WAAMH

Western Australian Association for Mental Health

Western Australian Association for Mental Health

Submission: Draft Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan 2018–2025 consultation

February 2018

Contents

1. Background

The Western Australian Association for Mental Health (WAAMH) welcomes the opportunity to comment on the draft Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan 2018–2025 (Prevention Plan).

WAAMH is the peak body for the community mental health sector in Western Australia and exists to champion mental wellbeing, recovery and citizenship. WAAMH recognises a continuum of supports - built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection - are essential to the promotion, protection and restoration of mental wellbeing. WAAMH promotes, advocates for and further develops this network of supports.

WAAMH's membership comprises community managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. WAAMH also engages a wide network of collaborative relationships at a state and national level with individuals, organisations and community members which share its values and objectives.

In putting together this submission, WAAMH offered all members the opportunity to provide feedback on the draft Prevention Plan; this submission incorporates the input from the responses received from WAAMH members, both individual and organisational. WAAMH would like to formally acknowledge the contributions made by its members.

WAAMH would like to commend the Mental Health Commission (MHC) on elements of the Prevention Plan, including:

- A focus on increasing funding for promotion and prevention in the areas of mental health and alcohol and other drugs;

- A life course approach;

- The incorporation of a range of strategies, including whole-of-population, localised and targeted programs and initiatives;

and

- An acknowledgement of agreed principals in health promotion, such as the Ottawa Charter.

The following document offers a number of recommendations to enhance the content of the Prevention Plan. These recommendations are summarised in the table below, and are addressed in full in the subsequent submission.

Summary table: Recommendations

Recommendation 1:	That the Prevention Plan include specific and measurable outcomes, targets, and time lines to guide the implementation of the strategies and include a clear governance framework.
Recommendation 2:	That information be provided about what strategies have already been addressed, which strategies are considered a priority for WA, and what services already exist to address particular strategies.
Recommendation 3:	That the language in the Prevention Plan be modified to create a more inclusive document which supports an integrated approach to mental health and AOD use.
Recommendation 4:	That dual-diagnosis be formally acknowledged within the document, and specifically included in strategies outlined in the Prevention Plan.
Recommendation 5:	That the Prevention Plan have a greater focus on the social and environmental determinants, including those for Aboriginal and Torres Strait Islander people, and recognise the widespread prevalence and impacts of trauma on the consumers and families.
Recommendation 6:	That the Prevention Plan include clearly articulated strategies to facilitate multisector collaboration to address the social and environmental determinants of health to improve mental health and AOD use.
Recommendation 7:	That the Prevention Plan include strategies to address social isolation and exclusion, including in the older adult age group.
Recommendation 8:	That the Prevention Plan include strategies which address the built and natural environments, and promote and facilitate interactive, safe, inclusive environments across the life course.
Recommendation 9:	That the Prevention Plan provide more detailed strategies addressing employment, and include strategies relevant to young people.
Recommendation 10:	That the Prevention Plan Link the Prevention Plan to the WA Aboriginal Health and Wellbeing Framework 2015 – 2030, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023.
Recommendation 11:	That the strategies for all priority populations be revisited and increased in consultation with these groups, taking a systemic approach with a focus on social and environmental determinants.
Recommendation 12:	That the Prevention System Supports section be revisited, with a focus on Workforce Strategies and Priority Groups.
Recommendation 13:	That the Prevention Plan explicitly emphasise the importance of co-design across all the life stages, with co-design incorporated into the Prevention Plan strategies.
Recommendation 14:	That the Prevention Plan provide definitions of co-design and coproduction, and include them in the glossary.
Recommendation 15:	That the concept of recovery be addressed within the Prevention Plan, and that strategies which clearly incorporate recovery-oriented principles be created.
Recommendation 16:	That thorough consultation with suicide specific services in WA be conducted to inform this section of the Prevention Plan and the corresponding strategies.

Recommendation 17:	That the Prevention Plan use the same age streams as the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.
Recommendation 18:	That the Prevention Plan include youth-specific strategies.
Recommendation 19:	That a thorough consultation process be conducted to inform the direction and content of the Prevention Plan before it is released (in addition to the current consultation period), including public engagement with consumers, carers and families.
Recommendation 20:	That information be made available regarding the stakeholders involved in the development of the Prevention Plan.
Recommendation 21:	That the wording of this information be changed to reflect the true statistics.

