Public Advocate and Children and Young People Commissioner
ACT HUMAN RIGHTS COMMISSION

THE SOCIAL AND ECONOMIC BENEFITS OF IMPROVING MENTAL HEALTH

PRODUCTIVITY COMMISSION ISSUES PAPER

APRIL 2019

ROLE OF THE PUBLIC ADVOCATE AND CHILDREN AND YOUNG PEOPLE COMMISSIONER (PACYPC)

The Human Rights Commission (HRC) is an independent agency established by the *Human Rights Commission Act 2005* (ACT) to promote the human rights and welfare of people in the ACT. As part of the HRC, the Public Advocate and Children and Young People Commissioner (PACYPC) has a range of statutory functions including advocacy (individual and systemic), representation, investigation, and monitoring. Some of these functions are specific to children and young people, and others relate to people with complex disability needs, including those with mental health conditions and/or forensic patients.

The PACYPC welcomes the opportunity to respond to the Productivity Commission's Issues Paper, *'The Social and Economic Benefits of Improving Mental Health'*. It should be noted that the PACYPC views mental health broadly and includes the ongoing effects of trauma and its impact on a person's wellbeing. This submission focuses on reforms that prioritise early intervention supports, trauma-informed care, and the further development of an integrated collaborative service system. Feedback and recommendations are informed by our statutory advocacy functions, which promote the rights, participation, and protection of people accessing mental health services in the ACT.

HEALTHCARE

Public policy often fails to adequately recognise the importance of the social determinants of mental ill health such as violence, disempowerment, social exclusion, and the breakdown of communities brought about by socio-economic disadvantage and harmful conditions at work and school.[1]

Mental Health Care Reform

Underpinned by person-centred and recovery-oriented care approaches, mental health reform in Australia is premised on key principles of community psychiatry with four interlinked action areas: deinstitutionalisation; development of alternative community services and programs; integration with other health services; and integration with social and community services.[2] However despite a succession of national plans and strategies underpinned by these principles, the mental health system is still characterised by high rates of re-admission to acute care and the use of compulsory treatment orders and seclusion, indicative of a system that is hospital-based and fragmented, where community based care and supports are inadequate and poorly integrated.[3]

As part of our commitment to systemic reform in this area, the PACYPC is often alerted to and is compelled to intervene in cases where the system has failed an individual. This provides insight into how systemic failures impact vulnerable people first hand, thus allowing us to build a case for systemic reform.

[1] "Report of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", Human Rights Council, 35th Session, June 2017.
[2] Furst, M.C., Salinas-Perez, J.A., Anthes,L.,Bagheri,N.,Banfield,M.,Aloisi,B., SalvadorCarulla, L. (2018). The Integrated Mental Health Atlas of the Australian Capital Territory Primary Health Network Region. Centre for Mental Health Research, Australian National University
[3] Ibid.

Case Study

A man in his mid-twenties was homeless and living in a tent at the top of a mountain with no supports other than daily contact with an Early Morning Centre. He came to the attention of the PACYPC when he was involuntarily detained at the Adult Mental Health Unit after refusing to leave Centrelink and coming to the attention of the police. It was obvious that his needs were not being met and he was slipping through the gaps in the system. The PACYPC identified the services needed to improve this man's circumstances and immediately initiated advocacy action. Within one month he had permanent housing, the Disability Support Pension and a Mental Health Community Team to support his mental health recovery. Six months later, his mental health is stable, he is in full-time study with secure accommodation and a regular income. He has made new friends and is now leading a fulfilling life.

The PACYPC is involved in regular 'Long Stay Meetings' at the Adult Mental Health Unit with other external stakeholders to discuss barriers to discharge for individuals who have been inpatients for extended periods. These meetings highlight the need for effective discharge planning and collaborative practice, and also the systemic issues that need to be addressed for those with complex needs who do not fit the parameters of mainstream services in the ACT. This is a rich source of information for the PACYPC in that it gives a human face to the consequences of a poorly integrated system.

