Commissioner for Children and Young People
Western Australia

All enquiries

Our reference: 19/1642

Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

To Whom It May Concern:

Submission to Mental Health Inquiry – The social and economic benefits of improving mental health

Thank you for the opportunity to make a submission to the Productivity Commission Inquiry about the role of improving mental health to support economic participation and enhancing productivity and economic growth. As Commissioner for Children and Young People in Western Australia, my role is to advocate for the best interests of all children and young people under the age of 18 in Western Australia, and to promote and monitor their wellbeing. In doing so, I must have regard for the United Nations Convention on the Rights of the Child, and give priority to Aboriginal children and young people, and children and young people who are vulnerable or disadvantaged for any reason.

Given that approximately one in every seven children and young people are estimated to have a mental health disorder,[1] and estimations that approximately half of all lifelong mental health disorders emerge before a young person has turned 14,[2] the mental health of children and young people, and the unique experiences and vulnerabilities that they face, has been a priority for my office for a number of years.

My office has conducted a range of work around the mental health and wellbeing of children and young people in Western Australia, including the *Report of the Inquiry into the mental health and wellbeing of children and young people in WA (2011)*, and the *Our Children Can't Wait: Review of the implementation of recommendations of the 2011 Report of the Inquiry into the mental health and wellbeing of children and young people in WA.* The Inquiry, and follow up report, outlined a range of systemic issues impacting on the mental health and wellbeing of children and young people, and my office made numerous recommendations regarding what was required to improve their

---

[1] Lawrence D et al 2015, *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Department of Health, Canberra.

[2] Kessler RC et al 2005, *Lifetime prevalence and age of onset distributions of DSM-IV Disorders in the National Comorbidity Survey replication*, Archives of General Psychiatry, 62, p. 593

outcomes, and the systems that support them. The *Speaking out about mental health report* was also released by my office, hearing directly from children and young people about their views on their mental health and wellbeing and their perspectives on the systemic changes required to improve their outcomes.

Further to this, over the past ten years since the Commissioner's role was established, my office has conducted a range of advocacy work relating to issues affecting children and young people, including child protection, youth justice, and the early years, and conducted extensive consultation with children and young people on a variety of issues impacting their lives, including education, health, the built environment, and alcohol-related harm. Consultation has also explored the unique experiences and needs of diverse groups, including children and young people who are Aboriginal, from culturally and linguistically diverse backgrounds, have a disability, experiencing homelessness, in the justice system, or in out-of-home care.

My office has recently undertaken work with a specific focus on understanding the factors that contribute to vulnerability and poor outcomes for children and young people, and identifying opportunities to more effectively address and support children and young people and families who are experiencing vulnerability. As part of this project, my office facilitated a forum with 72 Aboriginal leaders to discuss Aboriginal solutions to improving the wellbeing of Aboriginal children and young people in the State, which, amongst other things, outlined the need for Aboriginal people to take the lead role in determining and addressing issues facing Aboriginal children and young people.[3]

Last year my office also undertook work with a focus on the rights and experiences of lesbian, gay, bisexual, trans and intersex (LGBTI) children and young people. Working with a number of LGBTI young people, my office explored a range of priority issues impacting on the mental health and wellbeing of LGBTI children and young people, including a lack of legal protections and recognition of their identity, experiences of bullying and discrimination, challenges being recognise respected within their schools and in broader community, and a lack of safe spaces to connect with peers.[4]

In this submission, I will provide feedback on some of the specific questions posed in the Issues Paper, as well as provide some strategic considerations for the Inquiry in relation to the needs and experiences of infants, children and young people and their families. Throughout the document, I will also be using quotes from children and young people and stakeholders that have been involved in consultations with my office, to outline their relevant lived experiences of mental health.

General comment

The case for prevention and intervention in early life - a focus on infants, children and young people

The Productivity Commissions' Issues Paper (the Issues Paper) outlines a range of areas where the Commission are keen to focus their attention to be able to maximise

---

[3] Commissioner for Children and Young People 2018, *Supporting Aboriginal-led solutions,* Commissioner for Children and Young People WA, Perth.

[4] Commissioner for Children and Young People 2018, *Final report: Commissioner for Children and Young People's 2018 Advisory Committees,* Commissioner for Children and Young People WA, Perth.

the potential improvements in population mental health, participation and contribution, and which will deliver the most benefit. This included a focus on people with mild or moderate illness, young people, disadvantaged groups, and suicide prevention.

In the Issues Paper, the Productivity Commission acknowledges that onset of most mental health issues occur in childhood and adolescence. However, the Inquiry does not adequately acknowledge or recognise the presence of mental health or emotional disorders in infancy or early childhood, despite suggestions that the prevalence in rate of disorders is comparable to those of older children and adolescents.[5] The most serious mental health issues amongst younger children often manifest as severe social, behavioural or emotional difficulties[6], and without appropriate prevention and intervention, even less severe issues can develop into more serious disorders over time,[7] influencing an individual's life course, general wellbeing and future outcomes.

> *"I think some places see young people with mental health issues as being a 'phase' and therefore do not treat it as a serious matter."* 17 year-old (Mental health consultation)

In 2009, the projected national costs of mental illness were $10.6 billion for young people amongst 12 to 25, with a further $20.5 billion attributed to lost wellbeing (disability and premature death).[8] There is a significant body of evidence to demonstrate the economic benefits of early intervention, both early in the life course, as well as in the early stages of symptoms where mental health issues are mild or emerging.[9] The return of investment for early intervention is much higher than those that intervene later in the life course[10], with some studies suggesting that the delivery of prevention and early intervention activities to address initial onset of depression and anxiety for 50,000 children and young people in Australia would deliver $200 million in long-term investment of $7.90 for every $1 spent, as well as cover costs in the short term. Whilst not specific to mental health, the Western Australian Education and Health Standing Committee found that adequate investment in child health services in the community would prevent a substantial number of hospital admissions for both children and adults, and could save the State's health system approximately $60.6 million per year.[11]

There are a range of risk factors which potentially influence the development of mental illness and poor mental health outcomes, with many of these impacting wellbeing

---

[5] Klitzing, K et al 2015, *Mental disorders in early childhood.* Deutsches Arzteblatt International, 112(21–22), p.p. 375– 386.
[6] Zeanah, C 2009, *Handbook of infant mental health*, Guilford Press.
[7] National Scientific Council on the Developing Child 2008/2012, *Establishing a Level Foundation for Life: Mental Health Begins in Early Childhood: Working Paper 6. Updated Edition.* Center on the Developing Child, Harvard University.
[8] Access Economics 2009, *The economic impact of youth mental illness and the cost effectiveness of early intervention*, Access Economics.
[9] Ontario Centre of Excellence for Child and Youth Mental Health 2014, *Supporting Ontario's youngest minds: Investing in the mental health of children under 6,* Ontario Centre of Excellence for Child and Youth Mental Health.
[10] Heckman, JJ 2000, *Invest in the very young,* Ounce of Prevention Fund and the University of Chicago Harris School of Public Policy Studies, Chicago.
[11] Education and Health Standing Committee 2010, *Invest now or pay later: Securing the future of Western Australia's children*, Western Australian Parliament, Pert.