2. Lack of accountability, outcomes and existing activity

To call this a plan is a misnomer, as there are no outcomes, accountabilities or metrics, no governance, and no funding associated with the strategies outlined in the document. The document reads more as a guideline, outlining strategies which the MHC would like organisations to align with. The Prevention Plan itself states that it provides a, "guide for all stakeholders… in the development and implementation of effective, evidence-based prevention activity" (p. 4). However, as a guideline it is very generalised; to best enable implementation the accessibility of the document could be improved.

While implementation of the strategies suggested in the document is meant to reside with a "range of stakeholders", with the MHC providing "high level oversite", it is difficult to envisage how this will be possible if there are no clear measures of outcomes provided, no defined targets, and no time lines for implementation. While organisations may choose to follow some of the strategies suggested in the Prevention Plan, the Prevention Plan does not articulate how the success of these initiatives will be measured, when outcomes will be followed up, and what outcomes would be considered sufficient to have fulfilled the purpose of the Prevention Plan.

The Prevention Plan is designed to cover a seven-year period. This time-period is very long, especially in the absence of any meaningful indication of how the progress of implementation will be assessed. It would benefit from a mechanism to take into account changes in priorities and practices over time and the need to adapt to changes in the mental health, alcohol and other drug (AOD) and prevention and health promotion spaces.

While the Prevention Plan refers to the fact that many of the recommended prevention initiatives are already being implemented across Western Australia, the provision of information about which initiatives currently exist or are underway would assist in implementation. As written, organisations have no way of knowing which strategies need to be addressed, what the priority initiatives are, or what other

organisations are working in the space. This significantly reduces the utility of the document.

It was also noted that the Prevention Plan does not make refence to, or link to, federal initiatives such as the work of the Primary Health Networks (except in relation to suicide), or the National Disability Insurance Scheme, which are relevant to preventative mental health and wellbeing and AOD services and programs. It is important that the Prevention Plan is aligned and integrated with these initiatives.

Recommendation 1: That the Prevention Plan include specific and measurable outcomes, targets, and time lines to guide the implementation of the strategies and include a clear governance framework.

Recommendation 2: That information be provided about what strategies have already been addressed, which strategies are considered a priority for WA, and what services already exist to address particular strategies.

3. Distinction between alcohol and other drug use and mental health

The inclusion of both AOD and mental health in the same Prevention Plan is welcomed. However, WAAMH has some concerns about the extent to which these have been effectively integrated in the document.

The Prevention Plan states that, “The MHC Prevention Model is premised by the fundamental difference between alcohol and other drugs and mental health. That is, alcohol and/or other drugs are commodities that may or may not be consumed by an individual, whilst mental health is an inherent part of being human” (p. 3).

WAAMH believes that this an unhelpful distinction to make and does not align with current best practice approaches to mental health and alcohol and other drug (AOD) use, while also explicitly ignoring the importance of co-occurring conditions and dual diagnosis. This distinction is problematic for a number of reasons.

Referring to alcohol and drugs as ‘commodities’ makes an implicit value judgement on the use of these substances, while also minimising the truth of addiction as a physiological, medical, and psychological reality for many people. This view places the full responsibility of AOD use solely on the individual, ignoring the important role of biological, social, environmental, psychological, and genetic factors that are associated with substance use (Office of Disease Prevention and Health Promotion, 2018).

The Prevention Plan consistently uses language which refers to mental health and AOD as two distinct and separate domains. The distinction segregates the two issues rather than aligning them, which does not correspond with current

understandings of co-occurring mental health and AOD conditions. It also does not reflect state and federal policy to establish an integrated approach to mental health and AOD; reform examples include the merger of the Mental Health Commission and the Drug and Alcohol Office, and improving integration through Primary Health Networks.

