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RESPONSE TO THE DRAFT REPORT OF THE PRODUCTIVITY COMMISSION ON MENTAL HEALTH

Volume 2
Part IV – Early intervention and prevention

Draft Recommendation 17.1 – PERINATAL MENTAL HEALTH
The Commission's inclusion of a chapter on the issue of perinatal mental health in this draft report is welcome. However, it is afforded just 1 page of the 1,200-page report despite perinatal depression prevalence being reported as between 6% and 17% in the general population and even as high as 30% in women from disadvantaged communities [1, 2, 3, 4, 5].

Perinatal mental illness has short- and long-term consequences for mother, child and family. Infants whose mother has perinatal mental health issues may be at risk of lower rates of immunisation, reduced growth and developmental concerns [6].

The report has a drafted recommendation to achieve universal screening for perinatal mental illness but there is no reference to provision of services for this group. There is clear evidence to suggest that infants whose mothers have perinatal mental illness need to receive additional child health screening.

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Draft Recommendation 17.3 – SUPPORTING CHILDREN AND YOUNG PEOPLE DURING THEIR SCHOOL YEARS

The Commission's inclusion of a chapter on supporting children and young people during their school years life in this draft report is long awaited.

The education reforms and the emphasis on teachers learning about the social and emotional development of children is welcomed. Additionally, there is also the need of knowing how to teach children with social and emotion development difficulties. The drafted recommendation 17.5 – wellbeing leaders in schools' role is well received, but there also needs to be comprehensive services for the wellbeing leader to liaise with for this to be effective when working with children with social and emotional difficulties.

It appears that the model for supporting children and young people is still largely an adult-centric model with a typically medical-oriented stepped care approach. This does not work well for child mental health, especially where there needs to be expert intervention early for young children to prevent the cascade of impacts.

There is a clear need for a greater emphasis on child mental health services having to provide consultation and advice early to schools and primary health care services, especially in the under 5's. Child mental health assessment and diagnosis is challenging and does require specialist assistance - it is far more difficult to assess a child's mental health than it is for an adult. Teaching social and emotional development is a good starting point, and provides a foundation for understanding the social and emotional development of children, but without the back-up of specialist mental health expertise there is a risk that children will end up with an even greater epidemic of ADHD diagnosis, misdiagnosis, and a lack of understanding of the role and impact of trauma resulting in more children being prescribed medication even earlier.

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Response to Chapter 21: SUICIDE PREVENTION

We commend the Commission on the summary of findings related to suicide prevention. Our comments below relate primarily to young people aged 12-25 years.

Targeted suicide prevention:

There is a clear focus in the Commission's draft report on targeted suicide prevention for Aboriginal and Torres Strait Islander people. We strongly agree with the draft recommendation 21.2 – Empowering Indigenous Communities to Prevent Suicide and believe that a specific Indigenous plan is necessary and that this needs to be implemented in the short-term.

Other groups who are highly vulnerable for suicide are identified in the draft report (Figure 21.7), but these groups are not considered in the recommendations. We have produced data on the mental health of trans and gender diverse young people in the Trans Pathways report (Strauss et al. 2017; Strauss et al. 2019). Here we demonstrated that almost one in two (48%) of trans and gender diverse young people aged 14-25 years have attempted suicide. Because many people may die by suicide before being "out" as trans or gender diverse, it is not possible to estimate what proportion of suicides are of trans and gender diverse individuals. The same is true for same gender attracted and other LGBTQIA+ people. No guidelines exist on providing targeted suicide prevention for LGBTQIA+ people.

As such, there is a lack of consideration of intersectional identities and individual needs. For example, an Aboriginal person who identifies as LGBTQIA+ and has experienced homelessness may require a different approach to one who has just one of these experiences/identities. Our recommendation would be to broaden the report to include young people experiencing multiple diversities.

Emergency department (ED):

We agree that hospital emergency departments are not adequately addressing the needs of young people who present with self-harm, suicidal ideation and/or suicide attempts. We would like to refer the Commission to our recent report "Informing youth suicide prevention in Western Australia" (Freeman et al. 2019). We conducted focus groups with 55 young people and an online survey with 198 professionals working in youth mental health services. Findings indicate that emergency departments in Western Australia are failing our young people. The ED is not youth friendly nor "mental health friendly": staff lack training and empathy, discharge planning is poor, and alternatives to presenting to the ED are lacking. Recommendation 9 of our report relates directly to improvements needed in the ED environment:

Improve responses to young people with acute risk or who have attempted suicide by:

- Educating and training emergency department staff and first responders in the assessment and management of young people who present with acute emotional distress and suicidal ideation.
- Providing a crisis response alternative to the emergency department for young people with suicidal ideation and behaviours, such as a Youth Crisis Assessment Team.
- Upon discharge, providing a coordinated and integrated approach to follow up all young people presenting to the ED with suicidal-related behaviour.
- Increasing resources around post ED presentation and discharge.

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School-based programs:
We agree that school-based suicide prevention programs are effective in
reducing suicide and support the draft finding 21.2 – School based awareness programs can be cost-effective and the draft recommendation 17.3 – social and emotional learning programs in the education system. The "Informing youth suicide prevention in Western Australia" report found that almost all young people would like to have the skills to help their peers who might be suicidal. Findings related to schools included:

- Young people reported that staff in schools should be able to provide support or at least receive training to be able to support young people with mental health concerns.
- Over 90% of professionals surveyed reported that teachers should receive suicide prevention training.
- When considering school psychologists, issues raised by young people related to fears about confidentiality, lack of awareness that a school psychologist was available to them, lack of availability of the psychologist and/or the psychologist being unapproachable.

School based approaches are even more important for young people who have limited family support (e.g., children with a parent with mental illness).

There is also evidence that only 9% of teachers feel confident in dealing with suicidal ideation (King et al. 2009). Recommendation 8 of our report states:

Enhance the role of schools in suicide prevention by:

- Embedding universal suicide prevention training for students at a developmentally appropriate level.
- Providing developmentally appropriate mental health education and positive coping strategies for students in schools.
- Increasing confidence of staff to have conversations about suicide risk.
- Reviewing resource allocation and service models for student support within Western Australian schools.

We hope that this submission will inform the final version of the Productivity Commission Mental Health Report.

References

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