

# Submission in response to Productivity Commission (2019) Mental Health Draft Report

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We are concerned about the discussion and recommendations about children in the Productivity Commission (2019) Draft Report.

This includes the recommendation of universal screening of preschool children for social and emotional development. We believe that this recommendation is well intentioned but insufficiently thought through in terms of not only its public health impact, but also its public acceptability, particularly given the lack of clarity about what the screening would entail.

Furthermore, the suggested supports for children identified as vulnerable seem to have an inappropriately narrow range.

Related to this, we are concerned about the fact that the Draft Report explicitly rules social determinants of mental health, including family poverty, as out of scope of the inquiry, despite acknowledging their impact on mental health. Such social determinants are crucial influences in early (and later) childhood development.

## Preschool screening recommendation

The Key Points section of the Draft Report recommends universal screening of preschool children for social and emotional development as a strategy to enable early intervention for mental illness and suicide attempt:

*'Reform area 1: prevention and early intervention for mental illness and suicide attempts*

- Consistent screening of social and emotional development should be included in existing early childhood physical development checks to enable early intervention.' (p. 2)

Despite Commissioner King's (2020) assertion that it is not *mental health* screening that is being recommended, we believe that the phrase 'early intervention for mental illness' in the title of Reform area 1, coupled with 'screening... to enable early intervention' in the dot-point, invites the interpretation that the screening will focus on mental health/illness, particularly given that Recommendation 17.2, which does not mention 'mental illness', is not stated until page 83.

The Draft Report notes the 2012 controversy about the proposed addition of social and emotional wellbeing to the Healthy Kids Check:

'In 2012, the Government convened an expert working group to develop the Enhanced Healthy Kids Check, designed for 3 year olds, which was intended to contain questions on social and emotional wellbeing. However, this version of the check was never rolled

out, partly due to public criticism as the check was perceived by some as a mental health check for children (Oberklaid 2014).' (pp. 657-658)

We were among those who criticised the Healthy Kids Check. However, we did not merely *perceive* it as a mental health check. Instead, we pointed out (Jureidini & Raven 2012, p. 924) that it was originally announced by the Department of Health and Ageing (2011) as 'an evidence-based mental health and wellbeing check as part of the current Healthy Kids Check', and a joint ministerial statement on the website of the Minister for Mental Health and Ageing, referred to 'Helping to detect potential mental health problems in the early years' and 'identify emerging mental health problems early' (Roxon et al., 2011). We discussed in some detail the problematic lack of clarity and transparency, and the subsequent denial of, 'mental health' terminology.

Despite such Government statements on the public record, Oberklaid (2014) referred to concerns raised about the mental health orientation as 'uninformed criticism' (p. 369), and further argued that it was not screening test, but rather 'an opportunity for parents to raise any concerns with their child's GP' (p. 370).

The problematic lack of clarity about the 2012 Healthy Kids Check also applies to the social and emotional development screening recommended in the Draft Report. Not only is social and emotional development blurred with mental health and mental illness, but also there is no clear explanation of what is meant by 'risk factors', which seem to be narrowly conceptualised.

The Draft Report argues that the expanded health check would enable early identification of risk factors and provision of support/assistance for families and children to address those risks:

'Expanding the scope of existing health checks for 3- to 4-year-olds... to consistently encompass social and emotional development can result in risk factors being detected early and support offered to families and children as they prepare to start school.' (p. 658)

The existing physical development checks of Australia's 1.25 million 0 to 3 year olds in community health services can be expanded to incorporate social and emotional wellbeing aspects of development, so that any necessary assistance can be provided to both the child and parents/carers.' (pp. 11-12)

We agree that identification of risk factors could be useful. However, the suggested support/assistance for children identified as vulnerable seem to have an inappropriately narrow range, primarily restricted to education and therapy:

'Some of these risk factors can be ameliorated through early intervention. Over many years, and in many developed countries, studies and trials have shown that early intervention for vulnerable children significantly improves outcomes. Early intervention usually takes the form of integrated education and therapeutic services,' (p. 661)

Furthermore, it is not clear what risk factors would be assessed. However, it seems likely that they would not include social determinants of mental health such as poverty, housing insecurity, and food insecurity.