The PACYPC also participates in monthly meetings with operational staff in the mental health units to review decision-making in relation to seclusion and restraint. Using data and case examples, the PACYPC identified the need for pressing systemic reform and advocated for the implementation of Safewards, a model of care developed to reduce the restrictive practices of seclusion, restraint, aggression and violence in mental health facilities.

The PACYPC supports the balanced care model outlined in *The Integrated Mental Health Atlas of the ACT Primary Health Network Region*.[4] According to this model, in high-resource settings such as Australia, mental health reform needs to focus on: recognition and treatment of mental illness in accessible primary care settings; a good range of general adult mental health services, including outpatient clinics, community mental health teams, acute inpatient services, community residential care and the provision of specialised mental health services such as eating disorder clinics and early intervention teams). Alternatives to acute inpatient care (e.g. in home treatment), alternative types of long-day community residential care (e.g. lower supported accommodation), and specialised services to access employment (including vocational rehabilitation) should also be prioritised.

Moving mental health into the mainstream

In adopting a rights-based approach, mental health care needs to be integrated with physical health and delivered in primary and general health care settings that prioritise early intervention and have clearly defined health pathways. 'Scaling up' the funding of more restrictive and acute mental health services, needs to be replaced with a 'scaling across' approach to bolster diverse community-based supports within a recovery oriented psycho-social framework. Supporting a person within their community, whether it be within the family or at work, is integral to responding to their particular psychosocial and emotional vulnerabilities. An integrated population-based responsive service system that incorporates programs to address the social and environmental determinants of mental ill health, uphold a person's right to be safe, healthy, and enabled within an environment that is free from violence and discrimination.[5]

[4] Furst, M.C., Salinas-Perez, J.A., Anthes,L.,Bagheri,N.,Banfield,M.,Aloisi,B., SalvadorCarulla, L. (2018). The Integrated Mental Health Atlas of the Australian Capital Territory Primary Health Network Region. Centre for Mental Health Research, Australian National University

[5] "Report of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", Human Rights Council, 35th Session, June 2017.

Case Study

The PACYPC advocated for a woman in her thirties with diagnosed Borderline Personality Disorder (BPD) following repeated admissions to acute mental health services. Despite multiple support strategies being implemented over many months, her mental health status and safety declined. The PACYPC advocated for a comprehensive analysis of her situation. After several meetings with clinical staff and decision-makers, a Multi-Agency Response Group (MARG) document was generated with an agreed treatment and response plan for all agencies including triage staff, emergency response staff, and clinical teams. This collaborative approach enabled the person to be treated in an accountable, consistent and transparent manner according to documented recommendations every time she presented at hospital.

Recommendation: Invest more in population-based early intervention and prevention services in community and primary health settings, including alternatives to acute hospital-based service provision.

Culturally and Linguistically Diverse Communities

In a report commissioned by the Capital Health Network (CHN), a number of areas were identified where there was a lack of services for people with lived experience of mental ill health.[6] These include acute and non-acute alternatives to hospitalisation, day programs, employment-related services, and culturally and linguistically diverse (CALD) services.[7]

Mental health tribunal hearings provide a forum for people with diagnosed mental illness to have their voice heard; these are undertaken with a human rights focus. The PACYPC attends tribunal hearings to determine whether a person may experience vulnerability in this process and to advocate as needed.

Case Study

An elderly woman from Sudan was an inpatient in an acute mental health facility and did not speak or understand English. An application for a Psychiatric Treatment Order (PTO) was made and the PACYPC attended to oversee the process, and ensure appropriate and reasonable adjustments and the upholding of her rights. An interpreter was arranged, and the PACYPC's presence ensured that sufficient time was given to the hearing to enable the person to understand the process and have the opportunity to ask questions. The process also allowed the person's family to make contact with the PACYPC should they require support in the future.

While the PACYPC acknowledges Companion House, a community organisation that provides therapeutic support to asylum seekers and people from refugee backgrounds to manage and process the effects of past trauma, the CHN report was unable to identify any specialist CALD mental health services in the ACT. It is imperative that funding priorities reflect the growing proportion of individuals in Australia who speak a language other than English at home. It is predicted that by 2021, 30% of Australians over the age of 65 will be of CALD background and that with this ageing population will come increased likelihood of depression, isolation and unmet needs if the current service landscape continues.[8]

Recommendation: Engage with the National Multicultural Mental Health Project[9] to ensure reform is culturally responsive, including by funding specialist mental health services within CALD specific community organisations to address the emerging needs of this cohort, notably those of young people and of older persons.