Contemporary approaches to AOD use, and mental health, either alone or as co-occurring conditions, acknowledge that there is significant overlap between the two, and that there may be factors that are common to both the AOD and mental health condition, increasing the likelihood that they will co-occur (Marel et al., 2016). It is widely accepted that the division in the health sector between mental health and AOD use is a barrier to accessing and providing treatment (Baker & Kay-Lambkin, 2016). The siloing of MH and AOD use problems has been identified as perpetuating stigma surrounding dual diagnosis and can prevent people with co-occurring mental health and AOD issues from accessing appropriate treatment (Commonwealth of Australia, 2006).

It is important that any health promotion and prevention strategy tackling mental health and AOD issues addresses and clearly aims to improve awareness and reduce stigma surrounding co-occurring conditions, as this will help to facilitate better access to services for at-risk individuals. The Prevention Plan should include information and strategies which address co-occurring conditions, given that research indicates that more than one-third of individuals with an AOD use problem have at least one comorbid mental health condition, and that rates may be even higher among those in drug and alcohol treatment programs (Marel et al., 2016).

Recommendation 3: That the language in the Prevention Plan be modified to create a more inclusive document which supports an integrated approach to mental health and AOD use.

Recommendation 4: That dual-diagnosis be formally acknowledged within the document, and specifically included in strategies outlined in the Prevention Plan.

4. Social and environmental determinants of health

The Prevention Plan mentions the social and environmental determinants of health, which is welcomed. However, the Prevention Plan requires improvements to adequately address these in the strategies presented.

The influence of social and environmental determinants on mental health and AOD use is widely acknowledged (Rickwood et al., 2008). Mental health and many common mental disorders, and AOD use, are shaped significantly by the social, economic, and physical environments in which people live, and social inequalities are associated with increased risk of many common mental disorders (Spooner &

Hetherington, 2004; World Health Organization & Calouste Gulbenkian Foundation, 2014). Importantly, common causal pathways exist between mental health problems, suicide, and harmful substance use, in terms of the social determinants of health (Rickwood et al., 2008).

The centrality of social determinants and their impact on mental health is of key concern to consumers, carers and family members; it is one of the major themes that is repeatedly emphasised in our engagement with people with lived experience. Social exclusion, lack of appropriate housing options and homelessness, low income, interrupted education and poor labour force participation, stigma and poor physical health are all associated with the lived experience of mental health conditions (NMHCCF, 2011).

The NMHCCF (2011) has stated that mental health consumers with psychosocial disability and their carers require systemic policy approaches to redress community stigma and social exclusion. Policies must focus on recovery and aim to maximise the capabilities of each consumer and carer (NMHCCF, 2011), and as suggested by Professor Michael Slade, Professor of Mental Health Recovery and Social Inclusion, Faculty of Medicine & Health Sciences at the University of Nottingham, this approach should be viewed as an integral part of primary prevention for mental health and wellbeing (Coopes, 2017)

Effective prevention of harmful substance use needs to focus on social determinants and multiple risk and protective factors (Rickwood et al., 2008). Prevention focused solely on changing individual behaviours, has a limited impact when changes are not made to the social determinants of drug use, such as the social and cultural environment, the economic environment and the physical environment (Poznyak, Saraceno & Obot, 2005; Spooner & Hetherington, 2004).

Addressing the social and environmental determinants of health and making the settings of daily life more supportive of good health has long been a fundamental principle of health promotion (VicHealth, 2015). It is therefore disappointing that the Prevention Plan does not give more consideration to social and environmental determinants and strategies to address them. Addressing social and environmental determinants should be a key focus of the strategies across all the life course stages, and strategies should clearly articulate the need for multisector collaboration to address the social and environmental determinants of health to improve mental health and AOD use, and specific strategies on how to facilitate this collaboration.

4.1 Social exclusion and isolation

A specific example of the absence of key social and environmental determinants from the Prevention Plan is the failure to mention of loneliness, social isolation or social exclusion, which the evidence shows is a key issue for mental health

(Brophy 2017). This is particularly the case for Older adults, with research showing that social isolation among older people increases the risk of poor mental health and AOD use in this age group. Loneliness in older people is linked with depressive symptoms, poor mental health and cognition, alcoholism, suicidal ideation, and mortality (World Health Organization & Calouste Gulbenkian Foundation, 2014). It is recommended that the Prevention Plan include strategies to address social isolation and exclusion, including for Older adults.