during infancy, early childhood, and even prior to a child being born.[12] These risk factors can relate to individual factors – including health, temperament or presence of a disability; family factors such as limited supervision or monitoring of a child, childhood neglect, harsh or inconsistent discipline styles; life events and situations such as early experiences of neglect or abuse, family poverty and homelessness; as well as community and cultural factors such as socioeconomic disadvantage, discrimination, and a lack of available support services.[13] Parental mental health issues can also impact on attachment and bonding between parent and child, and may lead to poor infant mental health. [14] [15]

Effective treatments address risk and protective factors for children and young people early in life, and when targeted at at-risk populations of children and young people can reduce the onset and recurrence of mental health issues, and other adverse outcomes.[16] This then mitigates the long term psychological and economic consequences of not providing treatment, and avoid economic costs in terms of service access or reliance, and the social costs to the individual in terms of their relationships and participation.[17] Research demonstrates three priority intervention points that can positively impact children and young people's development and wellbeing, and their long-term trajectories, which are important to consider in terms of investing resources to create maximum benefit and impact. These priority intervention points include:

- The antenatal period (through high quality antenatal care for mothers).
- Infancy and early childhood (0-3 years).
- Preschool (4-5 years).[18]

Beyond early childhood, there are key transition points which create opportunities for further intervention for children and young people and to promote overall wellbeing and development, including the transition into primary and secondary school, as well; as the period immediately following secondary school.

The questions and approach used by the Inquiry would benefit from strengthening the focus on opportunities to improve mental health and wellbeing outcomes early in the life course, and the important role that other sectors such as the early years and parenting sectors, as well as that of parents, families and communities, can play in addressing mental health amongst infants, children and young people. I therefore

---

[12] 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.
[13] Ibid.
[14] Fletcher RJ et al 2017, *Mental health screening of fathers attending early parenting services in Australia,* Journal of Child Health Care, 21(4): 498-508.
[15] Henrichs J et al 2009, *Maternal pre-and postnatal anxiety and infant temperament: The* generation R study. Infant and Child Development, Vol 18, No 6, p. 556-72.
16 Brown H & Sturgeon S 2005, *Promoting a healthy start of life and reducing early risks*, Prevention of mental disorders: effective interventions and policy options. Oxford, Oxford University Press.
[17] Smith JP & Smith GC 2010, *Long term economic costs of psychological problems during childhood*, Social Science & Medicine Vol 71, No 1, p. 110-115.
[18] Fox S et al 2015, *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*, Australian Research Alliance for Children and Youth (ARACY), Canberra.

recommend that the Commission include a focus of infants, children and young people in its Inquiry, as well as refer to the associated sectors and fields that are relevant to infants, children and young people, including maternal health, parenting support and early childhood care.

Recognising the social determinants of mental health in improving outcomes and realising benefits

Whilst it is important to have strategies to specifically address and improve mental health outcomes, these are likely to have limited impact if they are considered in isolation of the other contextual factors influencing the mental health and wellbeing of an individual. Improvements in mental health will be limited if a person has continued exposure to ongoing risk factors, such as poverty, economic disadvantage, family violence, homelessness, and experiences of discrimination. Family poverty in particular is linked to a range of poor life outcomes, including limited educational attainment and lifetime earnings, as well as poor physical and mental health, and early death.[19] Without a holistic approach to addressing the social determinants of health, the impact in terms of improving mental health outcomes and realising the benefits of economic and social participation will be limited.

Aboriginal-led solutions

It is vital that Aboriginal communities, including Aboriginal children and young people, are engaged to identify need, design, develop, implement and evaluate strategies within their own communities to address local needs and the mental health and wellbeing of their people. This involves building community capacity through policies to drive Aboriginal economic participation and improving education, training and employment opportunities. Services and programs that support the mental health and wellbeing of Aboriginal people must also build their cultural competency, and provide services which consider the context of family, community and culture.

The following sections will comment on the questions posed as part of the Inquiry's Issues Paper.

Addressing and responding to diversity

In my functions as Commissioner for Children and Young People, the legislation outlines that I must have regard for any child or young person who is vulnerable or disadvantaged for any reason. My office's 2011 *Inquiry into the mental health and wellbeing of children and young people in Western Australia* identifying and exploring a range of groups of children and young people who were vulnerable and disadvantaged in the context of their mental health. The circumstances and experiences of these children and young people place them at a greater likelihood of experiencing poor mental health and other wellbeing outcomes, and includes Aboriginal children and young people, children and young people who were living in regional and remote communities, in contact with the criminal justice system in care, had parents with a mental illness, who were experiencing difficult circumstances, from Culturally and

---

[19] Center on the Developing Child at Harvard University 2016, *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families*, Harvard University, Cambridge.

Linguistically Diverse backgrounds, particularly those from refugee or asylum seeking backgrounds, who had a disability, and had diverse sexuality, sex or gender identity.[20]

> *"[To have a healthy and happy life, I need] acceptance, inclusion, to be seen as a person with potential and for help to reach that potential."* 12 year-old (Disability Consultation)

Assessment approach

In order to best direct investment and resourcing in mental health expenditure, and maximise the benefits of future investment, it would be important for the Productivity Commission to conduct further investigation and assessment of social and economic benefits associated with:

- *Interventions for specific age groups,* including infants, younger children, older children and young people, as well as parents and families.
- *Interventions for specific mental health issues*, including specific interventions which target depression, anxiety, schizophrenia, conduct disorder and other forms of mental illness.
- *Intervention for specific target groups or priority populations*, including for Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse (CaLD) people – particularly those from a refugee or asylum seeker background, lesbian, gay, bisexual, trans and intersex (LBGTI) people, and other diverse groups.

I would also recommend that the Inquiry utilises direct consultation mechanisms with children and young people and their families, to better understand the unique perspectives and experiences of children and young people affected by mental illness. It would be beneficial for the Inquiry to utilise a framework which reflects what participation looks like for infants, children and young people and their families, for example, participation in schooling, sports and recreation, or cultural activities.

Structural weaknesses in healthcare

There is growing recognition of the need to rebalance the service system to invest more in mental health promotion, prevention, and early intervention, however there is difficulty diverting funding away from tertiary and acute treatment services. This largely has to do with the statutory duties that health agencies have in terms of prioritising service based on clinical need, and the competing resources which see funding for specialist treatment services prioritised over prevention and early intervention activities or strategies.