[6] Furst, M.C., Salinas-Perez, J.A., Anthes,L.,Bagheri,N.,Banfield,M.,Aloisi,B., SalvadorCarulla, L. (2018). The Integrated Mental Health Atlas of the Australian Capital Territory Primary Health Network Region. Centre for Mental Health Research, Australian National University

[7] "When NDIS came to town: A story of hope and disruption in the mental health sector:, Mental Health Community Coalition ACT, June 2018.

[8] "Mental Health and Australia's Culturally and Linguistically Diverse Communities", The Federation of Ethic Communities' Councils of Australia (FECCA), 2011.

[9] https://mhaustralia.org/national-multicultural-mental-health-project

Participation

To achieve sustainable long-term positive outcomes requires a multi-sectorial a systemic response that values meaningful participation of consumers in decisions about their health and wellbeing.

In the ACT, the *My Rights, My Decision* initiative, created and developed by the ACT Mental Health Consumer Network (MHCN), provides consumers with the opportunity to record their views and preferences about their mental health treatment, care and support in advance. This includes documenting electronically Advance Care Agreements, Nominated Person Authorities and Advance Consent Directions as set out in the *Mental Health Act 2015.* Alongside Legal Aid, the PACYPC has been involved with the monthly education sessions held by the MHCN for the purpose of responding to questions from consumers who may need clarity about their human and legal rights in this context.

Recommendation: Mental health services, including acute and community-based programs, incorporate accountable participation mechanisms into their policies and procedures.

SPECIALIST SERVICES FOR CHILDREN AND YOUNG PEOPLE

In a review of the main types of care in mental health across the ACT, 62% of services were targeted to adults, and 9% were specialist services for children and young people. An identified service delivery gap was a lack of targeted support services for young people transitioning to adult services (5%). The majority of services for children and young people were provided by government departments, with fewer services integrated into not-for-profit community-led organisations. When the onset of psychosocial disability is before 25 years of age, there needs to be targeted funding in the early intervention and support services for young people transitioning to adulthood.[10]

The PACYPC is advocating strongly for the formulation of a clear policy and guidelines in relation to the use of seclusion and restraint with adolescents. The absence of this was initially brought to the attention of the PACYPC upon being alerted to restraint being used in a medical ward without the PACYPC being notified as required under the *Mental Health Act 2015*. The issues raised were multiple, and included legislative and human rights breaches. It also highlighted the need for policy guidance and associated training to address these shortfalls in caring for adolescents with mental health issues admitted to non-mental health wards.

Recommendation: Adequately fund community based specialist mental health services for children, young people, and those transitioning to adulthood.

Early Intervention

With a focus on early intervention and prevention, education, child protection, community services, health and justice must work together to collectively hold responsibility for effective wellbeing and mental health outcomes for all people.[11] Given the continuity of mental health conditions from childhood to young adulthood (0-25 years), the evidence base suggests that a model of early intervention is most effective when the following principles are incorporated across systems: integration of service delivery; consumer and carer involvement; duration and intervention not linked to outcome; cross-disciplinary care team approaches; joint care planning; promotion, prevention and early detection; enhanced information sharing protocols in the best interests of the child; and early family education about mental health and treatment.[12]

[10] Furst, M.C., Salinas-Perez, J.A., Anthes,L.,Bagheri,N.,Banfield,M.,Aloisi,B., SalvadorCarulla, L. (2018). The Integrated Mental Health Atlas of the Australian Capital Territory Primary Health Network Region. Centre for Mental Health Research, Australian National University

[11] Catania,L., Hetrick,S.,Purcell,R.,& Newman,L. (2011). 'Prevention and early intervention for mental health problems in 0-25 year olds: Are there evidence-based models of care?', *Advances in Mental Health, 10,* 3-16

