inquiry will look at all stages of a child's life - from before birth, through early childhood, the time of transition from pre-school to primary school, and the teenage years.

It will look at what needs to be done in the Western Australian community to prevent mental health problems and disorders, what strengthens the mental health and wellbeing of children, what is already working well and what more needs to be done.

The inquiry will deliver a road map, setting the direction Western Australia needs to take to improve the mental health of all its children and young people.

The Commissioner wants to hear from children and young people, from family members, carers, providers of services and from anyone who works with, or has experience or an interest in, the mental health needs of children and young people in Western Australia.

This pack sets out how to make a written submission to the Commissioner's inquiry.

Critical Dates:

30 July 2010	Inquiry launches
30 July 2010	Submission period opens
17 August 2010 – 9 September 2010	Information sessions in metropolitan and regional areas
1 November 2010	Submission period closes (5.00pm)
End of February 2011	Final report

Background

Michelle Scott was appointed as Western Australia's (WA) inaugural Commissioner for Children and Young People in December 2007 pursuant to the *Commissioner for Children and Young People Act 2006* (the Act).

Under the Act, the Commissioner has responsibility for advocating for all Western Australian citizens under the age of 18 and for promoting strategies and outcomes that enhance the wellbeing of children and young people. Section 20 of the Act provides that in carrying out all of the functions the Commissioner must have particular regard to Aboriginal and Torres Strait Islander children and young people, and to those who are vulnerable or disadvantaged for any reason.

Since her appointment, the Commissioner has travelled extensively throughout Western Australia and consulted widely with government and non-government agencies, as well as with children and young people and their families and communities. The Commissioner has also had the opportunity to see collaboration between government, non-government agencies and the private sector resulting in effective, and sometimes inspiring, programs and services.

One issue that has been consistently raised has been the mental health and wellbeing of children and young people and what more needs to be done to strengthen the mental health of children and young people throughout the State.

The Commissioner for Children and Young People has determined (under Sections 19(f) and 19(i) of the Act[835]) to conduct an inquiry into the mental health and wellbeing of children and young people in WA.

835 Under section 19(f) of the Act, the Commissioner has the powers to initiate and conduct inquiries into any matter, including any written law or any practice, procedure or service affecting the wellbeing of children and young people. Under section 19(i) of the Act, the Commissioner is able to conduct, coordinate, sponsor, participate in and promote research into matters relating to the wellbeing of children and young people.

Terms of Reference

The purpose of the inquiry is to report on the mental health and wellbeing of children and young people in WA and to make recommendations that will strengthen and enhance the mental health and wellbeing of children and young people.

It is important that the mental health and wellbeing of children and young people is understood within the broader context of health and wellbeing. There are a range of complex interactions between a child or young person, their family and their social, physical and economic environments. Individuals, families, communities and agencies – both government and non government – have important roles to play in the mental health and wellbeing of children and young people.

The inquiry will examine and report on:

1. the mental health and wellbeing of children and young people in Western Australia
2. the experiences of children and young people and their families in relation to the mental health and wellbeing of children and young people
3. agencies that have a critical role to play in strengthening the mental health and wellbeing of children and young people
4. models and interventions that strengthen the mental health and wellbeing of children and young people in Western Australia, including those that reduce the risk or prevent mental health problems or disorders
5. opportunities for coordination and collaboration within the government sector and between government, non government and private sectors to assist in the promotion of the mental health and wellbeing of children and young people
6. positive approaches and partnerships that are evidenced based and are proving effective in strengthening the mental health and wellbeing of children and young people (in Western Australia or elsewhere and which would be relevant to Western Australia)
7. recommendations to inform future directions that will strengthen the mental health and wellbeing of children and young people, including interventions aimed at reducing the risk or preventing mental health problems and disorders and effective treatment.

Considerations

In particular the inquiry will:

- have regard to the best interests of children and young people as the paramount consideration in accordance with Section 3 of the Act
- consider the interests of all children and young people in Western Australia, but, in accordance with Section 20 of the Act, will give priority to, and have special regard to, the interests and needs of
    - Aboriginal children and young people and Torres Strait Islander children and young people
    - children and young people who are vulnerable or disadvantaged for any reason
- ensure that the views and experiences of children and young people, their families, service providers and others with an interest are taken into account.

Exclusions

The inquiry is not about resolving individual cases (although the experience of individuals may be referred to as an example), nor about issues that are outside the jurisdiction of the Commissioner for Children and Young People or the scope of the terms of reference.

Conduct of the Inquiry

The Commissioner will conduct the inquiry with the assistance of a Reviewer – Mr Julian Gardner.

