

Emerging Minds Response to the Productivity Commission

April 2019

Emerging Minds is a national organisation dedicated to advancing the mental health of Australian infants, children, adolescents and families. Emerging Minds develops innovative education and training materials, knowledge translation strategies, health promotion programs and implementation/change management resources for organisations, professionals, children, young people and their families. We partner with family members, national and international organisations to implement evidence-informed practice in the Australian context.

Emerging Minds is funded by the Department of Health to lead the National Workforce Centre for Child Mental Health. Through this program, Emerging Minds is developing workforce support resources for health, social and community services to:

- improve mental health literacy around child mental health, trauma and adversity
- apply a continuum of promotion, prevention and early intervention supports for children at risk of or experiencing mental health conditions and trauma; and
- advance multi-generation focused practices and interventions for children and families.

These resources are targeted at:

- child health and development services
- child mental health services
- adult mental health services
- alcohol and other drug (AOD) services
- services working with families experiencing family and domestic violence
- child wellbeing and protection services
- primary care settings
- services responding to community trauma incidents (e.g. natural or man-made disasters)
- services supporting parents experiencing severe or chronic health difficulties
- social services for children and families
- Family Relationship Services
- Disability Services
- Long-term support for the continued development, refinement, implementation and evaluation of these strategies will support Australia's leadership in this area. However, a number of implementation barriers to this work have been identified:
- Health and social service professionals are being restricted by funding and/or organisational systems requiring them to focus on individual, rather than child, family or multi-generational centred care.
- Multi-generational and family focussed interventions are not included in or supported by the MBS/NDIS.
- Services for adults and services for children rarely work together to provide wraparound support for the whole family due to a range of professional, organisational and systemic barriers.
- Most health and social service professionals are trained to react to presenting issues, rather than integrate pro-active or preventative responses.
- Data and client management systems are not designed for family or multi-generational focused practices and interventions.

Emerging Minds recognises that many reform efforts have articulated a commitment to promotion, prevention, early intervention and treatment. However funded service delivery remains focused on responding to the impacts of mental illness on the *individual*, with priority attention being given to adults and (to a growing, but lesser extent) adolescents. Data is showing that these investments are not resulting in changes to the mental health of the Australian population. There is a need to balance investments in strategies that support *mental prosperity* as a resource for society's productivity alongside current strategies to manage the impact of mental illness on the community.

Emerging Minds recommends a much stronger investment in 'early action' to support the mental health of current and future generations, with a focus on addressing the prevention and treatment gap in infants and children. This includes:

Recommendation 1: Early action, early in life

- Due to the brain's heightened sensitivity to its environment, the first years are critically important for brain development and the development of other bodily systems.
- Exposure to high-stress events and environments early in life can alter organ systems which have lasting impacts on mental and physical health.
- The quality of early caregiving relationships plays a critical role in shaping a child's behaviour, mental health, future productivity and future parenting.
- Adverse Childhood Experience (ACE) studies have found that persons exposed to early traumatic experiences in childhood, including child maltreatment, parental mental illness or substance use, domestic violence, parental separation, and incarceration of a household member were at higher risk of:
 - suicide
 - substance use; and
 - mental illness.
 - and comorbid physical illnesses such as cardiac, respiratory and metabolic diseases resulting in reduced life-span and productivity
- ACE studies have also found that the specific risk factor is less important than the cumulation of adversities in regard to capacity to cope with life's challenges.

A range of investments have been made across governments and services to support early childhood development including prenatal care, child health and development services, family home visitation programs, parenting programs, parental leave, programs for at-risk families, access to quality early childhood education and care, welfare services, and environments that support child/family community participation and engagement.

A number of cost-benefit studies internationally have demonstrated good 'return on investment' for many of these programs and policy responses across a broad range of human development, health and mental health domains.

In practice, the delivery of these programs to support infant and child mental health are challenged by:

- the need to match the outcomes achieved in research trials with real-world service settings
- mismatched intensity of support (e.g. low intensity universal programs being delivered to families with multiple and complex needs)
- coordination of efforts, with many funders funding many different programs and organisations to deliver services
- investment in high-cost packaged programs (often from overseas), rather than translating the evidence into 'core practices' that better reflect their use in service delivery
- programs outside of the mental health system which do not explicitly pay attention to, or measure, the impact of programs and services on the mental health and resilience of infants and children (e.g. parenting programs tend to focus on 'parenting skills' or on 'child safety' as outcomes); and
- shortages in tertiary services (in mental health and child protection) resulting in many of the prevention and early intervention programs 'holding' and 'responding' to the needs of complex populations. This leads to:
 - prevention investments not being delivered to the intended populations
 - children and families with severe presentations being managed by services who cannot offer the intensity or quality of support required to achieve improved mental health outcomes.