[12] Catania,L., Hetrick,S.,Purcell,R.,& Newman,L. (2011). 'Prevention and early intervention for mental health problems in 0-25 year olds: Are there evidence-based models of care?', *Advances in Mental Health, 10,* 3-16

Infant Mental Health

The prevalence of mental ill-health detected in pre-school children in Out of Home Care (OOHC) is 60.5%, which highlights the importance of early intervention and mental health screening for this cohort.[13] Integrating early development and parenting services with early education, preschool and school preparation programs is essential to early mental health intervention.[14] [15] An economic evaluation of such programs has shown that savings exceed the cost of the program four-fold.[16] Education programs delivered in early childhood settings, with home visiting components have showed similar positive outcomes.[17] The PACYPC recognises the need to work closely with community to ensure necessary adjustments are made to these programs to meet the needs of families from diverse communities, and the importance for these programs to be run in community-controlled organisations.[18] [19]

Children of parents with mental illness

Children of parents with mental illness represent one of the population cohorts at highest risk for psychiatric conditions.[20] [21] Research indicates the effectiveness of early intervention home visiting programs and school-based group programs in reducing mental ill health in this cohort.[22] A particularly invisible group of children are those caring for parents with mental illness. The interface between the education system and community support services, including mental health is vital in identifying children as carers and linking these children to other peers with a shared experience. The opportunity for children to discuss their parents' mental health is also known to mitigate the harmful impacts.[23] [24]

A particular consideration when reviewing the systemic response to adults in psychiatric care is whether or not, and to what extent, children and young people are considered in treatment planning. Psychiatric services have a significant role to play in identifying the need for and initiating child-focused treatment planning with an emphasis on promoting interagency collaboration with other community welfare support services. The implementation of child-focused strategies and interagency collaboration will ultimately support children and parents by moving away from individual perspective to one that includes addressing the need of families.[25]

Recommendations: Re-focus mental health funding so there is greater investment in community-based early intervention programs, co-located with early childhood centres, preschools, and schools. Review assessment and treatment plans to ensure early identification of children who have parents with mental illness, and prioritise child-focused, collaborative planning

[13] Lok, L., & Tzioumi, D. (2015). Mental health needs of children in out-of-home-care. Journal of Paediatrics and Child Health, 51(S2), 7-8. Available at: http://onlinelibrary.wiley.com/doi/10.1111/jpc.1291324/full)

[14] A Woodward, D Ward, J Jackson, Exploring the Long-term Influence of the Family Nurse Partnership on the Lives of Young Mothers: Jessica Jackson, *European Journal of Public Health*, Volume 27, Issue suppl_3, November 2017, ckx186.308, https://doi.org/10.1093/eurpub/ckx186.308

[15] Sawyer MG, Frost L, Bowering K*, et al* Effectiveness of nurse home-visiting for disadvantaged families: results of a natural experiment *BMJ Open* 2013;**3 :**e002720. doi: 10.1136/bmjopen-2013-002720

[16] Catania,L., Hetrick,S.,Purcell,R.,& Newman,L. (2011). 'Prevention and early intervention for mental health problems in 0-25 year olds: Are there evidence-based models of care?', *Advances in Mental Health, 10,* 3-16

[17] Schweinhart, L. (2002). How the HighScope Perry Preschool study grew: A researcher's tale [Electronic Version]. Phi Delta Kappa Center for Evaluation, Development, and Research (research report 32).

[18] Nguyen,H., Zarnowiecki,D, Segal,L., Gent,D., Silver,B., Boffa,J, (2018). 'Feasibility of implementing infant home visiting in a central Australian Aboriginal Community'. *Prevention Science.* 19(7), 966-76.

[19] Sawrikar,P. & Katz,I. (2008). 'Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia'. *Australian Family Relationships Clearinghouse (3).*

[20] "Prevention of mental health disorders: effective interventions and policy options: summary report", World Health Organisation (WHO), 2004.

[21] Karin T M van Doesum & Clemens M H Hosman (2009) Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: II. Interventions, Australian e-Journal for the Advancement of Mental Health, 8:3, 264-276.