The Reviewer will be supported by staff of the Commissioner for Children and Young People and will consult with a Reference Group established for the Project.

The Reference Group will assist the Commissioner by providing advice, comment and information. The Reference Group membership is set out in the table below.

Ms Michelle Scott	Commissioner for Children and Young People WA
Mr Julian Gardner	Independent Reviewer
Dr Caroline Goossens	Infant, Child and Adolescent Psychiatrist/ Chair, WA Faculty of Child Psychiatry
Mr Aram Hosie	WA Manager, Inspire Foundation (a non profit organisation which works directly with young people aged 14-25 to deliver innovative and practical online programs that prevent youth suicide and improve young people's mental health and wellbeing.)
Prof Helen Milroy	Child Psychiatrist / Director Centre for Aboriginal Medical and Dental Health (CAMDH), University of Western Australia
Ms Tricia Murray	Chief Executive Officer, Wanslea (a not-for-profit, non-government agency providing services to children and families in Western Australia)
Prof Steve Zubrick	Curtin University Centre for Developmental Health / Head, Division of Population Science Telethon Institute for Child Health Research
Mr Neil Guard	Acting Mental Health Commissioner

The Commissioner will receive submissions from organisations, individuals, children and young people and their families.

Information sessions

The Commissioner for Children and Young People will be holding information sessions about the inquiry for community organisations, professionals and any interested individuals. Information sessions will be held in several metropolitan and regional areas.

Dates

Metropolitan

- 23 August 2010 Subiaco

Regional

- 17 August 2010 Northam
- 24 August 2010 Westlink Network
- 25 August 2010 Broome
- 27 August 2010 Bunbury
- 31 August 2010 Kalgoorlie
- 3 September 2010 Geraldton
- 7 September 2010 Port Hedland
- 9 September 2010 Albany

See the Commissioner's website for more detail on the dates, times and venues for these sessions.

Making a submission

Children and young people

The Commissioner is interested in hearing the voices of children and young people but recognises that some children and young people and their families may need assistance in preparing a submission for the inquiry.

The Commissioner will be working with selected agencies to ensure the inquiry is informed by the views and experiences children and young people, including vulnerable groups such as those with existing mental health problems, in care and with disabilities.

A guide to making a submission has been developed to assist children and young people to put forward their ideas and concerns.

Organisations and individuals

Organisations, family and community members, and individuals are all encouraged to submit to the inquiry and, wherever possible, to include the views and voices of children and young people in their submissions.

This guide includes a set of questions (on page 9) that may assist you in preparing your submission. You may choose to focus on one or more of the questions or you may like to cover other relevant matters in your submission.

APPENDIX 1: SUBMISSION INFORMATION PACK - ADULTS

Lodging a submission

You can write your own submission or you can use the online submission form.

If you choose to write your own, please complete and print the submission cover page (see page 10) and send it with your submission to the Commissioner for Children and Young People either by post or by email:

Email: mentalhealthinquiry@ccyp.wa.gov.au

Post: Commissioner for Children and Young People
1 Alvan Street
Subiaco 6008

The deadline for submissions is 5.00pm on 1 November 2010.

Contacting us

For further information you can contact staff at the Commissioner for Children and Young People's office, or go to www.ccyp.wa.gov.au/mentalhealthinquiry

Telephone: (08) 6213 2297
Toll free call: 1800 072 444

Email: mentalhealthinquiry@ccyp.wa.gov.au

Mail: Commissioner for Children and Young People, 1 Alvan Street, Subiaco 6008

Suggested submission questions

Your submission could address the inquiry's terms of reference (see page 4) or, alternatively, you could answer one or more of the following questions.

- What are the mental health problems of children and young people?
- What needs to be done to prevent these problems?
- What are the important services and supports that are needed at each stage from pregnancy to pre-school to teenage years?
- What programs and/or agencies are working well in strengthening mental health and wellbeing of children and young people and in reducing/preventing problems? Why are they working well? Is there evidence for this?
- What are the gaps or short-comings in services and programs for children and young people?
- What are the experiences of children, young people and their families – good and bad – in accessing services and programs?
- Are there some groups of children and young people who have particular needs (for example, children in rural and remote communities, Aboriginal and Torres Strait Islander children and young people, or children from culturally and linguistically diverse communities)? Please describe.
- What opportunities for collaboration within and between the government, non-government and private sectors would promote the mental health and wellbeing of children and young people?
- What needs to be done in the future to improve the mental health and wellbeing of children and young people? What interventions or effective treatment should be prioritised?

Deadline for submission is 5.00pm 1 November 2010

Submission cover page

Please complete this page and send it with your submission.