In Western Australia, the Mental Health Commission has outlined a commitment to reforming the mental health system in its *Better Choices Better Lives: Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025*. However, in a recent update on the progress of the Plan, the Mental Health Commission outlined a range of factors influencing the prioritisation and progression of strategies in the Plan, including:

---

[20] Commissioner for Children and Young People 2011, *Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia,* Commissioner for Children and Young People, Perth.

- The need to prioritise investment in services where there is the highest need.
- The prioritisation of clinical safety and human rights.
- The length of time required to engage consumers as important stakeholders in the development, design and delivery of services.
- Challenges in monitoring, evaluating and attributing the impact of individual health promotion and prevention initiatives.
- The impact that reconfiguration of resources has on other reform activities.[21]

Whilst many Government reforms and strategies outline a commitment to changing the status quo of service delivery, without appropriate resourcing and funding, realistic timeframes, and clear implementation strategies, the delivery of these strategies or reforms falls short of creating the impact that they set out to achieve. There continues to be a lack of integrated and holistic service responses to mental health and wellbeing across government, despite this being outlined as a priority of many mental health reforms. Whilst reform brings opportunity to reimagine the way that services are delivered, barriers also exist in terms of sustaining the momentum of change, aligning reform priorities, and making the case for Government to often commit to funding and resourcing reforms, when the return on investment and benefits may not be realised for a number of years, potentially outside of their political remit.

The mental health of infants and younger children is often overlooked, with limited strategies specific on how to address mental health issues early in life, or provide appropriate supports to parents and families to address children and young people's mental health needs. Promotion, prevention and early intervention in this space is often delivered through the early years and parenting sectors, however there is scope to improve and incorporate collaboration with mental health agencies, to maximise benefits during the early years. It is important that families are supported in their capacity to provide nurturing and supportive environments to enable and support positive mental health and wellbeing of their children.

> *"I think the biggest problem is caused at home and has a big impact on how children behave... I mean things such as family separation, violence... which causes depression and anger through us teenagers."* 14 year-old (Mental Health Consultation)

In addition to this, there is a need to move beyond traditional forms of intervention to address the social and economic factors that contribute to mental health issues. This is particularly important in the context of growing economic inequality between those with the highest incomes and lowest incomes in Australia,[22] and the impact that financial stressors and poverty have on the long term outcomes for children and young people.[23]

---

[21] Mental Health Commission 2019, *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Draft Plan Update 2018,* Government of Western Australia.

[22] Australian Council of Social Service 2015, *Inequality in Australia 2015,* Australian Council of Social Service, Sydney.

[23] Monks H 2017, *The impact of poverty on the developing child: CoLab Evidence Report,* Telethon Kids Institute, Perth.

> *"Both my parents work hard because dad says things are not cheap no more. I get scared because dad says it's going to get harder to get a job because nobody wants to give Aboriginals work. He has two jobs and I hardly see him, which makes me sad..."* 11 year-old Noongar young person (ATSI Consultation)

> *"[If I were boss of this town] I would include more opportunities and support for children who want to go to school but can't afford to buy basic school supplies..."* 17 year-old Jabirr Jabirr young person, Kimberley (ATSI Consultation)

There can be significant delays between when a child or young person first experience symptoms of mental illness and when they receive support for this,[24] with services often being provided once the symptoms have escalated in their severity and urgency. Limited resourcing, and subsequent waitlisting of children and young people further delays treatment, leaving children and young people without a timely response at the point in time that they require it.[25] Further, community based supports for children and young people under the age of 12 are limited, leaving a gap for children and young people who may be experiencing mild to moderate systems which require specialist treatment beyond the scope of primary care services, but which are not serious enough to meet the threshold to access acute treatment or support.

There are significant data and measurement gaps in terms of tracking the prevalence of mental illnesses for infants, children and young people. This lack of information makes it challenging to be able to adequately and appropriately model the demand for service provision, or identify where investment is best made to improve outcomes for infants, children and young people. Similarly, a lack of evaluation and outcomes measurement for treatments and services makes it difficult to demonstrate the efficiency of services in addressing need. Research indicates that many children and young people accessing evidence-based mental health treatment do not actually "fit" or meet the criteria in terms of the suitability for the treatment, and that most children and young people with complex needs or mental health issues will not actually benefit from these standard treatments, rather, the treatments are addressing and managing the risk to that child or young person.[26] Having clear measurement of outcomes of particular treatments and services is vital to ensure that services are making a difference and having a positive impact on children and young people's mental health outcomes.

Specific health concerns

There are a range of evidence-based mental health promotion activities which can improve population outcomes for mental health and wellbeing. A resource released by VicHealth provides a good overview of the background to evidence based mental health promotion, and practice which address mental health, including initiatives which increase social connectedness, decrease/eliminate violence and discrimination, and which increase economic participation.[27] Of particular relevance to infants, children and

---

[24] Khan L 2016, *Missed opportunities,* Centre for Mental Health, London.
[25] Access Economics 2009, *The economic impact of youth mental illness and the cost effectiveness of early intervention*, Access Economics.
[26] Wolpert M et al 2017, *High integrity mental health services for children: focusing on the person, not the problem,* BMJ Vol 357: j1500.
[27] Keleher H & Armstrong R 2005, *Evidence-based mental health promotion resource*, Report for the Department of Human Services and VicHealth, Melbourne.

young people are whole-of-school programs and approaches to addressing mental health and wellbeing, including school-based bullying programs and discrimination prevention, structured opportunities for participation, social support, physical activity and exercise, targeted programs for children at risk and their parents, and child care programs.

There are a variety of initiatives and strategies at both a State and National level addressing suicide, however very few of these look at specific strategies relating to children and young people, or address specific strategies for particular at-risk or vulnerable populations. In 2017, suicide was the leading cause of death for both Aboriginal and non-Aboriginal children and young people,[28] with these rates gradually increasing over the past 10 years.[29] Of particular concern is that the rate of suicide amongst Aboriginal children and young people aged 5 – 17 years is five times higher than that of non-Aboriginal children and young people.[30] Despite significant Commonwealth and State investment, and a range of inquiries and reports investigating both Aboriginal and child and youth suicide, there is little evidence to suggest that our investment and strategies are improving outcomes for children and young people.

Health workforce and informal carers

There needs to be more focus on building the capabilities of the professional health workforce to work alongside children and young people and their families, particularly those at risk. Through consultations with my office, young people have identified a range of barriers which prevent children and young people, and their families, from accessing the services and supports they need for their physical or mental health. These include feelings of shame, stigma, lack of confidence or discomfort in discussing issues, concerns around confidentiality and other people finding out, lack of flexibility and availability of services, lack of transport options, previous poor experiences with health services, or not knowing what services are available to them.[31] [32] Some children and young people, particularly those who are vulnerable or at-risk, may struggle with traditional methods of service delivery, such as attending face-to-face appointments at set times.

