2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"My focus is the needs of the 0-3 age group. For understanding of mental illness public education campaigns similar to Worksafe or TAC advertisements that convey nuanced and hopeful messages would be helpful. For example - messages about the cognitive capacities and memory of infants and toddlers, that they do remember and don't forget traumatic incidents, the fact that toddlers overhear and understand much more about what adults say than they can express in language, that child -led responsive playing with babies and children is growing their brain and their mental health. "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"My focus is the needs of the 0-3 age group. The recognition by policy makers of the importance of early childhood experiences for later health and mental health has been a significant advance. The mandate of CAMHS services being expanded to include infants is a positive step. Victoria has some excellent infant mental health practitioners and teams providing international best practice care. However there are many obstacles to emotionally distressed and disturbed infants and infant-parent relationships receiving the mental health services that they need. i)There is a lack of recognition (by funders, service managers, policy makers, the community) that people can have mental health problems from the first days and weeks of life. Symptoms of depression/withdrawal, medical traumatic stress responses overwhelming panic and anxiety are observable in these early days, weeks and months of life. Parents who recognise these symptoms often have their concerns dismissed. An Australian longitudinal population-based study found that 13.1% of 18 month old boys and 9.5% of girls had externalising behaviour problems and 5.2% of boys and 4% of girls had internalising problems in the borderline/clinical range (Bayer, Hiscock, Ukomunne, Price and Wake, 2008, Journal of Child Psychology and Psychiatry). Infants and their families need the same access as older children, adolescents and adults to skilled mental health practitioners who will form a collaborative alliance with their parents, assess their symptoms, make a formulation, make an individualised treatment plan and provide treatment until the mental health problem is resolved. (They should not be automatically channeled into parent group programs). ii)Common problems of early infancy - crying, sleeping and feeding difficulties are not recognized as potential early flags of a beginning mental health problem. Our research followed up babies who had been admitted to a paediatric hospital with persistent crying when they were aged 6-8 years of age. We found 24.6% met DSM criteria for a mental health disorder (Brown, Heine, Jordan, 2009, J Paediatric Child Health 45(5):254-62 ://dx.doi.org/10.1111/j.1440-1754.2009.01487.x). Many infants with these problems receive a helpful response from primary care services (Maternal and Child Health services, General Practitioners, Paediatricians). Others only receive medical treatments that have been proven ineffective e.g. anti-reflux medications. This begins a cycle of medicalisation of the problem and increasingly desperate parents who feel blamed for being

anxious. Many of these crying, sleeping and feeding difficulties settle with time and good primary care. However, when the problems don't settle there are no clear pathways for the primary practitioner to refer to an infant mental health specialist. Many parents are fobbed off with redundant behavioural advice (settling techniques, sleep management routines etc.) which the parents have tried and don't work for their infant because there is an underlying emotional and behavioural regulation problem sometimes accompanied by an infant-parent relationship problem. In the cases where the need for mental health input is recognized the problem is often seen as one of maternal anxiety and the mother is referred to adult mental health practitioner with the focus on her coping (no support for the father) and the infant remaining untreated. Parents don't have clear pathways for finding infant mental health practitioners themselves. iii)Infants and young children facing critical illness, born premature, or living with a physical impairment or chronic illness face significant risks to their mental health. There are many threats to the mental health of the hospitalised infant and these can be understood using the frameworks of toxic stress and adverse childhood experiences usually applied to the stress of social adversity. Discomfort e.g. exhaustion after feeding, breathing difficulties, altered perception due to medications may persist even in the presence of a responsive caregiver and excellent pain management regimes. Medical interventions and the paediatric intensive care setting may overwhelm the infant's capacity to regulate the input of the environment, leading to a constant thwarted sense of agency and the use of extreme psychological defences or continual vigilance against perceived threat. Many studies find that children with chronic illness have high rates of mental health co-morbidity. A recent US study found that after controlling for socio-demographic and health care access characteristics, children aged 5 to 17 with at least 1 chronic physical condition were 62% more likely to have a mental health disorder than were children without chronic physical conditions. Having a mental disorder was a significant predictor of total health care cost with the adjusted annual incremental cost due to mental disorders among children with chronic physical conditions being $2,631USD (Suryavanshi and Yang, 2016. Prev Chronic Dis. 13:150535). A meta-analysis published in 2017 found associations between childhood chronic physical illness and later adult depression (OR = 1.31; 95% CI [1.12, 1.54]) and anxiety (OR = 1.47; 95% CI [1.13, 1.92]) (Secinti , Thompson, Richards & Gaysin, 2017, Journal of Child Psychology and Psychiatry 58:7 pp 753769). Our own research found that infants who had cardiac surgery in the first 6 months life had altered regulation of the stress hormone cortisol and an elevated cortisol stress response compared to infants with congenital heart disease who had later or no surgery. This is evidence of the biological embedding of this early stressful experience. (McGauran, Jordan, Beijers, Janssen, Franich-Ray, de Weerth & Cheung, 2017, Stress: 20(5), 505-512). Parents' capacity to provide buffering support may be compromised due to their own acute stress response, bonding and attachment difficulties, and the demands of caring for other children (e.g. well twin newborn and toddler at home in the country far away from the sick infant in a city hospital). Children under five comprise 50% of the RCH Melbourne patients and 30% of patients are aged under 3. There needs to be significantly increased investment in the provision of social work, psychology and mental health services for sick infants, children and teenagers in all paediatric health care settings. The consultation liaison model of acute response is inadequate to address the mental health needs of this population. Mental health care needs to be integrated with physical care and many children and families spend much of their life at hospital so community-based care for them is hospital-based care. iv)Children and adolescents with intellectual impairments or autism spectrum disorders and their families are one of the most under -served populations in our community. Often the only mental health treatments offered to these children, who may be very distressed and behaviourally dysregulated, is medication and or behavioural modification regimes that may be experienced as un empathic and coercive. The subjective experience of the child is