- Name/Organisation:
- Contact person:
- Address:
- Contact details (telephone or email):

Did you consult with children and young people in the preparation of your submission? Y / N

If yes, please provide some brief information about the children and young people who were consulted:
- Number of children and/or young people:
- Age range of children and/or young people:
- Ethnic background of children and/or young people:

Do you/ does your organisation work with Aboriginal and Torres Strait Islander children and young people? Y / N

The Commissioner will not be publishing individual submissions on her website. However, she may need to refer to submission content in her final report and ongoing activities so please indicate which of the following applies to your submission:

☐ This submission is to remain strictly confidential to the inquiry

☐ Sections of the content may be shared but the author must remain anonymous

☐ Sections of the content and the name of the author can be treated as public information

☐ Other - please specify

APPENDIX 2: SUBMISSION INFORMATION PACK - CHILDREN AND YOUNG PEOPLE

A guide to making a submission for children and young people

About the inquiry

What is 'mental health and wellbeing' about?

Mental health and wellbeing is about feeling happy, enjoying life and knowing there are things you're good at. It can also be about feeling lonely, stressed and angry.

What is the inquiry?

The Commissioner for Children and Young People WA is inquiring into the mental health and wellbeing of children and young people in Western Australia.

The Commissioner wants to know about:

- what needs to be done to prevent mental health problems and disorders
- what strengthens the mental health and wellbeing of children and young people
- what is already working well
- what more needs to be done in the future.

The inquiry will look at all stages of a young person's life – from before birth, as a baby and infant, pre-school, primary school, and through to the teenage years.

Who does the Commissioner want to hear from?

The Commissioner wants to hear from children and young people, from family members, carers, providers of services and from anyone who works with, or has experience or an interest in, the mental health needs of children and young people in Western Australia.

How can I have a say?

You can lodge a submission to the Commissioner's inquiry in any format that you find best helps you express your views—writing, photography, video etc.

You can also use the online submission form if you want to.

Either way, you can use the suggested questions or the Terms of Reference on page 4 to help you think through what you might like to say.

APPENDIX 2: SUBMISSION INFORMATION PACK - CHILDREN AND YOUNG PEOPLE

How do I send my submission in?

Before you complete your submission, you need to complete a cover page. This is available on page 5 of this guide or on the inquiry website.

You can then send your submission and the cover page to the Commissioner for Children and Young People either by post or by email:

Email: mentalhealthinquiry@ccyp.wa.gov.au

Post: Commissioner for Children and Young People
1 Alvan Street
Subiaco WA 6008

When do I need to send it by?

You need to send in your submission by 5.00pm on 1 November 2010.

Contact us

For further information you can contact staff at the Commissioner for Children and Young People's office, or go to www.ccyp.wa.gov.au/mentalhealthinquiry.
Telephone: (08) 6213 229
Toll free call: 1800 072 444
Email: mentalhealthinquiry@ccyp.wa.gov.au

APPENDIX 2: SUBMISSION INFORMATION PACK - CHILDREN AND YOUNG PEOPLE

What shall I write about?

Some questions you might like to think and write about are:

- What mental health problems do children and young people have?
- What needs to be done to prevent these problems?
- Who would you speak to, or where would you go if you thought you needed help for a mental health issue?
- Why would you choose this person/place?
- Have you had any good experiences that have helped you feel better?
- Are there any problems with mental health services?
- How can the mental health of children and young people be made better?
- Is there anything else you'd like to tell the Commissioner about mental health and wellbeing?

Or you can write about one or more of the Terms of Reference, which are lists of areas that the inquiry will focus on. This inquiry's terms of reference are in the box below.

Terms of Reference

The inquiry will examine and report on:

1. the mental health and wellbeing of children and young people in Western Australia
2. the experiences of children and young people and their families in relation to the mental health and wellbeing of children and young people
3. agencies that have a critical role to play in strengthening the mental health and wellbeing of children and young people
4. models and interventions that strengthen the mental health and wellbeing of children and young people in Western Australia, including those that reduce the risk or prevent mental health problems or disorders
5. opportunities for coordination and collaboration within the government sector and between government, non government and private sectors to assist in the promotion of the mental health and wellbeing of children and young people
6. positive approaches and partnerships that are evidenced based and are proving effective in strengthening the mental health and wellbeing of children and young people (in Western Australia or elsewhere and which would be relevant to Western Australia)
7. recommendations to inform future directions that will strengthen the mental health and wellbeing of children and young people, including interventions aimed at reducing the risk or preventing mental health problems and disorders and effective treatment.