The Draft Report cites the NHMRC's acknowledgement that family socioeconomic status affects children's social and emotional development:

'The family and family environment (which includes cultural practices/approaches, the physical and mental health of family members, intra-family relations, household wealth, occupational status, and housing conditions) are the main sources of the child's experiences, and therefore have a key influence on a child's social and emotional development. (NHMRC 2017, p. 2)'

Problematically, however, the Draft Report rules social determinants of mental health, including family poverty, as out of scope of the inquiry:

'The social and economic circumstances of people's lives have a substantial influence on their mental health (WHO 2014). While acknowledging this important link, this inquiry focuses on improving the way systems and government services can support people with mental illness across all walks of life, and contribute to population wellbeing.' (p. 123)

Notably, the Draft Report explicitly rules out any consideration of the adequacy of Newstart payments:

'Whether payments are at a level that represents an adequate safety net is contentious (particularly in relation to the Newstart program), but as noted in section 14.5, that concern is not specific to people with mental illness and is outside the scope of this inquiry.' (p. 510)

'The issue of adequacy for these [Newstart and Youth Allowance] payments relates to all recipients, not just people with mental illness, and is beyond the scope of an inquiry focussed on mental health.' (p. 529 [section 14.5])

There is considerable evidence that the poverty experienced by many parents who are reliant on Newstart affects the mental health of parents (Kiely & Butterworth 2014; Uniting Vic.Tas 2019) and that children's mental health is affected by family poverty (Steele et al. 2015) as well as parental mental health (Reupert et al. 2013).

## **Screening**

We would also like to point out some more fundamental reservations about screening that need to be taken into account before any screening program is implemented.

Until relatively recently, it has been generally accepted that screening for potentially serious disorders and diseases is highly desirable because it is likely to lead to early diagnosis and treatment in many cases, and to generally increase treatment rates, and consequently improve outcomes. However, there is increasing recognition that screening (and early diagnosis and treatment) may not improve outcomes, and may in fact have harmful effects that outweigh the potential benefits.

For any screening program to be justified, certain conditions must be met, including:

1. A screening tool must be available that validly identifies the target problem with a high level of specificity and sensitivity. Those screened in must be far more likely to

develop disease than those screened out (Viera 2011). Even a small reduction in specificity will result in huge numbers of false positives.

2. Interventions must be widely and equitably available to those who screen positive, which when targeted to people with 'pre-disease', effectively reduces the likelihood of developing disorders.
3. The overall benefits to the population of intervening must outweigh the harms, factoring in those individuals who receive the intervention who have received false positive diagnoses.

The Draft Report does not state what screening tool would be used to assess children's social and emotional development, let alone discuss its specificity and sensitivity. Nowhere is it explained what screening tool would be used or what it would measure. It clearly fails to meet condition 1.

Condition 2 is also not met. In fact, the Draft Report acknowledges that it would be difficult to scale up early intervention programs such as the Early Years Education Program (EYEP) (Jordan et al. 2014):

'Scaling such programs to substantially increase the number of children attending is a very challenging task, due to funding shortages, a lack of services, limited coordination, poor tailoring of service provision to local circumstances and other problems.'  
(Productivity Commission 2019, p. 661).

Regarding condition 3, the Draft Report does not mention the possibility of harms associated with screening. Potential harms include adverse effects of any intervention. In particular, there is a danger that increased identification of apparent problems could lead to increased use of stimulants, antidepressants, antipsychotics, and other psychiatric drugs with known and unknown adverse effects. The use of these drugs in pre-school children is already at significant levels and increasing (Karanges et al. 2014).

In medicine more broadly, even established screening regimes are being questioned and downgraded (Schwartz and Woloshin, 2012), because harms and costs frequently outweigh benefits, and because of opportunity costs. In the US, the Choosing Wisely campaign, run by nine specialty societies (including the American College of Physicians, the American Society of Clinical Oncology, and the American Gastroenterological Association), has published lists of 'Five things physicians and patients should question' (Choosing Wisely, 2012), urging caution about many screening and diagnostic tests and medical interventions. The US Preventive Services Task Force (USPSTF) recommends not routinely conducting prostate-specific antigen (PSA) testing for prostate cancer (USPSTF, 2018), nor routine mammography for women aged 40–49 (nor teaching patient self-examination at any age) (USPSTF, 2009), nor spirometry for chronic obstructive pulmonary disease (USPSTF, 2016). Harris (2011) notes that, 'With few exceptions, the contribution of screening to improving the health of the public is small' (p. 1), with less benefit and greater harms than has been realised.

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