4.2 Physical environment

It is noted that there is nothing in the Prevention Plan that specifically addresses the built and natural environments, and in particular, the environmental determinants of health for children and young people despite the consistent evidence that the built and natural environments have an effect on physical and mental health (World Health Organisation, n.d.), and that access to green spaces is positive for child and youth mental health.

Evidence consistently shows that green spaces such as parks and gardens have positive effects on mental health outcomes, and in children and youth access to urban green spaces has been shown to increase attention and self-regulation, reduce emotional problems, and promote emotional wellbeing (National Collaborating Centre for Environmental Health and National Collaborating Centre for Determinants of Health, 2017). Green spaces may benefit mental health by reducing exposure to air pollution, noise and stress, and through enhanced physical activity, social networks and social participation (Dadvand et al., 2015).

In line with the need to give a greater focus to social determinants in the Prevention Plan, there should be corresponding increase in strategies which address environmental determinants and the built and natural environment, and promote and facilitate interactive, safe, inclusive environments across the life course.

4.3 Employment

Studies have shown correlation between employment and better health outcomes, improved self-confidence, self-esteem and happiness (Pharr, Moonie & Bungum, 2012). Employment can prevent social exclusion, isolation, poverty, long term dependency and homelessness, improve access to better healthcare and recreation, reduce stigma and discrimination.

Individuals attribute self-worth to being productive working members of their community. Being employed satisfies a psychological need – a need that must be filled to maintain good mental health. Employment strategies aligned with mental

health promotion and prevention goals are applicable to youth and school leavers as well as people of working age.

WAAMH acknowledges the strategies within the Prevention Plan that address employment in the 'Across the Life Course' and 'Adult' sections. It would be useful for the Prevention Plan to enhance these strategies, and to include strategies focused on employment in relation to young people, as this is also key population for whom employment is relevant.

4.4 Trauma

The very high rates of trauma amongst people with mental health issues is increasingly understood; the acknowledgement of this is a key concern for mental health consumers and requires inclusion in the Prevention Plan. Victorian consumer groups have identified that "experiences of past trauma are the single most prevalent problem facing consumers of publicly funded mental health services. Trauma is a more widespread issue than unemployment, more common than housing instability, more frequent than substance use" (Consumer Workforce Partnership Dialogue Forum, 2015).

4.5 Aboriginal and Torres Strait Islander perspectives

The social and cultural determinants of mental health from an Aboriginal and Torres Strait Islander perspective are different, and especially important given the disproportionate impact of mental health, AOD use and suicide in Aboriginal communities. They include cultural determinants such as connection to culture, country and community (Commonwealth of Australia, 2017). It is appreciated that the Prevention Plan acknowledges Aboriginal social and emotional wellbeing. It would be useful for the Prevention Plan to elaborate on this, with clear connections to the cultural, social and environmental determinants of health, and corresponding strategies within the Prevention Plan.

There is also an opportunity to link the Prevention Plan to a number of key documents that address Aboriginal and Torres Strait Islander social and emotional wellbeing, including the WA Aboriginal Health and Wellbeing Framework 2015 – 2030, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023. This would help to strengthen this element of the Prevention Plan, by offering additional information.

Recommendation 5: That the Prevention Plan have a greater focus on the social and environmental determinants, including those for Aboriginal and Torres Strait Islander people, and recognise the widespread prevalence and impacts of trauma on the consumers and families.

Recommendation 6: That the Prevention Plan include clearly articulated strategies to facilitate multisector collaboration to address the social and environmental determinants of health to improve mental health and AOD use.

Recommendation 7: That the Prevention Plan include strategies to address social isolation and exclusion, including in the older adult age group.

Recommendation 8: That the Prevention Plan include strategies which address the built and natural environments, and promote and facilitate interactive, safe, inclusive environments across the life course.

Recommendation 9: That the Prevention Plan provide more detailed strategies addressing employment, and include strategies relevant to young people.

Recommendation 10: That the Prevention Plan Link the Prevention Plan to the WA Aboriginal Health and Wellbeing Framework 2015 – 2030, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023.

5. Priority populations

While the Prevention Plan makes special mention of priority populations, the strategies for these populations is very inadequate.