APPENDIX 2: SUBMISSION INFORMATION PACK - CHILDREN AND YOUNG PEOPLE

Submission cover page

Please complete this page and send it in with your submission

- Name:
- Address:
- Age:
- Contact details (telephone and/or email):
- Are you Aboriginal or a Torres Strait Islander? Yes or no

Your submission will not be put on the Commissioner's website but she may like to use parts of it in her final report. Tick or mark the box to let the Commissioner know which of the following options you are most comfortable with:

☐ You cannot share what I write about with anyone at all

☐ You can share parts of what I write about, but don't share my name

☐ You can share parts of what I write about and you can share my name (first name only)

☐ Other - please specify

APPENDIX 3: BACKGROUND PAPER

Inquiry into the mental health and wellbeing of children and young people - Background paper

Importance of children and young people's mental health and wellbeing

Positive mental health and wellbeing are essential for everybody's personal wellbeing, constructive family relationships and the ability to participate in the community. Being mentally healthy is important for children and young people so they are able to realise their potential, cope with stresses and be involved with family and other aspects of community life.[1]

Mental health problems can result in behavioural issues, a negative sense of worth and a lack of coping skills. This affects a child or young person's quality of life and emotional wellbeing as well as their capacity to engage in school, community, sports and cultural activities – potentially having consequences into their adult life.

Some mental health facts

- 1 in 6 children and young people have a mental health problem[2]
- 25% of parents/carers think their child needs special help for emotional problems[3]
- Aboriginal children and young people are at higher risk of mental health problems[4]
- More than 6% of children have mental health problems at age 2 and likewise age 5 [5]
- Australian children rank 13th out of 23 OECD countries and Aboriginal children rank 23rd of 24 countries in the area of mental health[6]
- Many mental disorders first manifest in childhood and adolescence, and others that are diagnosed in adulthood have their origins in childhood.[7]

The early years

Between birth and the age of 8 years children's physical, emotional and cognitive skills and capacities develop at a rate which exceeds that of any other stage of life.[8] There is now strong evidence for the importance of these earliest years to a person's future mental health and wellbeing.[9] Predictors of major mental health problems in young children have been found to be risk factors in the antenatal, perinatal and postnatal periods.[10]

Influences on mental health and wellbeing

The mental health and wellbeing of individuals and populations can be affected by a range of factors. This may include social determinants (such as housing, educational and economic disadvantage); developmental factors; and parenting and family factors (including maternal depression, neglect and attachment issues). In each of these areas there can be specific risk and protective factors.[11] Risk and protective factors influence the likelihood that a mental health disorder will develop. For children and young people these factors are present in utero, through infancy, early and middle childhood and adolescence.

Examples of protective factors[12]

- Secure attachment between infant and carer
- Supportive caring parents
- Consistent parenting style

- Good social skills
- Adequate nutrition
- Positive school climate
- Opportunities for success and recognition at school
- Good physical health
- Strong cultural identity
- Access to support services

There is evidence that our efforts need to be directed to addressing these determinants and factors through policies, programs and services across the spectrum from universal promotion and prevention, to targeted early intervention and clinical services.[13] [14]

Mental health inquiry

The purpose of the inquiry is to identify ways to effectively prevent, reduce and treat mental health problems among children and young people from birth to adolescence.

It will also focus on the promotion of positive mental health and wellbeing for children and young people from the earliest stages of life.

The inquiry's findings and recommendations will provide a roadmap to give Western Australia a clear direction for action on how to strengthen children and young people's mental health, from the prevention of problems and disorders, through to appropriate treatment.

1 Australian Research Alliance for Children and Youth, The Wellbeing of Young Australians: Technical Report, ARACY, 2008, p.58.
2 Mental Health Division, Infancy to Young Adulthood: A Mental Health Policy for Western Australia, Department of Health Western Australia, 2001, p.3.
3 Daly A., Health and Wellbeing of Children in Western Australia, July 2007 to June 2008, Overview and Trends, Department of Health Western Australia, 2009, p. 47.
4 Zubrick S. et al., The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, 2005, p. 25.
5 Robinson et al., Pre- and postnatal influences on preschool mental health: a large-scale cohort study, The Journal of Child Psychology and Psychiatry, 2008, 49 (10), pp. 1118-28.
6 Australian Research Alliance for Children and Youth, The Wellbeing of Young Australians: Report Card, ARACY, 2008, p.4.
7 Australian Institute of Health and Welfare, A Picture of Australia's Children 2009, AIHW, 2009, p. 30.
8 National Research Council Institute of Medicine, From Neurons to Neighborhoods: The Science of Early Childhood Development, National Academy Press Washington DC, 2000, p. 30.
9 North Metropolitan Area Health Service, Infant Mental Health, Department of Health WA, 2009.
10 Robinson et al., Pre- and postnatal influences on preschool mental health: a large-scale cohort study, The Journal of Child Psychology and Psychiatry, 2008, 49 (10), pp. 1118-28.
11 Commonwealth Department of Health and Aged Care, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Aged Care, 2000, p. 9
12 Commonwealth Department of Health and Aged Care, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Aged Care, 2000, p. 15
13 Commonwealth Department of Health and Aged Care, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Commonwealth Department of Aged Care, 2000, p. 28
14 Marmot, M., Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010, Global Health Equity Group, 2010.

