

Submission to the Productivity Commission re Draft Report (31 October 2019) on Mental Health

by

Tasmanian Branch Australian Association of Infant Mental Health (AAIMH)

The Tasmanian Branch of the Australian Association of Infant Mental Health (“The Branch”) welcomes and applauds the Productivity Commission’s recognition of the importance of early in life experience for long term mental health and wellbeing, and the constructive recommendations made to build the capacity of mental health and other services to meet this need. A focus in this area, will significantly contribute to the inquiry’s desire for generational change.

The case for intervention early in life

The scientific evidence base is clear that experience in utero and the first two years of life is foundational to brain structure and function with life-long effects on cognition, social and emotional functioning and mental health. Crucial to lifelong mental wellbeing is a child’s secure attachment with an appropriately responsive caregiver. For parents to provide such care, they themselves need safety and security in their life circumstances and social supports. On the other hand, exposure during pregnancy and infancy to stressful experiences of trauma and neglect impairs neurodevelopment increasing risk of developmental disorder, cognitive and behavioural difficulties, mental illness and suicidality. Parents struggling themselves with poverty, social exclusion, mental illness, domestic violence and substance use need psychological and social supports, to be well in themselves, and so they can be the caring and responsive parent their child needs (Shonkoff, et al., 2012).

Research has indicated that conception to age two (the first 1000 days) is a ‘critical period’ in child development where a ‘good enough’ parenting experience is essential for normal development. Research also shows that interventions in this period to support optimal development are more clinically efficacious and cost effective than those undertaken in later years (Heckman & Masterov, 2007). Later interventions cannot completely redress neurological impairment and psychological compromise resulting from problems in the first 1000 days, with infants experiencing problems during that time being on a trajectory of increased risk for cognitive, emotional and behavioural difficulties, mental illness, substance use and suicidality (Zeanah, et al., 2015). Infants without ‘good enough’ parenting are also at risk for adverse outcomes of child protection involvement, educational failure, adolescent pregnancy, juvenile justice involvement, and longer term unemployment, relationship instability, chronic physical and mental illness, poverty and social welfare dependency (Zeanah, 2018).

These issues are of particular relevance in Tasmania, a state when compared with national data, has high rates of poverty and social exclusion, and transgenerational cycles of disadvantage (Kids Come First Report, Tasmanian Early Years Foundation, 2010). Early in life interventions in Tasmania would be most effective and cost efficient in improving the physical and mental health of the population; also in the longer term, increasing productivity and reducing costs in health and welfare sectors. Of particular concern is the high burden of developmental disability and mental illness in infants, children and young people in the out-of-home-care system; and of adolescents involved with juvenile justice in Tasmania. This need is currently poorly addressed.

Relevance of proposed reforms to Tasmania

The Productivity Commission identifies necessary changes to service priorities, organisation, funding and delivery to align with the evidence base and better meet the mental health needs of the population.

1. A key principle is recognition of the need for **early identification, intervention and prevention of mental illness**. “Mental illness tends to first emerge in younger people (75% of those who develop mental illness, first experience mental ill-health before the age of 25 years) raising the importance of identifying risk factors and treating illness early where possible”; and “Key factors driving poor outcomes in Australia’s mental health system include: under-investment in prevention and early intervention, meaning that too many people live with mental ill-health for too long.”

One of the major challenges is that brain changes underlying mental illness predate manifest behavioural change, emphasising the need for preventative interventions to address risk and support healthy development (Insel, 2019); also, mental illness in infants and children is often not recognised as it presents differently from adult disorder (Lyons-

Ruth, et al., 2017). Screening for mental illness in children at sequential points in development requires both identified points of contact with services; and developmentally appropriate screening instruments. The report identifies several such opportunities: perinatal screening for maternal illness and risk factors; 0-3 screening by child health nurses or general practitioners for developmental and socio-emotional indicators; school-based assessment and monitoring of child mental health. The evidence base suggests that best outcomes are achieved when perinatal and infant interventions are built on subsequently in further interventions in childhood and adolescence, indicating the need for a range of support services in perinatal care and throughout infancy, childhood and adolescence. When early in life prevention and early intervention is provided, subsequent interventions can be less intense, less expensive and more effective as difficulties are less severe and entrenched (Heckman & Masterov, 2007). The Branch welcomes and strongly supports these recommendations. Their implementation in the local context (with appreciation of regional specific accessibility issues in rural areas of Tasmania) will require development of service capacity for a range of responses proportionate to identified level of need; and integration and collaboration of care pathways and service responses to ensure each child and family can access the support they require in a timely and seamless manner.

