# Response

## The Social and Economic Benefits of Improving Mental Health – Productivity Commission Issues Paper

## About Karitane

Karitane is a respected and trusted service leader in child and family health, perinatal infant mental health, parenting and targeted early intervention. Karitane delivers high quality, comprehensive, evidence-based parenting services for families with children aged 0-8 years of age. Karitane uses evidence-based programs and collects clear empirical data to demonstrate the efficacy of programs. Karitane engages families using the evidence-based family partnership approach ensuring families are included and empowered in the process of initiating change (Day, Ellis and Harris, 2014). This contributes to family retention and participation in our services.

We also provide comprehensive education and training to healthcare professionals, non-government organisations and corporate partners.

Karitane is an affiliated health organisation under the joint governance of the Karitane Board and the South West Sydney Local Health District (SWSLHD), and is a registered charity and not-for-profit entity. Established in 1923, Karitane receives a combination of state government, federal government and own source revenue streams to support comprehensive child and family services.

As a provider of perinatal and infant mental health service to families at a vulnerable time in their parenting trajectory, Karitane believes it is essential to ensure that there are improvements in population mental health if we want to improve wellbeing, participation and productivity. For a new family this involves looking at the mental health needs of the mother, the father/partner and the infant, as well as other siblings.

To date most mental health interventions focus on treating mental illness rather than on prevention. For early intervention to truly be effective it needs to commence in infancy, through supporting and strengthening a secure attachment relationship. For this to occur we need to ensure that parental mental health is screened, assessed and treated.

The impacts of perinatal depression and anxiety on mothers are well documented. The screening, assessment and treatment pathway for women experiencing perinatal depression and anxiety is also well defined. The impact for an infant whose mother is physically and emotionally unavailable to them at a critical time in their social and emotional development can have enormous impacts on the infant's future wellbeing, participation and productivity, hence the imperative to treat maternal mental health at this critical time.

**SECTION 2**

**QUESTIONS ON ASSESSMENT APPROACH**

*What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment*

Karitane supports the assessment model as outlined in figure 4 on the costs of mental ill-health to the community, especially as it relates to the intangible costs of lower social participation. This is especially significant when considering infant mental health. When a parent's mental health issues prevents them from being emotionally and psychologically available for the infant this has significant and serious impacts on the children's mental health trajectory. The most complex presentation being a disorganised attachment that is reported as having significant impact on the child's development. To prevent adverse

outcomes later in life, and increased health & other related costs, children require their parents to be sensitively attuned to their needs. Parental mental illness severely impacts this and hence should be a priority in mental health early intervention and treatment.

**SECTION 3**

**QUESTIONS ON SPECIFIC HEALTH CONCERNS**

*Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?*

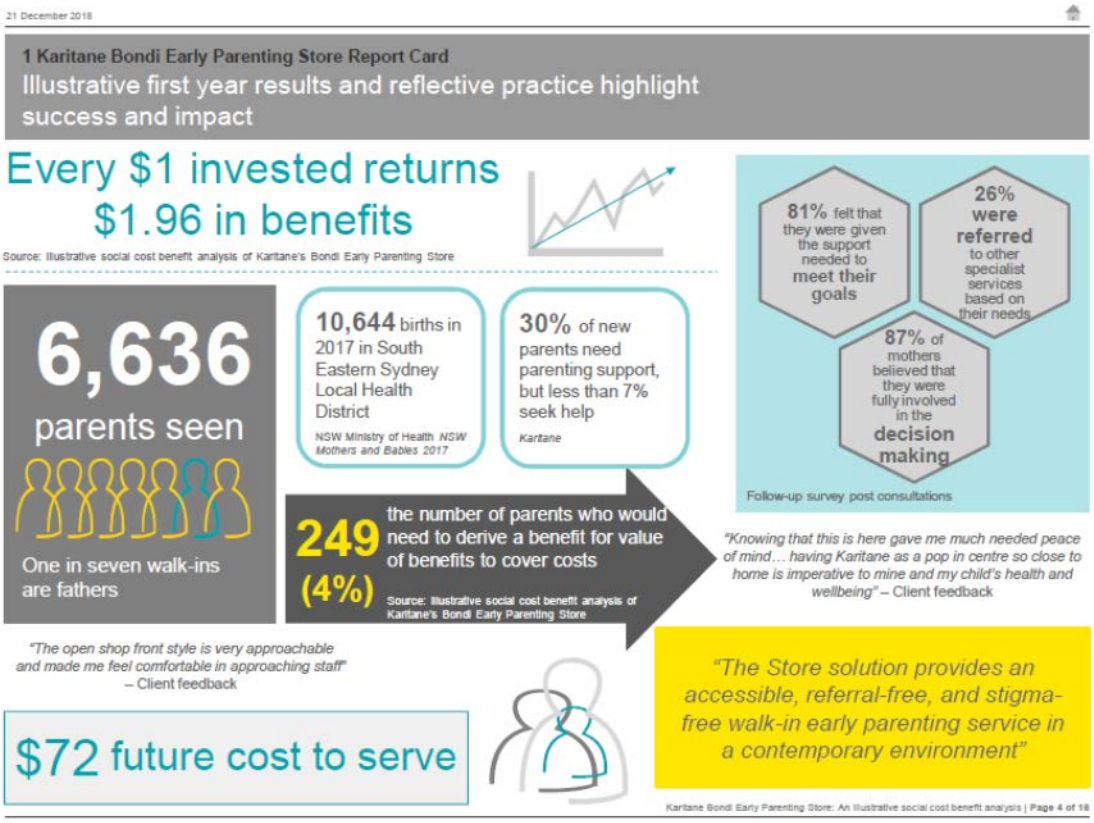
**Recommend: Focus on fathers – screening and early intervention**