APPENDIX 4: AGENCIES FROM WHICH INFORMATION WAS SPECIFICALLY REQUESTED

Association of Independent Schools of Western Australia
Auditor General (WA)
Catholic Education Office of Western Australia
Chief Psychiatrist of WA*
Council of Official Visitors
Department for Child Protection*
Department for Communities*
Department of Corrective Services*
Department of Education*
Department of Education, Employment and Workplace Relations
Department of Families, Housing, Community Services and Indigenous Affairs
Department of Health*
Department of Health and Ageing
Department of Indigenous Affairs*
Department of Local Government
Department of Sport and Recreation*
Disability Services Commission*
Equal Opportunity Commission
Health and Disability Services Complaints Office
Office of the Inspector of Custodial Services (WA)
Ombudsman Western Australia
Mental Health Commission*
Western Australian Local Government Association
Western Australia Police*

* These agencies' responses were collated by the Mental Health Commission and are referred to as Submission 141 throughout the Report.

APPENDIX 5: CONSULTATIONS COMMISSIONED WITH CHILDREN AND YOUNG PEOPLE

Beckenham Primary School Student Representative Council – Commissioner for Children and Young People's Metropolitan Advisory Committee 2010

Year 3 class, eight to nine years of age

Carers WA – the peak body for family carers in Western Australia, providing advocacy and support including for young carers specifically.

Five participants, four aged 14 to 18 years, one aged in late 20s

CREATE Foundation – the peak body representing children and young people in out-of-home care.

Twelve young people, 14 to 23 years of age

Geraldton's Indigenous Youth Council – Commissioner for Children and Young People's Regional Advisory Committee 2010.

Five young people aged 11 to 15 years

Metropolitan Migrant Resource Centre – a non-profit, community organisation based at Mirrabooka which provides services across the metropolitan area. It is aimed at facilitating the settlement and participation of migrants, especially refugees, and their communities in the Perth metropolitan area.

Forty-six children and young people, three to 19 years of age and 10 mothers (including young mothers)

Regional Development Australia (RDA) (Wheatbelt) – RDA is a Commonwealth Government initiative that aims to provide a targeted and strategic response to issues in regional areas. RDA Wheatbelt currently oversees the Youth Connections program for the Midlands and Narrogin Education Districts.

One-hundred-and-twenty-seven young people aged 12 to 18 years

Regional Secondary School – Department of Education

Three-hundred-and-twenty students aged 13 to 14 years

The Halo Leadership Development Agency – a metropolitan non-profit career and personal leadership development agency providing advocacy, programs, peer mentoring and networking opportunities to young men aged 15 to 25 years.

Forty-nine male children and young people, nine to 20 years of age

WA AIDS Council's Freedom Centre – a peer support and information service for young people with diverse sexuality, sex and/or gender.

Twenty-nine young people, 16 to 19 years of age

APPENDIX 6: SUBMISSIONS TO THE INQUIRY

No.	Name/Organisation
1	Ms Evelyn Vicker, Deputy State Coroner, Coroner's Court of Western Australia
2	Ms Sharee Sankey, member of public
3	Confidential submission
4	Kimberley Aboriginal Law And Culture Centre
5	Ms Caryn Tan, member of public
6	Samaritans Crisis Line
7	Mr Richard Waddy, Foster Carer
8	Ms Lydia Bensusan, Psychologist, The Wellness Centre
9	Confidential submission
10	Confidential submission
11	Peel Development Commission
12	Mr Rob Tyler, Community Nurse, Princess Margaret Hospital
13	Bunbury Early Years Network
14	Ms Jozay Longden, Clinical Psychologist, Mindfulness Now
15	Dr Prue Stone, member of public
16	Department of Education
17	Mr Glen Clarke, A/Auditor General
18	Health and Disability Services Complaints Office (Formerly Office of Health Review)
19	Ms Yvonne Henderson, Equal Opportunity Commissioner
20	Catholic Education Office
21	Mr Neil Morgan, Inspector of Custodial Services
22	Ms Debora Colvin, Head of Council, Council Of Official Visitors
23	Western Australian Secondary School Executives Association
24	Dr Karl O'Callaghan, Commissioner, Western Australia Police
25	Ms Fiona Taylor, member of public
26	Youth Advisory Council, Town of Mosman Park
27	Dr Alexandra Welborn, Chairperson, The Royal Australian and New Zealand College of Psychiatrists WA Branch
28	City of Melville
29	Magistrate Deen Potter and Magistrate Andre Horrigan, Children's Court of Western Australia
30	Indigenous Youth Council, Geraldton Streetwork Aboriginal Corporation
31	Ms Juliet Harrop, member of public
32	Wanneroo Senior High School
33	Western Australian Local Government Authority
34	Confidential submission
35	Discover Me Occupational Therapy
36	Bentley Family Clinic Team
37	Professor Trevor Parry, Chairperson, National Investment for the Early Years (NIFTeY) WA
38	Legal Aid WA
39	WA Primary Principals' Association
40	Physical Activity Taskforce Secretariat, Department of Sport and Recreation
41	Department of Culture and the Arts
42	Confidential submission
43	St Joseph's School Wyndham
44	Wanslea Family Services
45	Northcliffe Family and Community Centre