Recommendation 2: Early action in the life of mental health problems

- Half of all lifetime mental health conditions emerge in childhood.
- 1 in 7 Australian children under 12 experience a mental health condition.
- Emotional and behavioural disorders are the leading cause of disability-adjusted life years (DALYs) in Australians aged 5–14 years.
- Prevalence of mental health conditions is not decreasing.
- Mental health problems in childhood contribute to inequalities in health, social, developmental and educational outcomes.
- Mental health difficulties in childhood often persist into mental and physical health conditions that continue through adolescence and into adulthood, increasing health, social, economic and human development inequalities across the lifetime and across generations.
- Mental health promotion and prevention interventions for children and adolescents have been found to be effective, including screening (when there are appropriate and timely responses), psychological intervention and bibliotherapy for the prevention of childhood and adolescent depression, and parenting interventions for the prevention of childhood anxiety and conduct disorders.
- Current investments are not designed to respond to the age range during which a majority of mental health problems are likely to emerge (childhood).

Early intervention

Half of all lifetime mental health problems emerge in childhood. See table below with typical age ranges for first presentations of mental health problems.

Type of disorder	Age (years)																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Attachment																		
Pervasive developmental																		
Disruptive behaviour																		
Mood/anxiety																		
Substance use																		
Psychosis																		

Australia has shown world leadership in early intervention, with significant investments in early intervention for the small group of adolescents who develop psychosis (0.5% of the population). However, equivalent investments in high prevalence presentations that emerge in childhood (e.g. depression, conduct problems, anxiety and trauma) have not been made. National investments in early intervention should also be made for high prevalence/high societal cost conditions such as conduct disorders and depression. Similarly, an emerging issue in Australia that warrants further attention is the small number of children under the age of 12 that have died by suicide.

Treatment early in life

A range of evidence-based interventions and practices exist for many of the mental health conditions experienced in childhood. These interventions can have lasting effects when delivered early in life. Despite this, only one in six children experiencing mental health conditions receive professional help. For the children that do receive help, it is often delayed, insufficient and only received by those with the most severe presentations.

In Australia, state-funded Child and Adolescent Mental Health Services (CAMHS) or Child and Youth Mental Health Services (CYMHS) provide specialised child and youth treatment and continuing care services for children and young people experiencing mental health problems. In general, these services are intended to cover birth-18 years in most urban and regional areas, and in some rural and remote services across Australia. Services primarily target children and adolescents with severe mental health problems. Infrastructure has been established to support service delivery across most geographical regions in Australia. Extensive data relevant to mental health outcomes is collected by clinicians in all CAMHS in Australia and programs such as the Australian Mental Health Outcomes and Classification Network help to collate these outcome measures for child and adolescent mental health services.

In general, CAMHS services in Australia (with similar trends internationally) are inadequately resourced to respond to the needs of the population that they are designed for, particularly children under 12. Despite intent to provide broader coverage across childhood, managing severe and acute mental health presentations in adolescent populations is prioritised.

In recent years, the Commonwealth has invested significantly in youth mental health services (Headspace) and increasing access to psychological treatment services for children and adolescents through the Access To Allied Psychological Services (ATAPS) and Better Access initiatives through primary health care. These services have been designed to intervene earlier and improve access to evidence-based services for children and adolescents at-risk of or experiencing mild to moderate mental health problems

Recent reviews show that, despite these investments, service access and coverage for infants and children remains significantly lower than population need (see table below). Similarly, data is also showing no change in the mental health status of this population over time, reflecting a likely mismatch between need and the level of intervention allowed/offered.

Age	Prevalence	Multiple risk factors indicative of requiring specialist mental health support (4+)	Current level of access to specialist mental health services
0-4	No current data A range of international studies indicate up to 16-18% meet levels of dysfunction highly suggestive of diagnosis	16.1% (0-1 yrs) 12.1% (2-3 yrs)	Commonwealth MBS Any provider 0.9% (0-4 years) ATAPS 0.3% (0-11 years) State Ambulatory 0.4% (0-4 years)

5-11	13.6% meet criteria for diagnosis	19.2% (4-5 yrs) 25.2% (6-7 yrs) 28.9% (8-9 yrs) 32.8% (10-11 yrs)	Commonwealth MBS Any provider 5.7% (5-11 years) ATAPS 0.3% (0-11 years) State Ambulatory 1.4% (5-11 years)
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The flow on effects of inadequate service coverage for infants and children means that children with moderate to severe mental health presentations are being 'held' by education settings, primary care settings, child protection or social-service settings. Children in these settings are not receiving the evidenced based, multi-disciplinary mental health interventions required to achieve improved mental health outcomes. There is a very high need for a parallel focus on increasing coverage *and* quality of services where the burden is highest.

Recommendation 3: Early action on the causes of mental illness

Substantial evidence exists regarding the impacts that inequality, poverty, disadvantage and discrimination have on mental health. These issues increase the likelihood of exposure to adverse childhood experiences and flow on impacts to human development, mental and physical health, across generations. Actions on these issues require whole of Government responses.