Karitane believes that if we are going to support and improve both social and economic participation and therefore enhance productivity and growth, then we need to focus on father's mental health in the early months of parenting. This includes a strong focus on prevention and early intervention.

As we know, one in seven new fathers experiences high levels of psychological distress, and as many as one in ten experience depression and/or anxiety. Despite this there is no routine screening of depression and anxiety for fathers around the birth of their child in Australia. The UK has recently introduced routine mental health screening for fathers. If Australia is going to address the impact of perinatal depression and anxiety as a way to increase social and economic productivity then we need to consider screening fathers in the early months of parenting. UK fathers such as Israel Smith say in reference to the UK initiative " I think it would be good to extend it to all dads, whether at parenting classes or when a midwife comes for the home visit, not just for dads whose partners have a mental illness."

Screening could occur at a number of contact points, for example at antenatal classes, after delivery or in the postnatal ward, through contact with Child and Family Health nursing services, at the baby's 6 week post-natal check, at the mother's postnatal check with the GP or Obstetrician, at the father's workplace or through General Practice more broadly or through targeted telehealth and online channels.

One model to improve easier access to services for parents has been through **Karitane's Early Parenting Store**. Karitane has successfully piloted a **shopfront model** for 12 months in a shopping centre in Sydney. This has enabled over 7500 families to 'walk-in' to seek early parenting support. This has a low stigma, easy access, self-referral, self- booking model. We have also engaged many dads in the service due to location and 7 days/week service. Ernst & Young completed a Social Cost Benefit Analysis of the model in December 2018 demonstrating a $1.96 ROI for every dollar spent. This could be effectively scaled across shopping centres as an integrated care model which creates an access point for care and early intervention.




Offering checks for mothers, fathers and babies would be a way to screen for potential risk factors and the development of perinatal mood disorders in both parents. Increasing opportunistic exposure to healthcare services by encouraging father's to be present at postnatal checks; baby health checks shopfronts etc. would facilitate greater opportunity to implement routine screening. The aim would be to achieve a culture that promotes and encourages this practice.

In order to undertake these screening initiatives fundamental changes are required nationally on how we think about the delivery of mental health services, the promotion and resourcing of early intervention by healthcare providers. Specifically, there are insufficient services available for clients who are struggling but do not yet meet criteria for a diagnosis. Despite the existence of a stepped care model for offering intervention to struggling clients, our current model for accessing services continues to be an illness model. For example, clients need to meet criteria for a mental health diagnosis to qualify for either Medicare based psychological intervention services or more intensive Mental Health services. There are not enough services focused on those first earlier intervention steps, especially for fathers.

If we are want to address social and economic participation and productivity we need to address the systems in which mental health care is delivered. This includes ensuring that perinatal services, which are predominantly delivered by a female workforce, take into consideration how to make these services more welcoming, tailored and flexible for fathers.

Further can be learned from the UK model which includes the NHS Long term plan to proactively consider the priorities for future population need and health service delivery. Given that the UK and NHS could be considered as broadly comparable to our own population and public health system, it seems relevant to note their findings and objectives as we formulate a way forward.

To directly quote from the NHS Long Term Plan document:

"Around one in four women experience mental health problems in pregnancy and during the 24 months after giving birth. The consequences of not accessing **high-quality perinatal mental health care** are estimated to cost the NHS and social care £1.2 billion per year. The Long Term Plan will improve access to and the quality of perinatal mental health care for mothers, their partners and children by:

- Increasing access to evidence based care for women with moderate to severe perinatal mental health difficulties and a personality disorder, to benefit an additional 24,000 women per year by 2023/24, in addition to the extra 30,000 women getting specialist help by 2020/21. Care provided by specialist perinatal mental health services will be available from preconception to 24 months after birth (care is currently being provided from preconception to 12 months after birth), in-line with the cross-government ambition for women and children focusing on the first 1001 critical days of a child's life (ref 83 in paper).
- Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they include parent-infant, couple, co-parenting and family interventions.
- Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required. This will contribute to helping to care for the 5-10% of fathers who experience mental health difficulties during the perinatal period.