The strategies outlined for priority groups are very generalised, lack detail and direction, and do not sufficiently address the unique and specific needs of the individual priority groups addressed. They also place undue emphasis on individual behaviour change and fail to adequately address wider systemic strategies for change, especially in relation to the social determinants of health.

5.1 LGBTIQA+ community strategies

As an example, given the incidence of mental health issues, AOD use problems, and the higher rate of suicide amongst the LGBTIQA+ community (Rosenstreich, 2013), four brief dot points does not provide an authentic strategy for addressing the issues within this priority population. For many members within the LGBTIQA+ community issues of sexual health, mental health and AOD dependencies are intertwined and require a more comprehensive and nuanced approach than simply "increasing self-esteem" or promoting the "use of self-help".

More realistic examples of strategies for LGBTIQA+ groups should be co-designed. However, we offer for initial consideration some that have been

suggested to WAAMH by member organisations who specialise in working with this priority group. These are:

- Providing peer support mental health programs for people of diverse sexuality and gender;

- Using technology to link people of diverse sexuality and gender in rural and remote regions;

- Using social media to provide positive mental health messaging;

and

- Providing more alcohol & drug clinics at sexual health testing sites.

Strategies in this area should be comprehensive and address key social determinants, such as the strategies presented above which touch on social determinants including social inclusion and social supports (Wilkinson & Marmot, (eds.), 2003). They must take a systemic approach to supporting people in the LGBTIQA+ community to achieve positive mental health and AOD outcomes, without relying solely on individual behaviour changes. This is important, as health promotion activities based only on behaviour change alone may not be sufficient to inadequately address social inequities in health (Baum & Fisher, 2014).

5.2 People with disability

Similarly, the strategies suggested for people with disability rely almost exclusively on individual behaviour change. There is substantial evidence that systemic issues and social determinants of health play a significant role in the high prevalence of mental health and AOD use problems in this priority population, and as such strategies should reflect the need to address these wider factors.

For example, social connectedness and relationships have been shown to be are positive for mental health outcomes in people with disability (Tough, Siegrist & Fekete, 2017), and research has shown that the detrimental effect of disability acquisition on mental health is substantially greater for socioeconomic disadvantaged individuals (Aitken, Simpson, Bentley & Kavanagh, 2017). Prevention and promotion strategies could therefor aim to address social determinants such as social exclusion and socioeconomic disadvantage for people with disability, as well as strategies to help create and reinforce accessible and inclusive social environments.

These two priority groups are used as examples only. It is recommended that the strategies for *all* priority populations be revisited, taking a more systemic approach, with a focus on social and environmental determinants and wider system changes that can support improved outcomes to mental health and AOD use. Specific strategies should be co-designed with each priority group to ensure the strategies developed will be the most effective.

Recommendation 11: That the strategies for all priority populations be revisited and increased in consultation with these groups, taking a systemic approach with a focus on social and environmental determinants.

6. Prevention system supports

The Prevention System Supports section includes positives elements, including reference to multi-agency collaboration and cultural security; strategies to increase funding for prevention; and an emphasis on commitment to research in the area of mental health promotion and prevention. However, the section also misses key areas which need to be addressed.

We welcome the inclusion of Workforce development in the Prevention System Supports strategies. However, this section should include other, more comprehensive initiatives to equip staff members in the mental health and AOD sectors to deal with the priority groups. The existing workforce strategies in this section are very general and make no indication of a commitment to addressing the needs of priority groups.

As an example, the needs of LGBTIQA+ people have not been adequately addressed in this section. It is well known that many LGBTIQA+ people do not access services because they do not believe they are either understood or welcomed (Rosenstreich, 2013). Any strategy for addressing mental health and AOD issues and suicide must equip the workforce to deal sensitively with the needs of the different priority groups, by including specific workforce development strategies specific to LGBTIQA+ people.

Recommendation 12: That the Prevention System Supports section be revisited, with a focus on Workforce Strategies and Priority Groups.

7. Co-design

The important role of co-design in mental health and AOD prevention must be better addressed in the Prevention Plan.

