Advocacy for children, adolescents and families

Tu-S-388
The advocacy role of the family consultant in mental health systems: From clinical collaboration to advising government
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In Australia, Victorian State Government Mental Health Policy has embedded consumer and carer participation throughout its key domains. Policy stipulates that consumers and carers are actively involved in the development, planning, delivery and evaluation of services. Accordingly, in 2009 the Victorian Government provided funding for all Victorian Public Area Mental Health Services to employ Family/Carer Consultants within services, to work at individual, service and broader systemic government levels. This paper describes how the role of a Family/Carer Consultant, in the child and adolescent mental health area, has encompassed advocacy of the carer perspective, using a model of partnership with service users, clinicians, management and government. It discusses the achievements, challenges and dilemmas faced by a Family/Carer Consultant in advocating for improved service provision, and for accountability to those who use its services.

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Tu-S-389
Advocacy for child and adolescent mental health: The interplay of science, public opinion, human rights, legislated entitlements and professional interests: Trends in the USA
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Advocacy arises from the interplay between evolving public awareness of the challenges children face (often fostered by literature and other media), evolving clinical and scientific knowledge of effective interventions, and evolving political strategies. In this presentation, three periods of advocacy in the United States will be described. In a pre-professional period, before the child mental health disciplines arose, lay people created the field of advocacy and effected substantial reforms. In the professional period, specific services for children developed and children’s services expanded, often under medical auspices and buttressed by entitlement legislation. In the current phase, reaction to fragmented and professionally driven services created a new sphere of advocacy and service delivery. In this movement, parents have a larger voice and professionals a smaller one. The disconnection between this sphere and the academic-professional sphere will be described. In a pre-professional period, before the child mental health dis-

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Tu-S-390
A strategic proposal to advocate for increased funding in child and adolescent mental health
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One of the principal objectives of advocacy is to achieve a greater allocation of government resources to child and adolescent mental health. Because of the rigidities necessarily embedded in government financial planning, it is easier for government to re-allocate resources than to obtain completely new resources. It is also easier to re-allocate resources within a program or activity area than to transfer resources from one activity area to another. For the child and adolescent mental health field, this means the re-allocation of resources within the overall health budget, and most easily within the mental health budget. This presenta-
tion proposes that achieving such re-allocation would be facilitated if child and adolescent mental health advocates had allies within the health sector more generally. This needs to be explored. Professional groups likely to be receptive to the idea of increasing resources for child and adolescent mental health are general medical practitioners and paediatricians.

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Tu-S-391
Challenges facing IACAPAP in advocating for improvements in child and adolescent mental health in communities across the world
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Advocacy for child and adolescent mental health has been fraught with inter-

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Trauma and children

Tu-S-392
Public health emotional trauma initiatives: Bringing evidence to the community
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From global perspective large-scale natural disasters such as cyclones, floods or wildfires are reasonably common and invariably impact many children and families. Service providers and clinicians intuitively, or by experience, realise such events are associated with substantial mental health morbidity. However, very few services have sufficient surge capacity to meet the post-disaster service provision need. We will detail the model of care of an experienced Australian disaster response team highlighting a stepped care model that provides both low intensive universal and indicated responses as well as early interven-
tion services. Services featured will include our evaluation of a new program “Disaster Recovery Triple P” (the Positive Parenting Program) and our manuali-
sed Trauma-Focused CBT program. How the model is delivered “on the ground” will be emphasised including the central role of schools in screening and as a site for child therapy.

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