2. **A stepped care model:** effective early identification and intervention requires that a range of services is offered from universal 'self-management' options; to low, or medium, or high intensity interventions; to complex care. Ideally this range of interventions is offered in a proportionate universalism model, where level of need is identified in primary health care settings and escalation in care is provided in a non-stigmatising and accessible fashion. A major barrier to those most in need accessing appropriate care is the stigma attached to referral to a mental health service; understanding of mental health services; insight into their presenting problems and sequel; and difficulties in accessing specialist care, related to cost and transport difficulties; the level of organisation and persistence required by consumers; but also lack of trust in services. Delivery of services from low intensity to complex in primary health or community settings can enhance access and compliance with treatment. Co-location, co-ordination and collaboration between different levels of service supports access to necessary level of care in a non-stigmatising manner and promote service delivery in local areas.
3. **Organisation of services:** Services catering to the needs of infants, children, adolescents and families are siloed within multiple different government departments; with different service and financial priorities; located over multiple different physical sites. Yet integrated delivery of services is crucial to best outcomes, especially in those with the most severe and complex difficulties (Fraser Mustard, 1999, 2007, 2011). The report suggests "a range of approaches to collaboration, including co-location, alliances and networks, [that] can improve service delivery and benefit consumers. Depending on the scale and type of services involved providers could consider formalising links using memorandums of understanding to create clear accountability structures and overcome barriers to collaboration." Given the relatively small population and geography of Tasmania, integration of services in the infant, child, adolescent and family sector would seem achievable, however a whole of government approach that prioritises needs of children and families over conventional service arrangements would be necessary. Co-ordination of services cater for different age groups would be appropriate: perinatal and early childhood; childhood; adolescent; and young adult. Another key factor in effective organisation of services is the model of care adopted. A relevant model of care would be child and family-centred, developmentally appropriate and culturally sensitive.
4. **Care Co-ordination:** the report recognises that co-ordination of care to ensure access to and continuity of care is crucial across the spectrum of care, so that roles, responsibilities and pathways of care are clear. This is especially so for infants, children, adolescents and families with complex needs. Where multiple services are often involved, consumers can be left bewildered about roles of different agencies; expectations of them; and alienated by having to engage with so many different professionals. A model in which one professional from the most appropriate service takes a role as care coordinator can build engagement with those reluctant to trust services; clarify roles; and ensure co-ordination of services. The service and professional most appropriate for each child and family would depend on their level of need and the age of the child. In the perinatal and infant period a low intensity intervention might be co-ordinated by GP or early childhood nurse; a high intensity intervention by a CAMHS clinician; and a complex case by a child protection case manager. In childhood, school support staff might support a low intensity intervention; a paediatrician a moderate intensity intervention; and CAMHS involved in complex cases. In adolescents, schools or youth services are often involved with low intensity interventions; while CAMHS, Child Protection and Juvenile Justice take on complex case co-

ordination. For this model to work, service roles and responsibilities would need to be clearly established and defined and structure to support collaboration between services would need to be in place.

5. **Suicide Prevention:** the report focuses on the important issue of suicide prevention, but takes a perspective of identifying and addressing high levels of risk in established mental illness or distress. There is a strong evidence base from a number of longitudinal studies that a significant contribution to suicidality has its origins in early childhood adversity, disorganised attachment, disrupted family relationships, and trajectories from this early life experience to childhood emotional and behavioural problems; and adolescent personality disorder, depression, substance use and suicidality (Bruffaerts, Demyttenaere, Borges, et al., 2010). Therefore, early in life prevention and early intervention strategies have relevance for suicide prevention. Suicidal thoughts and behaviour emerges generally in adolescence. The report focuses on universal intervention strategies, for example in schools; and on follow up after emergency department presentation, both of which are relevant. However, high intensity interventions such as mobile youth outreach services employing systemic approaches and DBT or mentalising therapies are relevant also. For the most complex cases with mental illness, substance use and criminal behaviour multisystemic therapy has been demonstrated to be effective.
6. **Building capacity:** the need for greater investment in early in life interventions, especially perinatal and infant, but throughout childhood and into adolescence is supported by the report. The nationwide inequity in per capita funding for mental health, by which infants, children and adolescents receive significantly less per capita investment in mental health than does adult services, is greater in Tasmania than in any other state (Australian Institute of Health and Welfare, 2019). Thus further investment is warranted. However, investment needs to be in relevant workforce, services and intervention strategies as outlined above, not just 'more of the same'. As the report highlights, investment in mental health does not only mean money for mental health services, but investments across all levels of the health sector; in education; in disability services; in services for indigenous people; in social supports and community building; and in child safety and juvenile justice. Such investment will only produce meaningful improvements in mental health however, if workforce development and service reorganisation is achieved to improve collaboration, ensure access and continuity of care; and close gaps.
7. **Funding models:** the report outlines the confusion of funding arrangements across all levels of government and in the NGO and private sector that contribute to the current maldistribution of resources; and failure to meet need, especially in complex and chronic mental illness. The report's recommendations that government funding approaches should be simplified and clarified, with relevant investment in government services is supported. Also that where services are commissioned from NGOs or private sector organisations, accountability strategies to ensure delivery of required services are developed; integration of these services with government services is required; and length of contract significantly increased to ensure continuity and relevance of service delivery.