Emerging Minds would recommend investment in adapting and implementing a 'Mental Health in all Policies' Framework building on the World Health Organisation's 'Health in All Policies' Framework.

Further information on the 'Health in all Policies' Framework is available from:

World Health Organisation:

<https://www.who.int/healthpromotion/frameworkforcountryaction/en/>

Local examples of implementation for other health concerns are available from:

South Australian Government: Health in All Policies:

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+in+all+policies/south+australias+hiap+approach>

Recommendation 4: Measuring mental health

Most Australian population mental health measures focus on measuring the *prevalence* of mental health conditions in the population. Recognising the evidence of clear links between exposure to adversity and mental health, Emerging Minds recommends that in addition to prevalence, population measures of mental health should incorporate a focus on measures of psychological functioning alongside levels of exposure to adversity at each age and stage.

This would assist in:

- understanding population health needs across a mental health continuum
- estimating population health needs at each age and stage, and designing service responses accordingly
- predicting future mental health needs based on accumulation of exposure to adverse childhood experiences and risk factors
- identifying target groups for interventions
- identifying which interventions are most cost-effective for long-term outcomes (e.g. whole of population interventions, multi-generational/family interventions or individual interventions); and
- improving understanding of different levels of intensity and systems of care needed across the continuum of interventions (e.g. children with normal psychological functioning but living with high adversity are likely to benefit from high intensity prevention interventions).

The table below is a very simple example of this approach being applied to a sample of Australian children aged 4-5 years, using data from the Longitudinal Study of Australian Children.

	Level of Adversity		
	Low (0-1)	Moderate (2-3)	High (>4)
Normal	46.9%	27.7%	6.6%
Slightly Raised	3.1%	4.3%	2.1%
High Psychological Distress	1.5%	2.3%	1.5%
Very High Psychological Distress	.7%	1.6%	1.7%

Data in the table informed by:

Segal, L., Guy, S., & Furber, G. (2018). High levels of adversities in children and adolescents experiencing psychological distress: the rule rather than the exception. Manuscript submitted for publication.

Recommendation 5: Service delivery models integrate a focus on mental health and adversity

The relationship between experiences of adversity and poor mental health is well established. However, most service models assume adversity and complexity is only expected in the most severe presentations.

An example of this is the recently introduced 'stepped care' model, which uses symptom severity to inform the service mix/response. For example, current recommendations indicate that a low severity presentation = low intensity intervention. When applied to an infant or child population, this approach does not take into account:

- high developmental/lifetime risks for future mental health difficulties that are predicted by exposure to adversity/risk factors, but may not yet present in symptoms
- intergenerational needs (e.g. parallel complexities in parents and children and their impacts on each other and treatment effectiveness)
- current adversity and what this means for different levels of intensity of intervention across the promotion, prevention, early intervention and treatment continuum. For example, prevention interventions can be costly/intense in the short term, but cost-benefits are demonstrated longitudinally in relation to reduced welfare dependence, crime and illness.

The focus of stepped care requires further refinement for infants and children, and more broadly, needs to incorporate both the severity of symptoms and the number/severity of psychosocial adversities predicting short- and long-term mental health risks. This could inform the intensity of care, support and service coordination between mental health, health, social and education/care environments. Further refinement of this to incorporate the cost-benefit of interventions would provide a strong foundation for informing investments in mental health.

The table below provides a narrative description of how the model could be applied to describe the focus of interventions at different levels of need.

	Level of Adversity		
	Low (0-1)	Moderate (2-3)	High (>4)
Normal	<p>Family intervention: A preventive intervention directed to parents of shy, temperamentally inhibited pre-schoolers reduces the prevalence of childhood anxiety during the primary school years and also adolescent depression.</p> <p>Population intervention: A child with normal psychological functioning and no/low exposure to adversities is likely to benefit from universal programs such as social and emotional learning programs in schools</p>		<p>An infant with normal psychological functioning, but very high levels of adversity, would benefit from high intensity prevention interventions such as 'Intensive Family Home Visitation' to reduce lifetime developmental and mental health risks. Cost benefit studies have shown that high cost/high intensity prevention interventions have cumulative cost benefits due to lifelong reductions in costs associated with welfare, health and crime.</p>
Moderate Distress	<p>A school-aged child with raised anxiety symptoms might benefit from low intensity CBT programs delivered in the classroom, online or in a family mental health support service.</p>	<p>A family living through prolonged drought, resulting in high psychosocial stress/depression in parents would benefit from family prevention intervention delivered in a primary care setting.</p>	
High Psychological Distress	<p>A child with very high psychological distress and severe mental health symptoms would benefit from multidisciplinary and specialist mental health support provided by CAMHS.</p>		<p>A child with very high psychological distress and symptoms in an out-of-home care arrangement would benefit from multidisciplinary and multi-generational specialist support involving specialists in multi-systems family interventions, with collaboration between specialist adult and child-focused services.</p>