Mental Health Inquiry. Productivity Commission.

Submission by Danielle Malone 5/02/2020
Bachelor of Secondary Education (Family and Community Studies)
Diploma of Counselling
Current student master's degree Public Health, Griffith University.

My name is Danielle Malone and I am presenting an individual submission today, not representing any affiliations mentioned herein.

30 years of experience in public education as a teacher, and 10 years in educational wellbeing as a school counsellor and wellbeing leader for students aged between 5-18 years has provided an insight into opportunities this inquiry presents. Additional experience with chronically disengaged youth from 15 to 25 years of age with an NGO has equipped me to speak about transitions into adult life for young people with mental health barriers.

I highly commend and concur with the reform objective of '***Better use of childhood services to identify and enable early intervention for social and emotional development risks.'***

Early Intervention and Prevention recommendations 17 of the draft report acknowledge many necessary actions, however, without accountability the measures will have minimal impact as they are essentially in place already but resourced and utilised ineffectively.

I strongly believe that effective whole population mental health prevention and intervention will only occur through *enforced wellbeing standards* at Pre-School, Primary and Secondary levels of education. With standardised screening and compulsory intervention, life outcomes and productivity for individuals, and hence the wider community could expand exponentially.

Young people are highly susceptible to mental illness and as the issues paper notes, many mental illnesses commence at school age. After listening to submissions from Child Psychiatrists Dr Goodfellow and Professor Paul, I now understand mental health conditions can also present in infancy.

Children and families are legally obliged to interact with education facilities, public or private and as such teachers have a unique relationship with students that cannot be replicated. As with many industries, human resource accountability is key, and time is poor. This is especially the case for early childhood educators, primary and secondary teachers with student complexities presenting increasing difficulties.

The enforcement of NAPLAN within schools has diminished the focus on wellbeing within the department and therefore in schools. South Australia has highly commendable systems, processes and personnel, all that is needed is benchmarking to ensure SEL prevention and early intervention is undertaken as part of school compliance processes. A plethora of evidence indicates the benefits to learning of improved wellbeing, yet this is not emphasised in Education Departments. Should there be an enforced standardisation of wellbeing reporting and intervention, attention and resourcing would be redirected more equally to wellbeing.

Stigma is an issue that has undermined a great deal of intervention at individual and systemic levels and is a question that has been asked repeatedly in public hearings.

Use of specialist services is minimised by parental and possibly workforce fear of stigma. Like the infant mental health referral disconnect Professor Paul spoke of, school age referrals have a significant disconnect also. In the SA Department for Education Annual reports on behavioural incidences, the number of individuals exhibiting repeated behavioural incidences is considerably higher than those referred for specialist support services. All support services referrals require parent consent and many parents fear the stigma of a label of disability, be it physical, cognitive, social or emotional.

In order to reduce stigma in early prevention and intervention, I believe the Hierarchical Taxonomy of Psychopathology (hitop) model of risk identification and targeted intervention would prove highly effective. This model uses transdiagnostic spectra of 'Internalising and Externalising' as the first stage of general psychopathology and 'Fear or distress and substance use or antisocial behaviour' as the next stages.

Whilst undertaking a Masters in Global Public Health with preventative mental health being a focus, I have discovered research from a small number of scholars using this model for early intervention. Forbes, Rapee and Krueger present a stepped intervention using this model in their paper titled 'Opportunities for the prevention of mental disorders by reducing general psychopathology in early childhood', published in the Elsevier, Behaviour Research and Therapy Journal 119 (2019). Forbes and Rapee are affiliated with the Centre for Emotional Health, Department of Psychology, Macquarie University, Australia and I believe a valuable resource in this field.

In regard to recommendations in the paper, I will make notes in response to the points I have not addressed at this stage.

17.2, social and emotional development for pre-school children, the Australian Early Development Census has been effectively collecting this data about 5-year old's since 2009. This is a very well managed and implemented process and could easily be expanded to a younger age group.

17.3, social and emotional learning programs in the education system, the National curriculum includes SEL in the Health area. There are many other programs to support this area including the SHINE program and Keep Safe Child Protection Program in South Australia and similar interstate. These programs do not have accountability measures either.

17.4, educational support for children with mental illness, is in place in SA using an effective model of preventative and developmental wellbeing, but highly under sourced for the demands within the role. Referral pathways are used but waiting times are prohibitive, face to face access severely limited and apportioned funding allocations and hence number of sessions available, inadequate. The South Australia Department for Education has an excellent program of reengagement for students at risk, of which those with mental illness are in high number, called a Flexible Learning Option enrolment. The funding model for this is prohibitive but it combines Education, Health and Social Services departments. It is known as the ICAN-FLO model and having worked at reengaging students, I have personally witnessed immense improvements from high levels of self-harm and risky behaviours, to full engagement with education and training. Working with a local NGO, these students reported feel highly isolated and incompetent and when brought together to engage in meaningful

activities and dialogue, they begin to make positive changes. One of the best initiatives experienced within this role was an Art Therapy program. Australia is highly dominated by sport and athletic pastimes and a significant portion of disengaged students preferred creative pursuits such as music and arts. The sense of belonging, method of expression and sense of self worth emerging from this program was significant. The success of this program was assisted by my personal appreciation for the arts and my own experience of isolation, lack of creative expression and child abuse related depression. My passion for engaging rural minority groups into productive activity was born from my own circumstance and compassion for others and to see such great results such as social anxiety and early school leaver to international university exchange student was very rewarding. When the Federal Youth Engagement funding ceased in 2004, I returned to the educational setting as Wellbeing coordinator.

17.5 wellbeing leaders in schools, most schools in SA have a wellbeing coordinator/student counsellor to undertake the preventative model of wellbeing, alongside the intervention approach. Although I hold a Diploma of Counselling, in SA a school counsellor does not need to have formal qualifications other than in education. The role includes a teaching portion for most small schools which is problematic. I am a member of a local Secondary Wellbeing Coordinators network and there are many responsibilities included within the wellbeing role in most sites. Redefining this role would be of significant benefit. If the preventative model held accountability, requirements at the crisis intervention stage would be reduced. According to ABS (2017), suicide is the leading cause of death among 5-17 year old people in Australia, although this is largely concentrated from 15 to 17 years of age. Should the compulsory intervention be implemented the demand crisis intervention and post-vention would be significantly impacted.

17.6, Wellbeing data has been collected for schools across Australia, particularly at commencement of schooling in the Australian Early Development Index and where disengagement levels increase dramatically in the Middle Years of schooling, the Middle Years Development Index. This data has been extensive but does not appear to have been used to inform practice and therefore benefit population health.

There are so many fantastic initiatives already in existence, they do not need to be reinvented. The Positive Schools Network is a great resource of professionals but also an indicator that change requires boundaries of enforcement rather than encouragement as their progress is voluntary for sites and the cohort is dominated by private schools.

I truly hope that a renewed focus on wellbeing within education emerges from the inquiry. I would like to express my gratitude to the Productivity Commission for ensuring the process of public hearing is afforded to people like myself. The opportunity to be heard and valued as a professional with experience working with young people and as an individual with long term lived experience with mental illness.

Kind Regards

Danielle Malone