Draft recommendation 17.1 – Perinatal Mental Health

The Branch supports Draft Recommendation 17.1 but strongly recommends this be greatly expanded to include actions to follow from screening.

A decade ago, significant investment in the National Perinatal Depression Initiative led to the implementation of routine universal screening with the Edinburgh Perinatal Depression Scale (EPDS), the development of clinical guidelines endorsing this screening and the development of various perinatal service initiatives. Unfortunately, as funding was time limited, many of the service initiatives did not last. However, routine screening has continued, albeit to varying degree in different jurisdictions. Recently, MBS items have been modified or new items introduced to encourage screening in general practice and obstetric care settings in the perinatal period. The Australian Government has announced investment in perinatal mental health and wellbeing including, as part of the Maternity to Home and Wellbeing program, the allocation of \$16 million to rollout digital mental health screening (iCOPE) which will include the EPDS and the Antenatal Risk Questionnaire, in every public hospital in Australia.

We contend, that whilst routine universal screening is important and valuable it is not sufficient to make the changes needed to enable intervention early in life.

- (1) Screening is only the first step in providing mental health care for those who need this. There must be appropriate pathways of care (with adequate staffing) to follow up women identified as 'at risk' by their screening responses. When the EPDS and similar instruments signal that something is awry but cannot tell what that is- a comprehensive evaluation is required to determine whether the woman has a mental disorder (and if so the type and required treatment) or if, for example, the cause of distress is domestic violence, homelessness, poverty and so on.
- (2) Screening has significant limitations. The EPDS will not identify women who have more severe mental disorders such as schizophrenia, bipolar disorder, and complex personality disorders, or women who will experience a post-partum psychosis. The infants of women with these disorders may be at high risk and early intervention be urgently needed.
- (3) Early intervention will have the greatest impact if directed towards those most at risk and most in need. The research summarized above indicates that a child's secure attachment with an appropriately responsive care giver is crucial to lifelong wellbeing. Infants most at risk are those whose caregivers, by virtue of their early experiences have not themselves developed a secure attachment and the capacity for intimacy and empathy. Frequently these caregivers have themselves experienced childhood trauma, abuse and neglect; some have been involved with child protection system; many have severe personality disorders-these caregivers will have great difficulty in forming healthy attachments to their babies, leading to substantial problems with parenting. Universal screening will not identify these women- there is a need for more focused identification and then a clear path for intervention- with the aim of breaking a transgenerational cycle of problems.
- (4) Identification of 'high risk women' in their pregnancy can lead to improved postpartum outcomes for both the mother, infant and the mother-infant relationship, and enhance the likelihood of the mother continuing with therapy after their baby is born. These 'high risk caregivers' include
 - Women with co-morbid current perinatal mental health diagnosis or significant past perinatal psychiatric history and mother-infant relationship concerns, and
 - Women with past childhood attachment trauma, complex developmental trauma or diagnosed personality disorder/traits who are presenting with difficulties bonding to their unborn baby or newborn.

Thus, we propose that draft recommendation 17.1 be expanded to include

- *Governments should take coordinated action to achieve universal screening for perinatal mental illness **and ensure adequate pathways of care are in place to follow-up women identified through screening as at risk.***

Governments should take coordinated action to achieve targeted screening for 'high risk caregivers' and ensure adequate pathways of care are in place for follow-up and intervention.