46	Confidential submission
47	Ms Sue Clay, School Psychologist
48	Fremantle Multicultural Centre
49	Ellie, member of public
50	Mental Health Law Centre WA
51	Ms Penny Young, Wheeha!
52	Peer Support Australia
53	Confidential submission
54	Confidential submission
55	Ms Kerryn Boland, Children's Guardian, The Children's Guardian NSW
56	CLAN WA Inc
57	KidsMatter
58	City of Cockburn
59	Ms Maggie Dent, Esteem Plus: Counselling, Training and Education
60	FamilyVoice Australia
61	Richmond Fellowship of WA
62	Hon Nick Goiran MLC, Member for South Metropolitan Region
63	ASeTTS (Association for Services to Torture and Trauma Survivors)
64	Confidential submission
65	Ms Debbie Fieldwick, Principal, Halls Head Community College, Mandurah Area Public School Principals – representing various secondary, primary and education support public school principals in the Mandurah area
66	Student Services Manager, Atwell Primary School
67	South Metropolitan Mental Health Advisory Group (SuMMat)
68	Dr Corinne Reid, Clinical Director, Project KIDS/Alliance for Strong Kids, University of Western Australia
69	headspace National
70	Swan and Surrounding Suburbs Youth Network
71	Outcare
72	Starlight Children's Foundation
73	West Australian Coalition for Youth Mental Health
74	Child at Heart
75	Bridge Eating Disorders Reference Group for Western Australia
76	The Pacific Institute
77	Ms Heath Townsend, Clinical Psychologist
78	Western Australia Sports Federation
79	Eika Counselling
80	West Australian Foundation for Deaf Children
81	Mission Australia
82	BoysTown
83	Confidential submission
84	Ms Diana Koski, member of public
85	School Psychologists' Association of Western Australia Inc
86	Mr Martin Whitely MLA, Member for Bassendean
87	Ballajura Community College
88	Western Australian Council of Social Service
89	Confidential submission
90	Inspire Foundation

91	Australian Association for Infant Mental Health - WA Branch
92	Office of Multicultural Interests
93	Hon Alison Xamon MLC, Member for the East Metropolitan Region
94	Confidential submission
95	Child Australia
96	City of Swan
97	Mr Mark Porter, MST Program Manager, South Metropolitan Area Health Service - Mental Health
98	Confidential submission
99	Professor Donna Cross and Associate Professor Margaret Hall, Child Health Promotion Research Centre, Edith Cowan University
100	WA Perinatal Mental Health Unit
101	Social and Emotional Well Being (SEWB) Program Manager, South West Aboriginal Medical Service
102	Aboriginal Maternity Service Support Unit
103	Ms Jan Hudson, member of public
104	Relationships Australia
105	Dr Jeff Harmer, Secretary, Department of Families, Housing, Community Services and Indigenous Affairs
106	Mr Kevin Brahim, State Manager, Department of Education, Employment and Workplace Relations
107	Parkerville Children and Youth Care Inc
108	Mr Chris Field, Ombudsman, Ombudsman Western Australia
109	Aboriginal Legal Service of WA
110	Regional Secondary School
111	Professor Bonnie Barber, Youth Activity Participation Study, Murdoch University
112	Carers WA
113	Regional Development Australia Wheatbelt Inc
114	WA AIDS Council's Freedom Centre
115	CREATE Foundation
116	Beckenham Primary School
117	Ngala
118	Association of Independent Schools of Western Australia
119	The Smith Family
120	Community Health Nurses Western Australia
121	Australian Council on Children and the Media
122	Metropolitan Migrant Resource Centre
123	Australian Psychological Society Limited
124	Youth Advisory Crew, headspace Kimberley
125	Telethon Institute for Child Health Research
126	Dr Gervase Chaney, President, Royal Australasian College of Physicians
127	Dr Karen Martin and Dr Lisa Wood, Centre for Built Environment and Health, University of Western Australia
128	Arafmi Mental Health Carers and Friends Association WA Inc
129	Multicultural Youth Advocacy Network of WA
130	Swim for Life Project
131	COMIC (Children of Mentally Ill Consumers) WA
132	Mental Illness Fellowship of WA
132	State School Teachers' Union of Western Australia
133	Australian Research Alliance for Children and Youth
134	Youth Affairs Council of WA