> *"There should be more places where you can go and not worry about making an appointment or waiting to be booked in. It is wrong that people in need of help should have to wait for someone to help them."* 14 year-old (Mental health consultation)

> *"There's a lot of services out here to help people but I wasn't really exposed to these services except for like the chaplain at school but I never really talked to*

---

[28] Australian Bureau of Statistics 2018, *Causes of death, Australia 2017: Intentional self-harm in Aboriginal and Torres Strait Islander people,* Australia Bureau of Statistics.
[29] Robinson J et al 2016, *Raising the bar for youth suicide prevention,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne.
[30] Australian Bureau of Statistics 2018, *Causes of death, Australia 2017: Intentional self-harm in Aboriginal and Torres Strait Islander people,* Australia Bureau of Statistics.
[31] Van Dyke N et al 2014, *Young People's Experiences with Health Services: Final Report,* Commissioner for Children and Young People WA, pp. 67-75.
[32] Commissioner for Children and Young People 2017, *Co-designing technologies to support the mental health and wellbeing of children and young people,* Commissioner for Children and Young People WA, Perth.

them 'cause I thought I could manage everything by myself but that didn't turn out so good." 16 year-old, Uganda (CALD Consultation)

In order to address these barriers, it is vital that workers are sensitive and attuned to the experiences and needs of children and young people, and can build trusting relationships with them. Literature suggests that the provision of outreach, community-based, and culturally-specific services can also improve access to health care for vulnerable or at-risk young people, and address some of the barriers that they face in mainstream services.[33]

"Well first of all they should build relationships, bonding with the kids. They should take an interest in what the kids like and want to do and stuff like that. But after that they should help the kids you know, become independent people." 17 year-old Aboriginal young person (Out-of-Home Care Consultation)

"First time I went to a psych, they said to me 'this is the first week, we don't even have to talk about what your mum wants us to talk about, let's just talk about your week. Let me get to know you, let you get to know me.' Often people need an initial breakdown of their barriers before they can let you in." Young person (Youth Health Consultation)

Training for health professionals in delivering trauma-competent and culturally-competent care plays another important role. Workers should also be equipped to support diverse groups of children and young people, for example, with Aboriginal children and young people, children and young people with diverse gender identity or sexuality, or who may have complex needs or multiple issues of concern.

"Many psychs refuse to see someone if they have even the slightest sign of something they don't specialise in. I couldn't be seen for depression by a psych because I was also displaying symptoms of EDNOS [Eating Disorder Not Otherwise Specified]." 17-year old (Mental health consultation)

Service models which work alongside families to safely and appropriately support and care for the child or young person in the home, are critical in providing a holistic response. The use of multi-systemic therapy for families with young people with behavioural issues has been demonstrated as an effective method of addressing emotional and behavioural problems in older children and adolescents, and works intensively with families to improve parenting skills and functioning.[34] Whilst peer or lived experience workforces are gaining recognition as a distinct strategy for supporting mental health service provision, this is yet to be fully explored or extended in regards to children and young people and their families, and there are potential benefits to be identified in this space.

My office has previously recommended the need for more innovative and flexible service models for mental health service provision in regional areas. This includes identifying opportunities for the use of technology, the development of local community members to address workforce and recruitment challenges, and allocating funding which appropriately plans and accounts for the costs of regional service delivery. This is vital to ensure that children and young people living in regional areas

---

[33] Walker R and Riebel T 2013, *Young people's experiences with health services: A literature review*, p. 6, in Van Dyke N et al 2014, Young People's Experiences with Health.
[34] Porter M & Nuntavisit L 2016, *An Evaluation of Multisystemic Therapy with Australian Families,* The Australian and New Zealand journal of family therapy, Vol *37* No 4, p. 443-462.

have access to the continuum of services that they require to support their mental health and wellbeing.

There needs to be formal recognition and consideration of children and young people who take on caring roles in their homes, often the children of parents or family members with a mental illness. In 2016, there were approximately 151,600 young carers aged 15 – 24 years in Australia, accounting for approximately one in every twenty young people.[35] This figure is likely to be an underestimation, and does not account for younger children or young people aged under the age of 15 who are caring for family. Young carers often hold responsibility for caring for parents or adults, their sibling, and coordinating the household, which creates barriers to their engagement in education and study, and social and recreation activities.[36] Consultation by my office with young carers outlined the opportunities to improve the practical support for families, including cleaning and housework, and opportunities for participation in social and recreation activities. [37]

> *"[I would like] a break on the holidays or a weekend away where we can stay at a place and talk to people who you can relate to, and bond with other people who have gone through the same sort of thing."* 14-year old (Mental health consultation)

> *"[I would like] a carer or worker that comes to the home every two days for a few hours to help the person with the family member with mental illness. They could help around the house."* 14-year old (Mental health consultation)

It is important that young carers are considered in the scope of the Inquiry in terms of their specific needs, experiences, as well as the benefits of supports for this specific group of young people. In addition those with a caring role, children and young people with family members or siblings with a disability or mental health issues are also at higher risk of mental health issues and other challenges themselves,[38] even when they are in a non-caring role, and this is an additional area that the Inquiry may consider.

Housing and homelessness

People with a mental illness, and their families, require access to safe and appropriate accommodation and support options to support their recovery. The factors that influence or precede mental health issues, substance use and homelessness typically emerge prior to a young person turning 16,[39] and therefore strategies need to consider and provide support for younger children and young people and their families, as well as the general population.

---

[35] Australian Bureau of Statistics 2018, *Young Carers: Census of Population and Housing: Reflecting Australia – Stories from the Census, 2016,* Australia Bureau of Statistics.
[36] Moore T & Morrow R 2007, *Hopping off the roundabout: Supporting young carers in WA – a report of the findings from the Young Carers Roundtable 2007*, Carers WA, Perth.
[37] Commissioner for Children and Young People 2012, *Speaking out about mental health: the views of Western Australian children and young people,* Commissioner for Children and Young People WA, Perth.
[38] Hogan D et al. 2003, *Using Survey Data to Study Disability: Results From the National Health Interview Survey on Disability*. Research in Social Science and Disability, Vol 3, p. 185-205.
[39] Mallett et al 2005, *Young People, drug use and family conflict: Pathways into homelessness,* Journal of Adolescence, Vol 28 No 2, p. 185 – 199.

Strategies regarding the provision of housing and accommodation for people with a mental illness need to consider:

- Age appropriate accommodation options for children and young people, which provide supports based on their individual level of independence.
- Coordinated wrap-around supports for children and young people and families accessing multiple services.
- Supports for families, including in-home supports for families with children with a mental illness, as well as supports for parents with a mental illness and their children.