We propose a step further in Australia: that all new fathers are screened for perinatal anxiety & depression, not just whenever partners have a diagnosis of perinatal anxiety or depression.

In order **to support and improve both social and economic participation** and therefore enhance productivity and growth, Karitane believes that mental health prevention needs to be a priority. This is particularly important for new fathers. Routine screening of depression and anxiety for fathers around the birth of their child and an increased focus on father's mental health in the early months of parenting would be important preventative intervention, when considering social and economic participation.

References


1. NSW Health The First 2000 Days – Conception to Age 5 Framework https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_008.pdf
2. The 1001 Critical Days (2016) The 1001 Critical Days of Importance of the Conception to Age Two Period. Available from https://www.1001criticaldays.co.uk/sites/default/files/1001%20days_oct16_1st.pdf
3. https://www.fatherly.com/health-science/postpartum-depression-dads-perinatal/
4. **https://www.sciencedaily.com/releases/2019/03/190307091448.htm**
5. https://10daily.com.au/lifestyle/health/a181207pta/should-we-be-screening-new-dads-for-postnatal-depression-like-the-uk-20181207 ).
6. https://www.england.nhs.uk/2018/12/partners-of-new-mums-with-mental-illness-set-to-get-targeted-support-on-the-nhs/
7. Paulson, J. & Bazemore, S. (2010). Prenatal and Postpartum Depression in Fathers and Its Association with ?
8. NHS Long Term Plan available at https://www.longtermplan.nhs.uk/, pages 48-49
9. Clinical Skills in Infant Mental Health: The First Three Years, 2nd Edition. Sarah Mares, Louise Newman, and Beulah Warren. *ACER Press, Victoria, Australia, 2011,*

***Recommend: Parent Child Interaction Therapy (PCIT) & Internet Parent Child Interaction Therapy (I-PCIT) for rural and regional families.***

PCIT is a therapy program built around the importance of familial relationships and developing the strength of these relationships early on. The mental health of parents and their infants, toddlers and young children are demonstrably linked, and poor mental health in mothers has been clearly associated with poor outcomes in their children (Field, 2002; Murray et al., 1999; Hay, et al., 2001). PCIT focuses on developing strong relationships between parents and children to improve mental health outcomes for the whole family.

PCIT is known as one of the most powerful interventions for addressing behaviour concerns in children aged 2-7 years. It has been shown to be superior to other well-known evidence-based programs such as the Triple P parenting program, both in terms of cost-effectiveness and clinical changes seen for children and families (Thomas-Zimmer-Gembeck, 2007; Washington State University for Public Policy, 2016).

As mentioned, fathers are often underserved in perinatal mental health, despite 1 in 10 fathers experiencing perinatal depression (beyondblue, 2015), and identifies the risks in disruption to the parental relationship. PCIT is an intervention program that can be undertaken with both mother and father, just one parent, foster parents, or another primary carer, and ensures that the needs of fathers are addressed. Importantly, PCIT has demonstrated efficacy with vulnerable populations including maltreated children (Chaffin et al., 2011), children exposed to domestic violence and other trauma.

Emerging research (rated as promising on the Spectrum of Evidence) has focused on delivering PCIT over the internet using live video to families in rural and remote areas making it an increasingly accessible treatment for families across Australia. Comer et al. (2017) compared internet delivered PCIT (I-PCIT) to standard clinic-based PCIT amongst children aged 3-5 years with disruptive behaviour disorders. They found evidence of improved child behaviour problems and decreased burden on caregivers across time, regardless of treatment condition. They also found no difference amongst conditions in number of sessions needed for parent/care-givers to meet mastery criteria. Treatment satisfaction was high across both conditions, as rated by two questionnaires. Amongst the children who received I-PCIT, 70% showed a positive treatment response immediately after completion of the program and 55% continued to show treatment response at a 6-month follow-up. Furthermore, they found that at posttreatment and 6 month follow up, around half of the children treated with I-PCIT no longer met criteria for a disruptive behaviour disorder. One important finding was that I-PCIT was associated with fewer barriers to treatment participation than clinic based PCIT, which may make it particularly suited to families in rural and lower socioeconomic areas.