135	Office of Safety and Quality in Healthcare
136	The Halo Leadership Development Agency
137	Western Australian Association for Mental Health
138	Ethnic Disability Advocacy Centre
139	Aboriginal Consumer Participation Program Coordinator, Health Consumers Council
140	Anglicare WA
141	Whole-of-State-Government response which was coordinated by the Mental Health Commission. Information was provided to the Mental Health Commission by: Department for Child Protection; Department for Communities; Department of Corrective Services; Department of Education; Department of Health (including Office of Chief Psychiatrist and Child and Adolescent Health Service); Department of Indigenous Affairs; Department of Sport and Recreation; Disability Services Commission; Drug and Alcohol Office; Mental Health Commission; and Western Australia Police

APPENDIX 7: GLOSSARY

Aboriginal

The Commissioner recognises the diverse tribal and language groups of Aboriginal people in Western Australia. For the purposes of this Inquiry, the term 'Aboriginal' encompasses all of those groups and also recognises those of Torres Strait Islander descent.

Children and young people

The *Commissioner for Children and Young People Act 2006* defines 'children and young people' as people less than 18 years of age. For the purposes of this Inquiry 'children and young people' includes people up to 25 years of age.

Culturally and linguistically diverse

The wide range of cultural groups and individuals that make up the Australian population, including groups and individuals who differ according to religion, race, language and ethnicity except those whose ancestry is Anglo-Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander.[836]

Disability

In this Report disability is defined as a condition that '*results in an impairment, an activity limitation or a participation restriction in the context of their environment*'. This description is inclusive of intellectual, learning, sensory (for example, vision, hearing), speech, psychiatric, physical or medical conditions (including serious and chronic illness), and includes Acquired Brain Injury, Foetal Alcohol Spectrum Disorder, Autism Spectrum Disorders and Attention Deficit Hyperactivity Disorder.[837]

Early intervention

Early intervention strategies refer to the identification of early manifestations of mental illnesses, and the subsequent delivery of a prompt response aimed at preventing progression and reducing impact.[838] Note that early intervention can sometimes refer to early intervention in the treatment of psychosis. It can also refer to early intervention in the life course. This Report specifies when each of these definitions applies.

Integrated services on school sites

This Report refers to integrated services on school sites in relation to early childhood, primary and secondary school.

The Western Australian Premier has made a commitment to establishing integrated early childhood services on school sites, enabling them to become one-stop-shops for a range of early childhood services including child care, playgroups, kindergarten for three-year-olds, child health services, health services for young mothers and parenting services. These are sometimes described as early childhood 'hubs' on school sites and examples already exist in WA.

This model of service integration could be extended to primary and secondary schools, with the co-location of age relevant services including (but not limited to) parenting, mental health and health. 'Integrated services on school sites' is the term used throughout the Report to describe this concept.

Integrated Services Centres

Integrated Services Centres are a specific service to address the complex needs of humanitarian entrants. There are two Integrated Services Centres (Parkwood and Koondoola).

836 Western Australian Office of Multicultural Interests, Multicultural terminology – what's in a word? viewed 22 September 2010, http://www.omi.wa.gov.au/omi_terminology.asp

837 National Disability Services WA 2007, Children and Young People with a Disability in Western Australia, Appendix 2, National Disability Services WA.

838 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 5

APPENDIX 7: GLOSSARY

Mental disorder

A mental disorder is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Mental disorders are of different types and degrees of severity and are diagnosed by standardised criteria.[839] [840] Examples of mental disorders affecting children and young people are depression, anxiety, conduct disorders, substance use disorders, eating disorders and psychosis.