  > *"Was living with mum, there was a family trauma, mum had mental health issues which declined, she kicked me out, then kicked my brother out."* 23 year old (Homelessness consultation)

- Flexibility of eligibility criteria and requirements for people with mental health issues, as these requirements (for example to be enrolled in a day program) can be restrictive or inappropriate for young people with mental illness.

  > *"I've been in and out of hospital.....wasn't allowed to stay [in youth accommodation hostel] during the day, when came out of hospital had to crash at a mate's place, just wanted to sleep."* 15 year old (Homelessness consultation)

- Supports for people with complex or co-existing needs, for example, mental health and AOD use.

  > *"Being homeless is probably been the worst time of my life like, getting beat nearly every day, and being homeless has led to, getting depressed, and taking drugs, you know I abuse drugs, cos you think it's the only thing to do, you don't have any money to spend on anything, you pick up drugs, you end up in debt people you don't want to end up in dept with or you end up being really mentally unstable, because all your family's really rat shit."* 15 year old, homelessness consultation

- Flexibility in service models for young people who are under the age of 16.

  > *"The biggest barrier for me getting something is my age.....I'm just 15 and I'm almost a month away from being 16, you still have boundaries until the first second you turn 16."* 17 year old (Homelessness consultation)

- Supported transition between services and accommodation.

The use of a Housing First approach, as is being used in Western Australia with the 50 Lives 50 Homes campaign, prioritises the provision of safe and supportive housing to people with complex needs who are experiencing chronic homelessness, including those with mental illness. There is evidence to demonstrate that the Housing First model is effective in addressing chronic homelessness,[40] through improving housing stability, reducing hospital and psychiatric admissions, improving care continuity, and

---

[40] Council to Homeless Persons 2018, *Housing First: Permanent Supportive Housing – Ending Chronic Homelessness*, Council to Homeless Persons.

participation in community, education and employment activities.[41] [42] This model has predominantly been used with adults without children, however the principles and approaches can be adapted to be applied to young people, and families with children.[43]

Other youth specific accommodation models that demonstrate positive outcomes for young people with complex mental health needs include specialised support services such as the Perth Inner City Youth Service, who offer psycho-social support programs for young people with a diagnosed mental health issue at risk of, or experiencing homelessness.

Social Services

Children, young and families affected by mental illness require varying levels of support. Previous inquiries and reports by my office identified gaps for children and young person with a dual diagnosis of a mental illness and a disability, as well as gaps in supports where individuals were unable to access services because they did not meet the threshold for a formal diagnosis.

The roll out of the National Disability Insurance Scheme (NDIS) aims to provide support for people who have a psychosocial disability, that is, who have a disability as a result of mental illness. However, there may be gaps or barriers for people with a psychosocial disability in terms of being able to access support through NDIS, which are discussed below.

Psychosocial disability is a relatively new concept, and there is limited understanding about psychosocial disabilities amongst children, young people and their families. As a result, children and young people and their families may be particularly reliant on medical or allied health professionals, or other networks, for information about psychosocial disability, assessment processes and supports/services.

The criteria used to determine eligibility for supports under the NDIS in the NDIS Act require, amongst other criteria, individuals to demonstrate that impairments are a result of a psychiatric condition, are likely permanent, and that a person will likely require support for the rest of their lives. This is in direct contrast with the 'recovery model' used in mental health and allied health sectors, which recognises that it is possible to recover from a mental health condition. There may be a reluctance on the behalf of families and children and young people to actually identify as having a disability, and even more so where they would be required to enunciate (whether they believe it or not) that their mental illness is permanent in order to receive supports/services through the NDIS.

Some people with psychosocial disability have also found it difficult to engage with the NDIS because of their psychosocial disability, and as a result achieved poorer outcomes. In its 2017 report on NDIS Costs, the Productivity Commission stated a number of concerns had been raised regarding how some aspects of psychosocial

---

[41] Holmes et al 2017, *Housing First: permanent supported accommodation for people with psychosis who have experienced chronic homelessness*, Australian Psychiatry 25(1): 56 – 59.
[42] Bruce, J., McDermott, S., Ramia, I., Bullen, J., & Fisher, K.R. (2012). Evaluation of the housing and accommodation support initiative (HASI). Final report for NSW Health and Housing. NSW Social Policy Research Centre ARTD Consultants. Sydney, Australia: University of New South Wales.
[43] Collins et al. 2018, *Implementing housing first with families and young adults: challenges and progress toward self-sufficiency.* Children and Youth Services Review, Vol 96.

disability align with the design and operation of the Scheme.[44] A specialist 'psychosocial gateway' was recommended as a way of improving how the NDIS engages with people with psychosocial disability on an operational level. As a result, there has been a commitment from the NDIA to upskill its workforce to better understand psychosocial disability and make available new resources to support access to the NDIS and active participation in the planning process by people with psychosocial disability. However there is little evidence that specific strategies have been developed for children, young people, or their parents and families to support participation or to address workforce understanding about the implications of psychosocial disability for infants, children and young people. This is despite 46% of NDIS participants being aged between 0-18 years, and children aged 7-14 years being the single largest cohort in the Scheme (25%) (as of December 2018).[45]

It is critical that there is a clear understanding and agreement between the NDIA, government and 'mainstream' mental health service providers about where responsibilities lie between the NDIS and mainstream services. All parties need to be operating on a shared understanding to ensure children and young people don't fall through service gaps, and, where gaps are identified, there needs to be a commitment to working together to address them.

The NDIA, government and all providers supporting children and young people with a psychosocial disability need to assume a joint responsibility for monitoring the wellbeing of children and young people with a psychosocial disability and their families, to ensure that they are adequately supported, and that there are mechanisms in place to prevent escalation of issues or critical or adverse events for the child, young person or their family. It is also important to recognise that NDIS supports do not replace a person's mental health supports, and that other organisations, such as medical, allied health, child protection and education services, are working together with the child or young person and their family to ensure the best outcomes are achieved in each case.

Social participation and inclusion

Throughout various consultations with my office, children and young people have identified social participation, spending time with friends, and engaging in activities as important aspects for their mental health. I consistently hear from children and young people about their desire for more facilities to 'hang out' and participate in recreational activities, particularly from those living in regional and remote areas.

> *"I suggest more sporting grounds or youth centres where kids can make friends and get involved in fun activities, and even get counselling if they need it."* 15 year-old (Mental health consultation)

Social isolation can be more pronounced for particular groups of people, as a result of structural challenges for participation, including resources, physical or intellectual

---

[44] Productivity Commission 2017, *National Disability Insurance Scheme (NDIS) Costs*, Study Report, Canberra.