Although the research base for I-PCIT is still at an early stage, available evidence suggests that I-PCIT can be offered to families with no sacrifice in treatment efficacy. Karitane is currently offering I-PCIT to families from rural and remote NSW, including MNCLHD & WNSWLHD, as part of a NSW Mental Health Innovation tender sustained funding until December 2020.

The Karitane I-PCIT service was established as a pilot program, co-funded by NSW Health and Karitane for 14 months (Nov 2017 - Dec 2018), representing the first ever I-PCIT service available in Australia in a real-world clinical setting. The service provided free clinical treatment for families from rural, regional and remote New South Wales (NSW) struggling with disruptive toddler behaviours in 2 - 4 year olds. The program used the evidence-based program PCIT intervention to teach parents new strategies to manage

difficult child behaviours. The pilot showed I-PCIT to be a feasible and effective way to treat difficult child behaviours for families across NSW. Consumer satisfaction with the service was high, and qualitative feedback from parents highlighted the significant need for the service for families from rural, remote and regional areas of NSW, and the many positive impacts experienced. (*Full academic report available and publications currently in press).*

- **PCIT in Schools**

The University of New South Wales (UNSW) Parent-Child Research Clinic and a network of public schools in South-West Sydney (*Ingleburn PS, Warwick Farm PS, Macquarie Fields PS, Sackville Street PS, Robert Townson PS, Campbelltown Preschool)* have partnered to establish the world's first school-based clinic to provide Parent-Child Interaction Therapy, one of the most effective evidence-based programs for addressing disruptive behaviour problems in young children. Approximately 6% of Australian children have disruptive behaviour disorders. These problems persist throughout life and lead to later mental illness, family dysfunction and violence, academic failure, and criminality, making them a serious public health concern. Students with disruptive behaviour problems are a major concern to schools.

This program seeks to strengthen parent, school and teacher partnerships by working together to help children to learn appropriate behaviours that improve their social, academic and health and wellbeing outcomes.

Teachers with a student participating in the program will be invited to access informational and in-class support services tailored to the unique needs of both the student and teacher. These supports are designed to help teachers acquire and develop skills to better manage problematic child behaviours within the classroom, which helps create a more positive teaching/ learning environment for all.

The project will be run in South Western Sydney, in a vulnerable community with pockets of significant disadvantage. Some families, groups, and communities are characterised by financial instability and unemployment, shorter life span, poorer mental and physical health, and lower use of preventative services compared to the rest of NSW. A group that is particularly disadvantaged in South Western Sydney are those people experiencing violence. South Western Sydney residents suffer domestic and family violence at higher rates than the NSW average. Risk factors for family violence and child maltreatment are particularly high among South Western Sydney residents, and local children are more developmentally vulnerable compared to the NSW average. This vulnerability increases when families are socioeconomically disadvantaged and have limited support. While clinical and support services for vulnerable residents are available, a number of serious barriers prevent individuals and families from accessing health services. These barriers include a lack of knowledge and understanding about the availability and content of services, the cost of treatment including transport, lack of childcare, long waiting lists, lack of flexibility in the service, and an absence of cultural sensitivity of services. It is our goal to overcome many of these barriers by delivering PCIT directly in local South Western Sydney schools.

**Recommend: Mother-baby units for NSW**

Whilst not an early intervention for the mother's mental health, this service is a preventive factor for the infant's ongoing mental health. If the mother is effectively treated in a facility that allows for continuation of the parent-infant attachment relationship, something that our current public system in NSW doesn't do well by separating mothers and infants, we would improve the long term outcomes for the infant.

Maternal mental health has enduring effects on children's life chances. NSW Health provides a spectrum of state-wide mental health care for pregnant women and mothers with mild through to severe and complex mental health problems, their infants and families.

Recent estimates are that between 10 and 20% of women develop a mental illness during pregnancy or within the first year after having a baby (the perinatal period) and that approximately 90% of these women will require support and treatment from primary care level services[1]which in NSW includes services provided to women and their families through Maternity Health, Child and Family Health, GPs, Private providers and Non-Government Organisations (NGOs) such as Karitane. Of the remaining 10% of women who require specialist care for severe and complex mental health problems, a small proportion might require an admission to an inpatient unit and may also receive specialist care through public community mental health services, the tertiary NGO sector and the private/Medicare funded sector.

The recommended MBU model of perinatal mental health care is based on the following principles:

1. Care should be co-ordinated across phases of the mother's mental health episode and across public, primary and private care providers;

2. Care should aim to minimise risk, improve mother and infant outcomes, reduce unnecessary separation of the mother from the infant and be family focussed and partner inclusive;

3. Care should be provided where-ever possible in the community and as close to home as possible in order to minimise the separation of the mother from her infant and from her family and community;

4. The availability of specialist mental health community-based options has been shown to reduce the need for inpatient mother-baby beds;

5. Planned development should be based on evidence of cost-effectiveness and improved treatment outcomes, whilst recognising that this is an evolving field of practice and that cost-effectiveness studies supporting dedicated MBUs in particular are lacking.