Mental health

Mental health for children and young people has a strong inter-relationship with normal growth and development. Mental health for children and young people means the capacity to enjoy and benefit from a satisfying family life and relationships and educational opportunities, and to contribute to society in a number of age-appropriate ways. It also includes freedom from problems with emotions, behaviours or social relationships that are sufficiently marked or prolonged to lead to suffering or risk to optimal development in the child, or to distress or disturbance in the family.[841]

Mental health problem

A mental health problem interferes with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental disorder. Mental health problems are more common and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental disorders, but may develop into a mental disorder. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of severity and duration of the symptoms.[842]

Mental illness

The term mental illness is considered to be synonymous with mental disorder.[843] Throughout this Report the term 'mental illness' is used for ease of reading to cover mental health problems and mental disorders when both are being referred to.

Parents

Any person with a parenting role inclusive of, but not limited to, parents, carers, grandparents and guardians.

Prevalence

The percentage of a population experiencing a mental health problem or disorder at a given point in time or during a given period of time.[844]

839 Mental disorders are diagnosed by standardised criteria, such as those contained in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (American Psychiatric Association, 1994) and the International Classification of Diseases, 10th Edition (ICD-10) (WHO, 1992).

840 Mental Health and Special Programs Branch 2000, National action plan for promotion, prevention and early intervention for mental health 2000: a joint Commonwealth, State and Territory initiative under the second national mental health plan, Commonwealth Department of Health and Aged Care, Canberra, p. 5.

841 Raphael, B 2000, Promoting the mental health and wellbeing of children and young people. Discussion paper: key principles and directions, National Mental Health Working Group and National Community Child Health Council, Commonwealth Department of Health and Aged Care, Canberra, p. 5.

842 Mental Health and Special Programs Branch 2000, National action plan for promotion, prevention and early intervention for mental health 2000: a joint Commonwealth, State and Territory initiative under the second national mental health plan, Commonwealth Department of Health and Aged Care, Canberra, p. 5.

843 Mental Health and Special Programs Branch 2000, National action plan for promotion, prevention and early intervention for mental health 2000: a joint Commonwealth, State and Territory initiative under the second national mental health plan, Commonwealth Department of Health and Aged Care, Canberra, p. 5.

844 Commonwealth Department of Health and Aged Care 2000, Promotion, Prevention and Early Intervention for Mental Health: A Monograph, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra. p. 129.

APPENDIX 7: GLOSSARY

Prevention

Prevention strategies aim to maintain positive mental health through pre-emptively addressing factors which may lead to mental health problems or illnesses. These strategies can be aimed at increasing protective factors, decreasing risk factors or both, as long as the ultimate goal is to maintain or enhance mental health and wellbeing.[845]

Promotion

Promotion strategies refer to any action taken aimed at promoting positive mental health and maximising wellbeing among populations and individuals. Mental health promotion includes efforts to enhance an individual's ability to achieve developmentally appropriate tasks (developmental competence) and a positive sense of self esteem, mastery, wellbeing and social inclusion and strengthen their ability to cope with adversity.[846]

Protective factors

Conditions that improve people's resistance to risk factors and the development of mental illnesses. Protective factors can be individual, family or community related, social, environmental or economic.[847]

Risk factors

Factors associated with an increased probability of onset, greater severity and longer duration of mental illnesses. Risk factors can be individual, family or community related, social, environmental or economic.[848]

Treatment

[Treatment] interventions [are] targeted to individuals who are identified as currently suffering from a diagnosable disorder and are intended to cure the disorder or reduce the symptoms or effects of the disorder, including the prevention of disability, relapse, and/or comorbidity.[849]

845 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 5.

846 Faculty of Child and Adolescent Psychiatry 2010, Prevention and early intervention of mental illness in infants, children and adolescents: planning strategies for Australia and New Zealand, The Royal Australian and New Zealand College of Psychiatrists, p. 4.

847 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options - summary report, World Health Organisation, Geneva, p. 20.

848 World Health Organisation Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004, Prevention of mental disorders: effective interventions and policy options - summary report, World Health Organisation, Geneva, p. 20.

849 National Research Council and Institute of Medicine 2009, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young adults: Research Advances and Promising Interventions, National Academies Press, Washington D.C., pp. xxix, 65-67.

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Australian Bureau of Statistics 2008, *National Aboriginal and Torres Strait Islander Social Survey, 2008,* cat. 4714.0, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02008?OpenDocument

Australian Bureau of Statistics 2009, *Population by Age and Sex, Regions of Australia, 2009*, cat. no. 3235.0, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02009?OpenDocument

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Australian Bureau of Statistics 2010, *Australian Demographic Statistics June 2010*, cat 3101.0, http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0

Australian Bureau of Statistics 2010, *Causes of Death 2008*, cat. no. 3303.0, Canberra, www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/E8510D1C8DC1AE1CCA2576F600139288/$File/33030_2008.pdf

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