[45] National Disability Insurance Scheme 2018, *National Public Dashboard: 31 December 2018*, National Disability Insurance Scheme.

capacity to participate and location, as well as explicit exclusion such as racism, discrimination, homophobia and transphobia, bullying, refusals of friendship or lack of recognition. This is the case for diverse groups of children and young people, including children and young people with a disability or chronic health issues, non-English speakers, young parents, young carers, Aboriginal and Torres Strait Islander children and young people, children and young people who are LGBTI people, living in regional and remote areas, or CaLD. Some of these children and young people may be exposed to discrimination or bullying as a result of their diversity, which contributes to poor mental health outcomes. Strategies to address discrimination and improve community attitudes towards diversity are critical in addressing mental health outcomes for these groups.

> *"I was bullied at high school for looking, talking, walking and acting like a gay male. Obviously this didn't encourage me to come out."* Young person (Mental health consultation)
>
> *"...even though I was very young, I went through enough misery to last a lifetime. First we didn't have anywhere to live, after when I started school everybody teased me, I didn't have any friends, my accent was different, I was an outsider. I didn't belong."* 16 year-old, Yugoslavia (Culturally and Linguistically Diverse children and young people (CALD) Consultation)
>
> *"I was getting bullied... I was getting called 'charcoal chicken' and 'you're not an Aboriginal'... I was constantly telling teachers. One of the reasons why I left school was 'cause I was getting bullied... I was getting bullied for my dark skin... it was also through my primary school to my high school and I dropped out in Year 9. I'm supposed to be in Year 12 today and I still haven't gone back to school."* 17 year-old (Youth Justice Consultation)
>
> *"They'd tease us about not being able to hear and how we can't understand them, and they'd mock us by giving facial expressions or imitate ridiculous made-up signs. Sometimes they would be behind us mumbling and calling names when we can't hear until our hearing friends tell us what they did to us. It's an embarrassment when people watch this happen and we have no idea until we're told."* Young person (Disability Consultation)

There are a number of different sectors and agencies that provide opportunities for participation, including, but not limited to, sport and recreation clubs and programs, culture and arts programs, local government, youth centres, after-school care, churches and religious institutions, and structured volunteering opportunities. Many of these provide mainstream services to cater for all children and young people, however there is scope to enhance the targeted participation opportunities for particular groups of children and young people at higher risk of isolation, to encourage and support their participation.

Monitoring the progress of particular participation and inclusion initiatives to improve mental health could be measured by identifying the individual's sense of connection and belonging to others/their communities, and the role that the initiative has played in facilitating this.

Justice

Strategies to reduce young people's contact with the justice system must be grounded in an understanding of the underlying reasons for young people's offending, which stem from the broader social and economic disadvantage they experience. This

requires building robust service models that focus on early intervention in the cycle of disadvantage by identifying children and young people who may be at risk prior to any interaction with the youth justice system, to prevent them offending.

All programs and supports to address mental health specifically, and broader issues of disadvantage, must be culturally secure and trauma-competent. In 2016 my office undertook a consultation with young people in the youth justice system to seek the views of young people on why they get into trouble with the law and what support and assistance they need to help them develop positive behaviours in order to navigate away from criminal behaviour. Young people stated that breaking the cycle was difficult and there was a need for programs that offered sustained support. They described how accessing mental health and drug and alcohol services helped them overcome difficult times; however, there was a need for more mental health services including psychological support in the community.

> *"I still see the same psych as when I was in jail, yeah they do help, I didn't want to see another one, starting all over again, so they gave me the same one. They come every [week]...it's a bit full on at the start, you get used of it though."* 18 year-old male

Intervention and diversion once children and young people begin contact with the justice system is also critical to ensuring that the underlying causes and outcomes of offending, including mental health issues, are appropriately responded to and that further contact with the justice system is prevented or reduced.

This requires comprehensive needs assessment and support planning and can include implementing a child-centred review of any child or young person involved in criminal activity to identify the issues contributing to the offending behaviour to provide the basis for a coordinated, collaborative plan for intervention for the child and their family. This includes assessment of physical and mental health, education and learning needs, safety and basic care needs, and family support. This should also include formal neurodevelopmental assessments for young people entering the justice system to identify FASD and provide appropriate rehabilitation and therapeutic interventions.[46]

Findings from the Telethon Kids Institute that nine in ten young people within the Banksia Hill Detention Centre who took part in their study had some form of severe neuro-disability is further evidence that systems are not adequately identifying and supporting vulnerable young people who then come into contact with the justice system. The number of young people diagnosed with Fetal Alcohol Spectrum Disorder (FASD) through this study who had previously been undiagnosed is particularly alarming. These young people have had this impairment from birth and clearly have not received the support they need before they entered the justice system.

An estimated 80 per cent of incarcerated young people in Australia have experienced multiple traumatic stressors.[47] Therefore, staff working with young people in the youth justice system must be adequately trained to understand the effects of trauma on young people, their families and communities, recognise the signs of trauma, and

---

[46] Bower C et al 2018, *Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia*, BMJ Open, Vol. 8.
[47] The Royal Australasian College of Physicians 2011, *The health and well-being of incarcerated adolescents*, The Royal Australasian College of Physicians, Sydney, p. 16.

provide support to increase young people's sense of safety and hope and resist re-traumatisation.[48]

There is a need for continued funding for, and rapid expansion of, the forensic mental health service at the Children's Court, to ensure children and young people appearing before any court (in WA) have access to appropriate, comprehensive mental health assessment, referral and treatment services.

In detention facilities there is a need for significant improvement in and resourcing of rehabilitation and therapeutic services, as well as "through care" supporting children and young people when they leave detention and return to community. This includes:

- Employment and training programs.
- Psychiatric and psychological services.
- Drug and alcohol services.
- Education programs.
- Relationship and family support programs.
- Training for justice staff to ensure they are suitably skilled to work with young people with neurodevelopmental impairment and mental health issues.

There is a need for regular independent oversight and monitoring of detention facilities to protect the rights of vulnerable individuals. Oversight can ensure compliance with policy and practice (include individuals' access to mental health and other support services in detention) and human rights standards, identify issues as early as possible and provide access to effective procedures to raise complaints and concerns.

Specialist reports by service providers familiar with the offender and their community, and independent mental health/health assessors can assist to provide the court with a full picture of an individual's background and drivers for offending including social and systemic factors. This information can assist in a fair representation of the offender in court and to identify options for forms of sentencing which may be more effective than imprisonment or other conditions, and serve to rehabilitate the offender.

To address the significant over-representation of Aboriginal children and young people in contact with the justice system,[49] all strategies and programs in the justice system must be culturally secure and include Aboriginal led and controlled services and supports.