***SOCIAL PARTICIPATION AND INCLUSION***

*What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?*

*What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?*

*Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?*

*What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?*

Parents who may be at greater risk of perinatal anxiety and depression include those who are socially isolated or lonely**,** finding the adjustment to parenthood a challenge, adjusting to other changes in their lives, feeling isolated or lonely, parenting alone or lack confidence in their parenting
**Recommend: Volunteer Family Connect (VFC)** represents a collaborative joint alliance consisting of three leading parenting services providers (Karitane, The Benevolent Society, Save The Children Australia) and supported by rigorous evidence and return on investment studies(Macquarie University, Western Sydney University, Ernst & Young). VFC has an in-depth understanding of the issues impacting families accessing services, families with multiples risk factors and vulnerabilities, as well as issues facing service providers, workforce and parenting support services as a whole. We know that screening, early intervention and prevention of perinatal anxiety & depression is an important investment.

The VFC program involves matching of families with young children who are isolated and/or lacking in parenting confidence with specially trained community volunteers, who provide weekly support for a 3-12 month period depending on the needs of the family. Our recently completed randomized control trial (RCT) research (*publications pending)* rigorously examined the outcomes for vulnerable families who receive support from the VFC program, as well as for the volunteers who deliver the service. In addition, the research includes a social return on investment (SROI) analysis undertaken by Ernst & Young. This is a landmark study, and will make an important contribution to the Australian and international evidence-base demonstrating the value of volunteering, and its role within child and family services as an early intervention and prevention program.

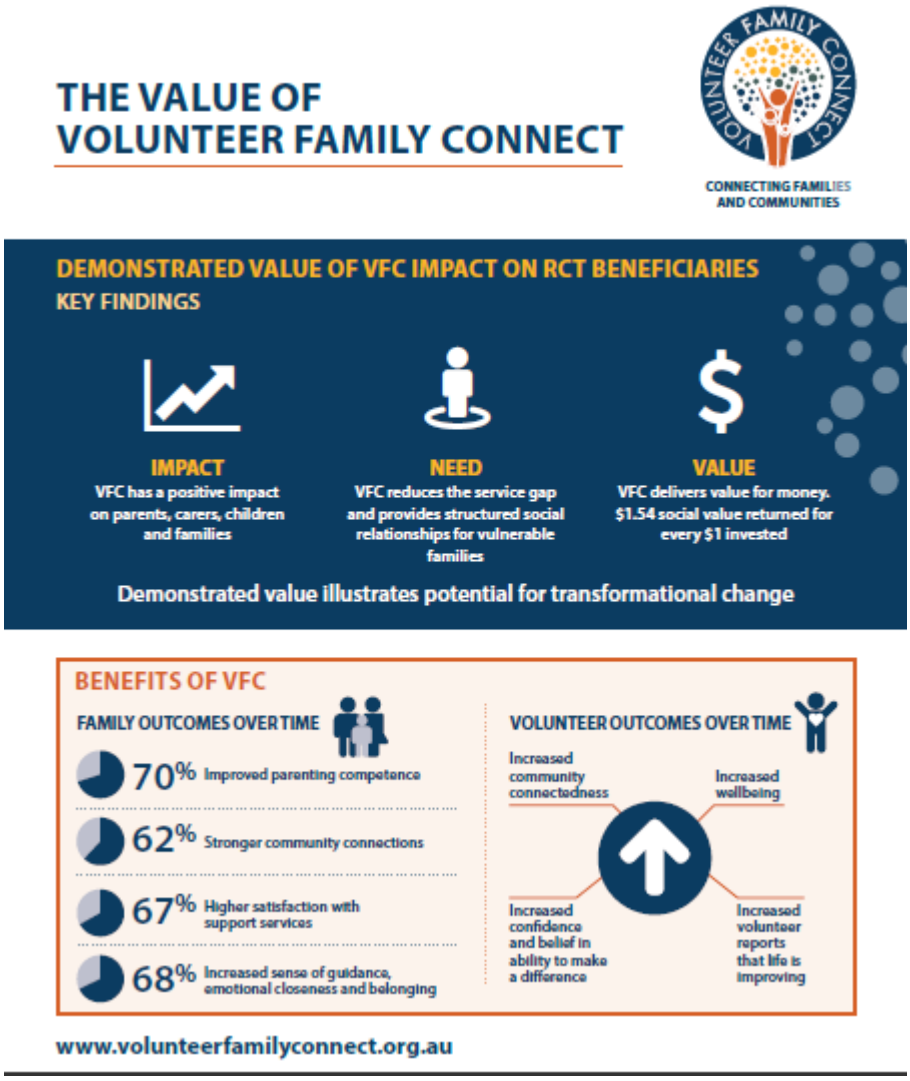
The program is a homebased family support service that brings together the best evidence and practice knowledge about the benefits of volunteer home visiting to support the wellbeing, social inclusion & participation of parents, children and volunteers. Operating in conjunction with professional services the VFC program provides a community based, early intervention model that focuses on the importance of connecting families with their local community and offers a unique opportunity to provide a service to both families and volunteers who assist and support families. VFC volunteers are skilled, trained and supervised. They are caring, experienced, respectful and confidential. VFC volunteers are not baby-sitters,