Co-design is fundamental to the delivery of successful health promotion initiatives. Co-design ensures that programs meet the needs of specific population groups, and

effective co-design in health promotion also empowers communities as they become part of the prevention and health promotion process (VicHealth, 2017).

While the Prevention Plan briefly mentions co-design (page 21), there is no further mention of co-design throughout the document and the recommended strategies. Given the important role of co-design in creating effective, responsive and meaningful interventions (WA Council of Social Services, 2017), the Prevention Plan should explicitly emphasise the importance of this process across all the life stages and in the implementation of all the suggested strategies. Additionally, it is important that definitions of co-design and coproduction are provided in the Prevention Plan and included in the glossary.

Recommendation 13: That the Prevention Plan explicitly emphasise the importance of co-design across all the life stages, with co-design incorporated into the Prevention Plan strategies.

Recommendation 14: That the Prevention Plan provide definitions of co-design and coproduction, and include them in the glossary.

8. Recovery

It is noted that the Prevention Plan does not address the concept of recovery (in relation to mental health, AOD use or co-occurring conditions). There is an important role for health promotion in reinforcing the concept of recovery in the mental health and AOD spaces, and this should be reflected in the Prevention Plan strategies.

WAAMH acknowledges that variation on the understanding of ‘recovery’ exist between the mental health and AOD fields, but broadly the concept encompasses the individual journey to fulfil and strengthen connectedness, hope and optimism about the future, identity, meaning in life, and empowerment in the context of mental health and or AOD use problems. There is considerable variation in terms of individual timelines and pathways to recovery, with recognition that, in most cases, recovery is an ongoing journey rather than an accomplished state (West & Lubman, 2012).

Health promotion and prevention activities can play a significant role in supporting the concept of recovery and reinforcing initiative and programs which promote and strengthen a recovery-oriented system (Australian Health Ministers’ Advisory Council (AHMAC), 2013). Recovery-oriented approaches can be implemented across the full spectrum of services, and at all stages of service delivery, including prevention and health promotion (AHMAC, 2013). For example, promoting a culture and language of hope and optimism which makes people feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism is central to recovery-oriented service delivery (AHMAC, 2013).

Recommendation 15: That the concept of recovery be addressed within the Prevention Plan, and that strategies which clearly incorporate recovery-oriented principles be created.

9. Suicide

Feedback has been provided to WAAMH by services which specialise in or work in the area of suicide prevention, in relation to the suicide-specific information provided in the Prevention Plan. The following section reflects this feedback.

Given that the audience for this document (as outlined on page 7 of the Prevention Plan) includes organisations not familiar with suicide prevention, it has been suggested that the discussion on the LifeSpan model and EEAD model and their relationship to the Suicide Prevention 2020 is superficial and creates confusion. This section seems to be striving to show how these models are in principle similar OR how this Plan integrates the fundamentals of all three. However, the discussion around these models remains descriptive, and requires greater clarity to achieve these aims.

The suicide section of the Prevention Plan document overlooks the role of the Mental Health Network and the Statewide Suicide Prevention Network, which seems a lost opportunity in the context of the intention of the Prevention Plan and the related work of both groups. This is an example where the Prevention Plan would benefit by providing information about existing initiatives and organisations currently working on the strategies suggested in the Prevention Plan.

Recommendation 16: That thorough consultation with suicide specific services in WA be conducted to inform this section of the Prevention Plan and the corresponding strategies.

10. Age streams and lack of youth focused strategies

It is noted that the age streams used in the Prevention Plan do not align with those outlined for implementation in WA's flagship mental health plan, the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (the Plan). This may create confusion during the implementation of the Prevention Plan, and creates discrepancies between the two documents, when they should ideally complement each other.

The Prevention Plan currently divides strategies according to "Priority areas for action", comprising:

- the Perinatal and the Early Years (0-3 years old); Children and young people (4-18 years old); Adults (18 – 65 years old); and older adult (65 years and above).