There is poor integration of services to support vulnerable children and young people who are at high risk of entering/re-entering the justice system. The justice system needs to work with human service agencies including child protection, police, courts, schools, out-of-home care providers and the health system (including mental health, drugs and alcohol) as well as working with families, communities and young people. This collaboration needs to be reflected across policy platforms and needs to include information sharing and training. Additionally, there is a lack of culturally appropriate bail support and diversion options for Aboriginal children and young people.

---

[48] Child Family Community Australia 2016, *Trauma-informed care in child/family welfare services*, CFCA Paper No. 37, Australian Institute of Family Studies, Australian Government.
[49] Australian Institute of Health and Welfare 2018, Youth justice in Australia 2016-17, Cat. No. JUV116, AIHW, Canberra.

We need a system that avoids detention where possible, and emphasises community-based programs that address the underlying causes of vulnerability and mental health issues, which ultimately lead to offending.

Child Safety

Many children and young people and families interacting with the child protection system experience circumstances which place them at risk of mental health issues, including poverty, family and domestic violence, unemployment, poor access to services, and unstable or inadequate housing. Working to keep children safe in their families where there is parental mental health issues requires strong inter-agency collaboration between child protection workers and mental health professionals.[50] This includes a strong assessment about risk and protective factors, an assessment of the potential impact of the mental illness on the safety and care of the child, including considering cumulative harm, how the family are currently coping, as well as the availability of multidisciplinary supports and resources that could assist children, parents and families.[51] It is also important to build the skills of all organisations to build the knowledge and skill base of staff and professionals, and ensure that culturally appropriate supports and interventions are provided.

> *I didn't know where to go to get the support from agencies. Pretty much they wanted a support person..... to watch my mental health and to help me along the way and that's what I struggled with. That's why my son was taken back into care, because I couldn't find a support network. I need someone to support me, because I do have problems with my mental health.* Parent (child protection practice consultation)[52]

Where children and young people are brought into out-of-home care, many require support and intervention to address trauma early in life, and mental health issues that they may be facing. During consultation with children and young people in out-of-home care for my office's Inquiry into mental health, they told us about the need for accessible, responsive and consistent services, the need to be involved in planning for their health and the services they receive, as well as the importance of improving understanding about mental health amongst children and young people in care and the support options available to them.[53] Importantly, young people spoke about placement stability as being vital to improving mental health outcomes of children and young people in care.

> "*A stable living environment would stop mental health issues from happening*"
> 13 year old in care (mental health consultation)

---

[50] Coates D 2015, *Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: Inter-agency collaboration,* Child and Family Social Work.
[51] State of Queensland 2010, *Working with parents with mental illness: Guidelines for mental helath clinicans,* State of Queensland (Queensland Health).
[52] Commissioner for Children and Young People 2018, *Issues paper – Parent's rights and participation in child protection practice*, Commissioner for Children and Young People WA, Perth.
[53] Commissioner for Children and Young People 2012, *Policy brief: the mental health and wellbeing of children and young people. Children and young People in care,* Commissioner for Children and Young People WA, Perth.

Recommendations in my office's original Inquiry, and subsequent follow up, included:

- The need for a collaborative service to address the needs of children and young people with complex needs, including considerations for the models of the Wraparound Milwaukee and the People with Exceptionally Complex Needs program.
- The use of the Rapid Response framework to identify and respond to the mental health needs of children and young people in care.

In addition to this, my office has suggested that the following is required to improve the mental health outcomes of children in care, including:

- The development of a strategic and comprehensive mental health plan for all children and young people, including specific requirements of children and young people in care.
- Interagency responses to ensure quality service responses for children and young people in care with mental health issues.
- Mental health screening, assessment and planning for all children and young people in care, to be comprehensively documented when they enter care through their care plans, and reviewed annually.
- Monitoring of care planning to ensure mental health screening, assessment and planning occurs.

It also important to consider the mental health needs and supports required for young people leaving care. My office has supported raising the leaving care age to provide continued support for young people leaving care until the age of 21, in recognition of the specific needs and vulnerabilities of this cohort, and the potential benefit of increased support as they transition into adulthood.

Education and training

There is strong evidence that poor student mental health adversely impacts academic achievement, attendance and attitudes towards school, and that children and young people with mental disorders (such as ADHD, depression and anxiety) are less connected and engaged with their schooling. [54] [55] Children and young people with a mental illness, or with other challenges in their lives, may experience difficulty concentrating or absorbing information in class or in course-work, challenges in their relationships with peers and teachers, or experience periods of absence from schools.

> *"When I went to school it was mainly to get away from [home]. So when I was at school for any of the time, I would side track myself, I wasn't actually learning. I wasn't in class to learn. I was just sitting there in class or just hanging around the school. I was at school but I wasn't actually there. When I did go to class I found the teachers weren't supportive. I never had clean clothes or lunch. I couldn't concentrate and was always crying a lot. They were*

---

[54] Lawrence D et al 2015, *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing,* Department of Health, Canberra.

[55] Leach L & Butterworth P 2012, *The effect of early onset common mental disorders on educational attainment in Australia,* Psychiatry Research Vol 199 No 1, p. 51–7.

> *just angry that I wouldn't turn up at class or when I'd leave there was just a lot of anger towards me. Everything was presented as though I was being naughty. Looking back, it was presented as "you're a naughty child" when really I think I just needed some help, some support."* 20 year-old (Out-of-Home Care Consultation)

In a consultation project with my office in 2017, in which over 1,800 children and young people in Western Australia participated, 40% of Year 7 - 12 s reported having difficulties with concentration, behaviour, feelings or getting along with people. These young people had a higher likelihood of:

- Being upset and distressed as result of these difficulties.
- Feeling that these issues interfered with their learning and/or friendships.
- Having other health issues.
- Reporting difficulties with schooling such as not liking school, feeling unsafe, afraid, being hurt or bullied, not feeling like they were a part of their school community and that their teachers cared about them.[56]

There is a body of research highlighting the important role that schools play in enabling early access to mental health supports for children and young people, including:

- Identifying early signs of mental health issues and other problems that children and young people are experiencing.
- Guiding students and parents to be able to access appropriate supports.
- Providing a platform for children and young people to learn key self-regulation, resilience and social emotional skills.

Although not addressed in the issues paper, children and young people with parents with a mental illness are also at risk in terms of educational engagement and attainment, influenced by the additional caring responsibilities these children and young people often have within the family home. Schools also play in role in supporting young carers with their education.