cleaners or cooks, and they are not super-nannies. They have extensive knowledge of their community and can help connect families with other child and family support services, as appropriate, and with other families in the area.

VFC volunteers visit a family for two hours every week and can help parents adjust to a new baby, cope with multiple children, assist parents to overcome feelings of isolation or frustration, and work with parents to help them meet some of the challenges they are experiencing. Volunteers help parents and young children, in-home or in a community space, or can assist parents by accompanying them to an appointment or errand. Working together with community and professional services, the Volunteer Family Connect program aims to increase parents' confidence in their parenting and increase families' connectedness to local community networks.

**WHAT ARE THE BENEFITS FOR FAMILIES?**

· Encourage positive parent and child relationships
· Reduce isolation, stress and anxiety
· Connect to a network of parent and community supports
· Have access to information and support
· Feel supported as a parent
· New ideas for playing with your children
· Build resilience and increased parental capacity
· Gain support and assistance adjusting to parenting roles
-Identify families early who may need to be referred for further professional support


THE VALUE OF
VOLUNTEER FAMILY CONNECT
VOLUNTEER FAMILY CONNECT
CONNECTING FAMILIES AND COMMUNITIES
DEMONSTRATED VALUE OF VFC IMPACT ON RCT BENEFICIARIES
KEY FINDINGS
IMPACT
VFC has a positive impact on parents, carers, children and families
NEED
VFC reduces the service gap and provides structured social relationships for vulnerable families
VALUE
VFC delivers value for money. $1.54 social value returned for every $1 invested
Demonstrated value illustrates potential for transformational change
BENEFITS OF VFC
FAMILY OUTCOMES OVER TIME
70% Improved parenting competence
62% Stronger community connections
67% Higher satisfaction with support services
68% Increased sense of guidance, emotional closeness and belonging
VOLUNTEER OUTCOMES OVER TIME
Increased community connectedness
Increased wellbeing
Increased confidence and belief in ability to make a difference
Increased volunteer reports that life is improving
www.volunteerfamilyconnect.org.au

# DEMONSTRATED VALUE ILLUSTRATES POTENTIAL FOR TRANSFORMATIONAL CHANGE

CONNECTING FAMILIES AND COMMUNITIES

## A SOCIAL RETURN ON INVESTMENT (SROI) ANALYSIS HAS SHOWN THAT GOVERNMENT INVESTMENT IN VFC IS WORTHWHILE, ULTIMATELY LEADING TO A REDUCTION IN SERVICE COST SAVINGS:

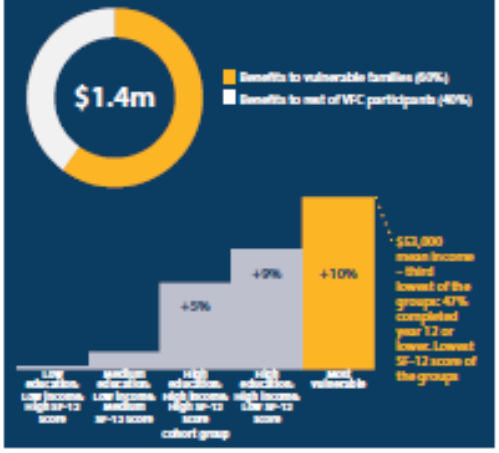
1. **IMPACT:** Positive impact for parents, carers, children and families
2. **HOW:** Reduces services gaps and provides structured social relationships
3. **VALUE:** Delivers value for money

### COST-EFFICIENT DELIVERY

A Social Return on Investment analysis found that the social impact evaluation ratio for the VFC program is between 1.21 and 2.39.