However, the 2015-2025 Plan states that while currently, “mental health services are generally provided in three age streams: infant, child and adolescent (0-17 years); adult (18-64 years); and older adult (65 years and above)”, the aim of the Plan is to, “…configure the existing and new mental health services into the following new age streams: infant, child and adolescent (0-15 years); youth (16-24 years); adult (25-64 years); and older adult (65 years and above) as soon as possible, in order to introduce a new, dedicated youth stream” (Western Australian Mental Health Commission (WAMHC), 2015). The Plan further explains that, “All services will be expected to meet the needs of young people with co-occurring mental health, alcohol and other drug problems. Youth mental health services must also have the capability to identify and treat early psychosis” (WAMHC, 2015).

It would seem prudent for the Prevention Plan to support the goals of the Plan, which was strongly supported by the community mental health sector following its release in 2015. Not only would this enable the aims of the Plan to be achieved, it would also ensure that initiatives undertaken as part of each plan would align and complement one another.

It also noted that the Prevention Plan does not include a Youth-specific section, despite the wide range of existing services which provide for this age stream, the strong rational for targeting the youth age stream, and the referencing of this age stream in the Plan. The economic imperative of preventing youth mental health issues before they arise should alone be sufficient to justify a very strong focus on youth prevention. Youth is defined as “ages 16 to 24 years (Mental Health)” and “ages 12 to 17 years (Alcohol and Other Drug)” in the Plan.

Youth experience the highest prevalence and incidence for mental illness across the lifespan. Research has shown that 75 percent of people suffering from an adult-type mental disorder (including psychosis, substance use, mood and anxiety disorders) had an age of onset by 24 years (McGorry, 2006). Young people with co-occurring conditions are at higher risk of poor outcomes because their age and stage of physical, neurological, psychological and social development makes them vulnerable. Studies across the developed world show that young people do not engage well with adult services (Singh & Tuomainen, 2015), and that there is a risk of not being able to access appropriate services when young people are lost in the gap between child and adult mental health services.

The Plan identified that increasing service capacity to meet the needs of young people, and the expansion of dedicated youth mental health, alcohol and other drug services across all service streams are urgent priorities to progress. A number of leading mental health services for young people operating in WA provide services

and health promotion activities aimed at a different age-stream to the Prevention plan, such as headspace and Youth Focus (young people aged 12-25). We urge inclusion of a youth-specific section in the Prevention Plan, to align with the priorities of the Plan, and to correspond with key youth-based services already operating in WA.

Recommendation 17: That the Prevention Plan use the same age streams as the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.

Recommendation 18: That the Prevention Plan include youth-specific strategies.

11. Consultation processes

Details about which stakeholders were consulted in the development of the Prevention Plan are vague, and do not provide sufficient information to assure readers of the document that the strategies and proposed initiatives have been informed by the diversity of the sector, consumers, carers and families.

In WAAMH's consultation with other organisations and service providers in the community mental health sector to inform this submission, it became apparent that there was little knowledge of who had been consulted, and that key groups in the sector had not been approached as part of the development process. Similarly, it was felt that a significant proportion of the content in the Prevention Plan did not reflect current approaches in or needs of the community mental health sector, which may be accounted for by insufficient consultation with relevant stakeholders.

Recommendation 19: That a thorough consultation process be conducted to inform the direction and content of the Prevention Plan before it is released (in addition to the current consultation period), including public engagement with consumers, carers and families.

Recommendation 20: That information be made available regarding the stakeholders involved in the development of the Prevention Plan.

12. Incorrect data

On page 39 of the Prevention Plan data has been incorrectly presented in relation to AOD harm in the older adult age group.

The Prevention Plan states, "Recent data suggest the prevalence of adults in the 50-59 year age group consuming more than 11 standard drinks over a month has increased from 4.1% in 2013, to 5.8% in 2016".

Actual data from the sited source states, “The proportion of people in their 50s (9.1% to 11.9%) and 60s (4.7% to 6.1%) consuming 11 or more standard drinks on a single drinking occasion in the past 12 months significantly increased between 2013 and 2016 (Table 4.13). This was also the case for people in their 50s in the last month (4.1% in 2013 to 5.8% in 2016)” (AIHW, 2017).

This data refers to the number of standard drinks consumed on one single drinking occasion, not over a month as presented in the Prevention Plan. The wording of this information should be changed to reflect the true statistics.

Recommendation 21: That the wording of this information be changed to reflect the true statistics.

13. References

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