Draft recommendation 17.2 Social and Emotional Development in Preschool Children

Similarly, we propose that draft recommendation 17.2 also include an emphasis on referral for appropriate interventions. Assessing children's social and emotional development is crucially important, but even more important is timely intervention when such development is not progressing as it should. This also needs to be conducted by clinicians with appropriate training to work with families of young infants and recognition that in some areas of Tasmania provision of specific training in early development and infant mental health will be required.

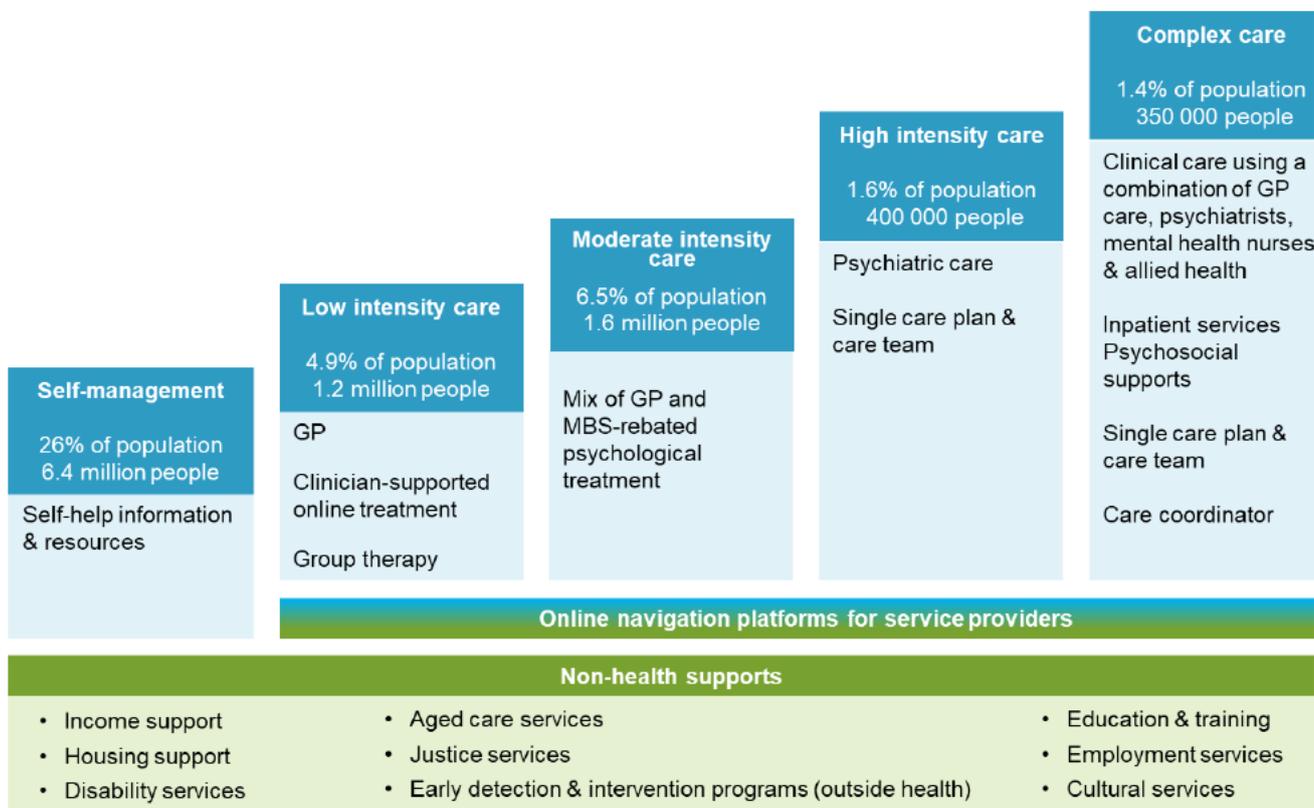
Summary:

The Branch appreciates the opportunity to make this submission to the draft report and wishes to acknowledge the important body of work conducted by the Productivity Commission thus far. The Branch fully supports the recommendation that identification of social and emotional difficulties in children must occur at the earliest possible opportunity rather than waiting until a child is at preschool or school age, given the impact of adversity on brain development and attachment. The State of Tasmania has geographical and social complexities that make access to services challenging for the most vulnerable families and infants at risk. The Tasmanian Branch of AAIMH has advocacy for infants in the forefront of mind when we request that the Commission consider not only perinatal and 0-3 child screening but also integrated and collaborative care pathways (with defined models of care), timely service delivery by appropriately trained and qualified professionals, and investment in intervention A stepped model of care that considers co-location, co-ordination and collaboration between different levels of service supports would assist in reducing stigmatization, improve accessibility issues and promote service delivery in local areas.