poorly misunderstood or discounted due to their cognitive impairments. The parent infant attachment relationship may be derailed very early in life due to distress, grief and acute stress responses in parents following diagnosis of their child's condition. Lack of appropriate support, disenfranchisement of the parental role, a culture of low expectations in service systems and the child's impaired communication abilities can further compromise the developing attachment relationship. There needs to be a significant increase in investment in mental health services for these infants, children and families and these need to be provided by clinicians skilled in non-verbal communication, who understand the dynamics of early emotional development and infant parent relationships, and who recognize the dignity, agency and subjectivity of the child with impairments and disability. v)Children living with significant family adversity and social disadvantage, and those involved with the child protection system, have great difficulty accessing CAMHS services and mental health services have difficulty engaging successfully with children and families living with these challenges. Our research trial of a model of a high quality, targeted infant mental health and attachment theory informed early years education and care program (EYEP, Jordan and Kennedy, The Early Years Education Program (EYEP) Model' 2019, https://fbe.unimelb.edu.au/__data/assets/pdf_file/0008/3059297/EYERP-Report-3-web.pdf) was able to reach these children. After two years of participation in the program (two thirds of the dose' of intervention) children in the intervention group improved their IQ by an average of 7 points and the reduction in incidence of social-emotional problems was 29% (Tseng YP, Jordan B, Borland J, Coombs N, Cotter K, Guillou M, Hill A, Kennedy A and Sheehan J, 2019. https://fbe.unimelb.edu.au/__data/assets/pdf_file/0003/3085770/EYERP-Report-4-web.pdf). The role of early years education and care services in promoting or hindering the mental health of young children needs further investigation. 21% of long day care centres in Australia are not meeting the National Quality Standard. Poor quality centres that struggle to retain staff and employ unqualified and unsupported, poorly paid staff are unlikely to support the mental health of the children in their care. They could be a source of mental health harms especially for children from disadvantaged backgrounds or children who have insecure attachment relationships with their parents. On the other hand, specialised targeted programs like EYEP can be a way of delivering a mental health service to the most vulnerable children. vi)CAMHS services need to have dedicated qualified infant mental health clinicians at the same ratio per head of population as other age groups. Intake roles need to be staffed by clinicians who understand the needs of the 0-3 age group. Infants and young children need equal access to mental health services - they should not be lower priority because of the demand of service for older children and adolescents (we might need quotas to achieve this). "

What is already working well and what can be done better to prevent suicide?
My submission is not focusing on this issue

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
My submission is not focusing on this issue

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
My submission is not focusing on this issue beyond the comments in response to #2

What are the needs of family members and carers and what can be done better to support them?

My submission is not focusing on this issue beyond the comments in response to #2

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"There are workforce challenges in primary care and specialist mental health services and workforce training issues. One issue is that many undergraduate education programs that train primary health care professionals (doctors, nurses, allied health professionals) do not provide any education in infant mental health or even communication with infants and toddlers, the emotional development of infants, toddlers and young children or attachment theory. This should be mandatory training for any clinician working in paediatric care settings. The second issue is that non-medical professionals must pay for their own post-graduate training in mental health (in contrast to psychiatrists and child psychiatrists who are paid as registrars and fellows with allocated paid education time while training). Students undertaking post graduate infant mental health courses must pay several thousand dollars for this training, and it is usually not financially supported by their employer. The one- and two-year courses (previously offered as Graduate Diploma and Masters through the University of Melbourne, now offered through Mindful) allow students to expand their scope of practice within their primary or secondary health care setting and equip CAMHS clinicians to assess and treat the 0-3 age group. Unfortunately, many psychology courses now only train students in cognitive behavioural therapy and not in psychodynamic and child psychotherapy treatments or attachment theory-informed interventions or transference and counter transference phenomena. CBT treatments are not applicable for the under three age group. Attachment theory and infant -parent psychotherapy treatment approaches are critical for treating under-fives. Attachment theory and knowing how to understand and work with transference and counter transference phenomena is essential for engaging children and parents who have had a long history of poor engagement with services and who mistrust helping agencies. "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

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Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
I am not focusing on these issues in this submission

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
I am not focusing on these issues in this submission

Is there anything else you would like to share with the Royal Commission?
I would be happy to meet with the Commissioners to answer any questions or elaborate on any of the issues that I raised.