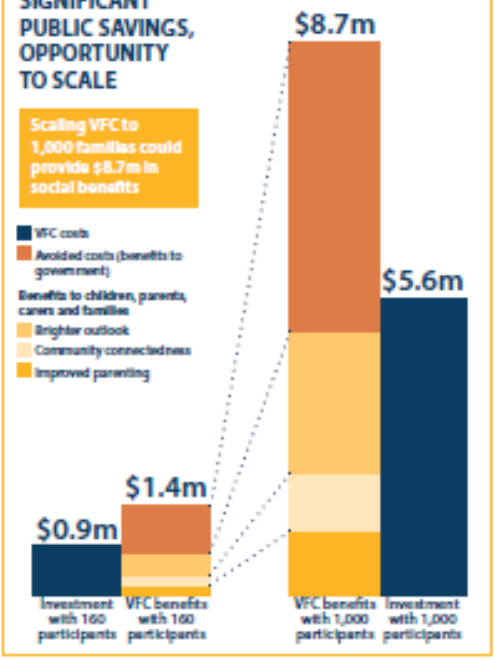
## TARGETED IMPACT FOR VULNERABLE FAMILIES

VFC participants were classed into cohort groups based on their average positive changed experiences through VFC. The cohort group that experienced the most change was also the most vulnerable and likely to avoid costly government-funded services. This group (20% of total participants) generated $830,000, or 60% of the total benefits. This means that every $1 invested in those families delivers $4.62 in social value.




## PROVEN SOCIAL VALUE FOR FAMILIES, SIGNIFICANT PUBLIC SAVINGS, OPPORTUNITY TO SCALE

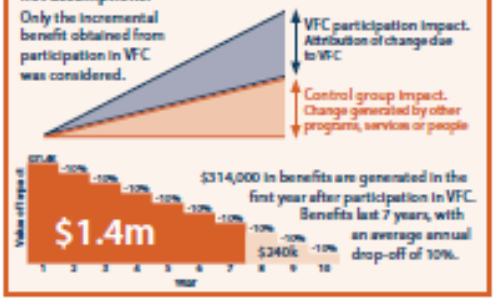
Scaling VFC to 1,000 families could provide $8.7m in social benefits




## ACCURATE, CREDIBLE RESULTS THAT DELIVER VALUE

The measurement of the impact of VFC is based on results not assumptions.

Only the incremental benefit obtained from participation in VFC was considered.




www.volunteerfamilyconnect.org.au

**JUSTICE**

- *What mental health supports earlier in life are most effective in reducing contact with the justice system?*
- *To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples' future interactions with that system?*
- *Where are the gaps in mental health services for people in the justice system including while incarcerated?*

**Juvenile Justice –Karitane Family Matters program**

With evidence suggesting that over ½ of children in custody have had a parent in incarcerated and increased rates of recidivism, higher than average aboriginal representation, it is essential to provide early support and education to young people in custody.

The Karitane Family Matters program is delivered by a qualified Child and Family Health Nurse from Karitane and is a support and education program for young people in custody. The program is delivered to young people who are parenting to facilitate and encourage the parent-child relationship during times of separation (parent is encouraged to record a reading DVD), supported visits are coordinated, the young parent completes evidenced based parenting programs such as Circle of Security &Tuning Into Kids. This program is for both male and female detainees. Family Matters is delivered within an attachment and relationship based framework.

Young people not parenting are also included so that early education around safe parenting practices, safe and respectful relationships as it is essential for young people to gain an understanding of the impacts of early childhood experiences. Increasingly epigenetics shows that children who experience sustained trauma can modify the gene in the brain that shape neuroendocrine and behavioural stress responsivity throughout life (CCCH 2017) When children are shown responsive ways of interacting they benefits come full circle as they then become healthy responsive parents (Centre for the developing child, 2017).
With increasing prevalence of domestic violence and violence against women, evidence has shown the following principles are essential to address these issues.

- Encourage and support children, young people and adults to reject rigid gender roles and develop positive personal identities that are not constrained by gender stereotypes.
- Challenge aggressive, entitled and dominant constructions of masculinity and subordinate or sexualised constructions of femininity.
- Promote and support gender-equitable domestic and parenting practices,
- Strengthen efforts to promote non-violent parenting and prevent child abuse, and all other forms of violence (such as race-based, community, public or lateral violence), especially through the provision of expertise on the gendered dynamics of these broader forms of violence (Vic Health, 2016)

**MENTALLY HEALTHY WORKPLACES**

*What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?*

**Karitane Workplace Support outreach programs**: Karitane delivers workplace programs in partnership to over 20 large corporate organisations nationally with recent sessions holding up to 470 parents.

The Karitane corporate/workplace outreach programs, established in 2016, makes parenting education and support accessible to working parents, including dads. Offering a mix of Webinars, "lunch and learn" seminars in major corporate offices nationally and a webinar series, the program has been accessed by over 1600 dads and has received positive consumer feedback.