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Figure 3 Stepped model of care
 Estimated number of people requiring each level of care



DRAFT RECOMMENDATION 17.1 — PERINATAL MENTAL HEALTH

Governments should take coordinated action to achieve universal screening for perinatal mental illness.

In the short term (in the next 2 years)

- The Australian Institute of Health and Welfare should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening, outcomes and referrals. This data should be reported by State and Territory Governments.
- State and Territory Governments should use the data to evaluate the effectiveness of health checks for infants and new parents, and adjust practice guidelines in accordance with outcomes.

In the long term (over 5 – 10 years)

- The National Mental Health Commission should monitor and report on progress towards universal screening.
- State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness for new parents. Such strategies should be implemented primarily through existing maternal and child health services, and make use of a range of screening channels, including online screening and outreach services.

DRAFT RECOMMENDATION 17.2 — SOCIAL AND EMOTIONAL DEVELOPMENT IN PRESCHOOL CHILDREN

Services for preschool children and their families should have the capacity to support and enhance social and emotional development.

In the short term (in the next 2 years)

- State and Territory governments should use existing guidelines to expand early childhood health checks, such that they assess children’s social and emotional development before they enter preschool.
- State and Territory departments of education should ensure that all early childhood education and care services have ready access to support and advice from qualified mental health professionals.
- The Australian Children’s Education and Care Quality Authority should review the pre service training programs for early childhood educators and teachers to ensure qualifications include specific learning on children’s social and emotional development.

In the medium term (over 2 – 5 years)

- State and Territory departments of education, as the regulators responsible for early childhood education and care, should review the quality improvement plans of all services to ensure they include professional learning for staff on child social and emotional development.
- Where this is not already occurring, funding for backfilling should be made available to enable early childhood education and care staff to attend accredited professional development, to support their knowledge of child social and emotional development and mental health.
- State and Territory Governments should expand the provision of parent education programs through child and family health centres.

DRAFT RECOMMENDATION 17.3 — SOCIAL AND EMOTIONAL LEARNING PROGRAMS IN THE EDUCATION SYSTEM

Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum.

In the short term (in the next 2 years)

- The COAG Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. This policy should include:
 - a clear statement on the role of the education system in supporting mental health and wellbeing, and the role of schools in interacting with the mental health system
 - a commitment to cooperate with the COAG Health Council in the implementation of mental illness prevention policy, and a clear delineation of responsibility, to prevent overlap and confusion in policy development
 - guidelines for the accreditation of initial teacher education and professional development courses for teachers, which will include social and emotional learning. These guidelines should be developed by the Australian Institute of Teaching and School Leadership
 - guidelines for the accreditation of external social and emotional learning programs offered to schools. These guidelines could be developed by an expert advisory panel.

In the medium term (over 2 – 5 years)

- State and Territory departments of education should use the national guidelines to accredit social and emotional learning programs delivered in schools.
- State and Territory teacher regulatory authorities should use the national guidelines to accredit initial teacher education programs and professional development programs for teachers. Ongoing learning on child social and emotional development and wellbeing should form part of professional development requirements for all teachers. This should include the social and emotional wellbeing of Aboriginal and Torres Strait Islander children.

DRAFT RECOMMENDATION 17.4 — EDUCATIONAL SUPPORT FOR CHILDREN WITH MENTAL ILLNESS

The education system should review the support offered to children with mental illness and make necessary improvements.

In the short term (in the next 2 years)

- The Disability Standards for Education are due to be reviewed in 2020. The upcoming review should:
 - include specific consideration of the way the standards affect students with mental illness and their educational outcomes.
 - examine application processes for adjustments and consider any necessary improvements.

- MBS-rebated health professionals treating children should be required to include recommendations for parents/carers and teachers in their report to the referring medical practitioner.

In the medium term (over 2 – 5 years)

- The Australian Government should use data collected by schools as part of the National Consistent Collection of Data on School Students with Disability to evaluate the effectiveness of its disability funding structures for children with social-emotional disability.
- State and Territory departments of education should review the funding for outreach services supporting students who have disengaged from education due to mental illness to return to school. Services should be expanded such that they are able to support all students who are at risk of disengagement or have disengaged from their schooling. Departments should put in place clear policies for outreach services to proactively engage with students and families referred to them, once the student's attendance declines below a determined level, and monitor their implementation.