> *"Schools are not helpful...the school doesn't understand what goes on at home. They expect me to do assignments but sometimes I have to take care of my newborn sister or the other kids or try to stop dad from hurting himself or running away."*Young person (Mental health consultation)

There are a range of barriers that exist for children and young people in accessing support, some of which I have spoken about previously in this document. However, in a school context, this may include limited resourcing within the school to provide individualised psychological support to students, lack of awareness about supports

---

[56] Commissioner for Children and Young People 2018, *School and Learning Consultation: Technical Report*, Commissioner for Children and Young People WA, Perth.

within the schools, and concerns about being "seen" by other students going to the school psychologists office.[57]

> *"The reason why I didn't go and get help? Embarrassment and not enough awareness on what I had."* Young person (Mental health consultation)

> *"I don't want to go to an office, someone might see me."* Young person (Mental health consultation)

Students also often lack an understanding about the signs and symptoms of mental health issues, and have spoken with my office about wanting more education about mental health issues within their school and class content, as well as the support services that are available to assist them. Given the prevalence of mental illness in early childhood and amongst younger children, it is important that this kind of education is provided in both primary and secondary schools.

The most effective mental health interventions and supports occur as part of a whole-of-school approach to mental health and wellbeing, which includes support for individual students, whole-of-school programs, staff training and capacity building, and student-specific programs developed to establish peer-support. There are a range of mental health programs in place in schools across Western Australia, many of which have a strong evidence base behind them. However, there is often poor and ad hoc uptake, inconsistent messaging about benefits of programs and need, and a huge number of initiatives for schools to choose from. Often programs and activities are delivered once-off to teachers or students, rather than being embedded as part of the principles and functions of our education system. Many of these initiatives also lack any comprehensive longitudinal evaluation, either because the measurement of outcomes is not established, or because the initiatives are not sustained over time, making it difficult to determine which of these are most effective in improving outcomes.

More recently, the Commonwealth Government has invested in the Beyond Blue National Education Initiative, which supports a whole-of-school approach to student mental health and wellbeing from the time they enter the school system. This is an important initiative, however requires close monitoring and review of resourcing to support uptake and implementation across the Australian education sector.

Schools can also play an important role in first spotting or recognising the symptoms of mental illness or distress, and ensuring children and young people are linked in with the supports they require. Whilst many schools have psychologists or student wellbeing workers, these positions are often small in number, and do not have adequate resources to be able to provide an individualised response or support to each child or young person experiencing challenges within the school.

> *"More preventative mental health care [is needed]. A lot of times schools and work places are not willing to start helping children with their mental health issues until it is actually a big serious problem."* 17 year-old (Mental health consultation)

The HeadStart Newham initiative in the United Kingdom is an innovative example of the way that mental health services can work alongside schools to provide whole-of-

---

[57] Commissioner for Children and Young People 2017, *Co-designing technologies to support the mental health and wellbeing of children and young people,* Commissioner for Children and Young People WA, Perth.

school supports, as well as work to identify, support and intervene with students with emerging mental illness. This initiative is still in its early iterations, however the evaluation of the project, and the impact that it has, is welcomed.

Given the majority of children and young people are more likely to disclose mental health concerns or issues to their peers or family members, there is further opportunity to explore the role of peer education and support programs, in addition to those for families, as a way of equipping friends and family members with the tools and skills that they need to support their loved ones.

Coordination and integration

Fragmented service provision and poor collaboration between agencies is challenging and confusing for families, and can actually discourage children and young people and their families from engaging. Current governance structures have done little to improve fragmentation, with limited planning and coordination occurring both within and between different Government agencies and non-Government organisations to address the holistic wellbeing of infants, children and young people with a mental illness, or provision of coordinated supports for people with complex or co-occurring needs.

> *"You know how [my son] is involved with justice system, so you have Corrective Services or whatever generally for education, housing and DCP, that's a bit confusing but there's like 20 different people every day. Well maybe there could be a service that's involved in that area, where they can get one person to deal with that family and their issues, and have one person allocated to that family... and communication can be done by that one person because it does get overwhelming." Mother (Youth Justice Consultation)*

The complex problems facing many children and young people are best addressed through coordinated multi-agency responses and service provision, and hearing from children and young people about the supports that they require. These responses need to be flexible and responsive to the changing needs and requirements of children and young people and their families.

Funding arrangement

There has been a chronic and consistent underfunding in infant, child and youth mental health across Australia. Failure to intervene early in the life course and in presentation of symptoms will lead to higher costs in tertiary mental health systems, as well as significant costs to the wellbeing of the individual.

The nature of funding models often prevents organisations from offering the continuum of services required by their clients or community members, and from addressing the other factors and social determinants impacting on their health. Moving towards place-based funding for locally identified initiatives would present better opportunity to achieve integration and collaboration of services. This would include financial commitment across Government agencies to achieve better integration of services delivered at a local level.

Addressing issues related to complex trauma, or supporting children and young people with complex needs, requires significant investment. The current Medicare scheme supports people with a mental health issues with rebates for up to 10 individual sessions with a registered psychologist, however this number of sessions is not sufficient to address the complex issues that many people face, and their need for

support will mean that they are required to pay full fees to access further sessions, which is not financially viable for many young people or their families.

Monitoring and reporting outcomes

There are significant gaps in terms of the data that is collected or reported on the mental health and wellbeing of infants, children and young people, or the prevalence of issues that they experience. These data sources are critical in terms of understanding the mental health experiences of infants, children and young people, and being able to monitor changes or patterns in prevalence data over time. This information is also required to be able to appropriately measure the number and nature of services required, and to guide service provision. Any data collection also needs to be able to highlight or ascertain any other co-existing issues or comorbidities.

It is similarly difficult to obtain a clear picture of the extent of, or expenditure on, mental health services and programs that exist for infants, children and young people.[58] Where data is available, key performance indicators and service reporting often outline the number of children and young people accessing services, readmission rates, and length of service, however little data is captured or publicly reported on the impact of services on their mental health outcomes. This means there is limited transparency or accountability in terms of whether the services being provided are actually meeting the requirements of infants, children and young people, or whether they are achieving the outcomes that they set out to improve.

It is strongly recommended that monitoring and reporting on outcomes is based on measures which hear directly from children and young people about their own experiences of mental health.

Summary

I thank you for the opportunity to contribute to the Productivity Commission's Inquiry, and provide my perspectives on the mental health of infants, children and young people. My office will be conducting a range of further work this year that has relevance to this Inquiry, including reflecting on progress made towards recommendations of the 2015 *Our Children Can't Wait Report*, further development of our Wellbeing Monitoring Framework, state-wide consultation with children and young people about their lives and experiences, involvement in a suicide modelling project, and a project exploring the role that schools play in supporting mental health and wellbeing of students. I would be happy to discuss these projects further with you if they are of interest, or details can be found on our website.

Yours sincerely

COLIN PETTIT

Commissioner for Children and Young People WA

5 April 2019

---

[58] Commissioner for Children and Young People 2011, *Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia,* Commissioner for Children and Young People, Perth.