Parental stress is a significant contributor to mental ill-health. Less than half of mothers experiencing postnatal depression seek support (NHS UK 2015). Beyondblue (2015) has demonstrated:

- 1 in 5 women and 1 in 10 men experience perinatal depression or anxiety
- Moderate mental health conditions can mean 45 hours of absenteeism and 150 hours of presenteeism per employee, per year
- Mental health conditions cause 1.1 million days of absenteeism and 1.5 million days of presenteeism per annum, seriously impacting company and individual performance

Workplace supports need to normalise caring responsibilities alongside career progression. Practical supports coupled with a cultural shift will significantly reduce the impact of mental health conditions relating to parenting stress.

We are increasingly aware of the challenges facing organisations who are seeking to support those juggling parenting with a busy career in your workplace. These challenges can include:

- The cost of losing skilled staff who find the parenting and work juggle too challenging or feel under supported
- The potential for discrimination of parents in the workplace
- Low return to work rates from parental leave
- Difficult or stressful transitioning in and out of the workplace for parental leave
- Stress or fatigue related to returning to work whilst managing babies' sleep patterns or young toddlers' behavioural issues
- Lack of awareness of how to support breastfeeding working parents effectively
- A poor reputation as a parent-friendly organisation

We are also seeing increasing emphasis and requirement for organisations to support their people on matters such as:

- Family violence disclosure
- perinatal anxiety or depression, with associated productivity and cost impacts from absenteeism and presenteeism

Our teams provide practical parental advice and support, educational seminars, one-on-one care, and informative material to assist organisations in creating an inclusive, supportive workplace culture for parents.

**SECTION 4**

**COORDINATION AND INTEGRATION**

*What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?*

- **Greater investment in early intervention and prevention**

The government should invest in specific early intervention and prevention (primary and universal) services. By focusing only on problems that already exist, crucial opportunities are being missed to prevent problems from escalating in the first place. Better early intervention will reduce the load of secondary and tertiary services. Service delivery should be varied to suit the wide range of families, needs and specific vulnerabilities.

- **Improved cultural sensitivity**

Improved cultural sensitivity has the potential to dramatically improve service access and effectiveness for Indigenous and CALD families. Delivering services that are culturally appropriate to the wide range of cultures that comprise our multicultural society is not simple, but it will yield significantly better outcomes for families.

- **Services more clearly aligned with client need**

Services must be structured to meet clients' needs, rather than delivering a prescribed program which may not actually be what each family requires. Programs must be evidence based, delivered by appropriately trained professionals who have a deep understanding of attachment theory, and delivered to the right clients at the right time. Clearly defined universal and tiered perinatal infant mental health services will support this.

- **Improved governance and accountability**

There needs to be clearer requirements for service providers and systems to have robust governance and accountability to ensure and maintain quality service delivery to vulnerable families. Existing perinatal infant mental health service providers should be mapped, including their governance structure, qualifications and competencies of their workforce. The maps should include which evidence-based programs are being offered, and whether any specific cohort is being targeted. This will support more

effective service and funding planning, enable areas of overlap and underservicing to be identified, and identify opportunities for collaboration.

- **Improved data collection to better target services**

Clear metrics should be defined so that perinatal infant mental health services can be more effectively targeted to where they are likely to have the greatest impact. Effective data capture will help identify the extent of the demand for services, enabling more useful planning, service design and delivery.

- **Better coordination between siloed services**

Siloing of services is common, and can have negative impact for service users. Key related silos from mental health services, such as child protection, family violence and drug & alcohol services, need to have much more effective support for collaboration between services to ensure that the best outcomes are achieved for children and their families.

- **Reduced burden of regulation**

Multiple funding for a plethora of mental health programs delivered through multiple funding bodies each with different reporting, governance, accountability and acquittal requirements has created a substantial regulatory burden and high corporate overheads. A regulation reduction program – without losing key safeguards ensuring accountability and quality – would support perinatal and broader mental health support services to become more agile, reducing overheads and directing more funds into key programmatic outputs.

**FUNDING ARRANGEMENTS**

*How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government*?

*Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?*

- Funding access, resourcing and distribution still seems uncoordinated and patchy. NGO and health sector providers receive different buckets of funding (Health v's FACS, State v's Federal) to support mental health early intervention and prevention services as well as more vulnerable families. There still does not appear to be an overarching equitable or strategic distribution of funding and no clear roles and responsibilities across agencies/jurisdictions despite much dialogue and identification of these issues.

- Funding should be directed to evidence-based programs that have demonstrable outcomes. Programs supporting new parents and babies regarding mental health interventions must be evidence based. Programs that have not yet been evaluated but that demonstrate a strong program logic and are likely to have positive outcomes should not be excluded, but programs that have a strong evidence based should be prioritised

Contact details:

Grainne O'Loughlin
CEO

<end>