[22] Beardslee W, Solantaus T, van Doesum K (2005). Coping with parental mental illness. In: Hosman C, Jané-Llopis E, Saxena S, eds. *Prevention of mental disorders: effective interventions and policy options*. Oxford, Oxford University Press cited in "Prevention of mental health disorders: effective interventions and policy options: summary report", World Health Organisation (WHO), 2004.

[23] Cooklin,A. (2009). 'Children as carers of parents with mental illness'. *Psychiatry,* 8 (1), 17-20.

[24] Manning, C. & Gregoire, A. (2009). 'Effects of parental mental illness on children'. Psychiatry, 8(1), 7-9.

[25] Maria Afzelius, Margareta Östman, Maria Råstam & Gisela Priebe (2018) Parents in adult psychiatric care and their children: a call for more interagency collaboration with social services and child and adolescent psychiatry, Nordic Journal of Psychiatry, 72:1, 31-38,DOI: 10.1080/08039488.2017.1377287

Vulnerable children and young people

In considering the needs of vulnerable children, young people, families and communities, the PACYPC supports recommendations made in the ACT Government submission and, as such, the contribution in this submission will be focused on the vulnerabilities of two specific cohorts: young people transitioning from out-of-home care, and young people who are parents.

Young people leaving care

The risk of emerging mental illness in the OOHC population is notably higher compared to the general population. A particularly vulnerable cohort in OOHC are young people living in residential care, or leaving care who show sharply elevated rates of mental ill health.[26] [27] The relative disadvantage experienced by young people leaving care spans a number of factors including ongoing poor physical and mental health, substance use, homelessness, unemployment and victimisation.[28] The uncertainty and fragmentation that is typical during transition from care can trigger acute mental ill health including self-harm and suicide.[29] [30]

The PACYPC has been involved in multiple cases where the transition for young people in OOHC from adolescent status to adulthood correlates with the abrupt cessation of longstanding and familiar services. The PACYPC is involved in early discharge planning well before young people turn 18 to advocate for a solid transition plan with all services and safeguards in place. Our advocacy is inclusive and includes the young person's views and wishes to the extent they are provided. Well planned and collaborative work is necessary to promote positive mental and physical health outcomes for young people.

Legislated changes to increase aftercare support to young people beyond 18 years of age in jurisdictions outside of Australia has demonstrated improved mental health outcomes, with a reduction in the duration and severity of conditions.[31] [32]

Recommendation: Adequately fund specialist mental health services for young people leaving care with better inter-agency collaboration between OOHC, health, justice and housing services.

Young people who are parents

To break the intergenerational cycle of out-of-home care and the increased onset of associated mental health conditions, it is crucial that mental health services are accessible and specific to the unique needs of young parents,[33] particularly young parents with an experience of out-of-home care.[34] Early intervention is crucial to address the social determinants of mental health for children and young people in OOHC. Universal and targeted early support services within an integrated, strength-based and trauma-informed system support wellbeing and provide opportunities for early mental health support from infancy. For this outcome to eventuate, there must be strong cooperative relationships between early childhood services, child protection, education, housing, justice and health.

Recommendation: Adequately fund early intervention mental health services for young people transitioning into parenthood.

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[26] Rahamin,A. & Mendes, P. (2015). 'Mental health supports and young people transitioning from OOHC in Victoria'. *Children Australia, 41, 59-68.*
[27] Akister, J., Owens, M., & Goodyer, I. M. (2010). Leaving care and mental health: outcomes for children in out-of-home care during the transition to adulthood. *Health research policy and systems*, *8*, 10.
[28] 'Raising our children: guiding young Victorians in care into adulthood. Socioeconomic benefit analysis by Deloitte Access', Report commissioned by Anglicare Victoria, 2016.
[29] Rahamin,A. & Mendes, P. (2015). 'Mental health supports and young people transitioning from OOHC in Victoria'. *Children Australia, 41, 59-68.*
[30] Dixon, J. (2008). 'Young people leaving care: wellbeing and outcomes'. *Child & Family Social Work,* 13, 207-17.
[31] Rahamin,A. & Mendes, P. (2015). 'Mental health supports and young people transitioning from OOHC in Victoria'. *Children Australia, 41, 59-68.*
[32] Lok, L., & Tzioumi, D. (2015). Mental health needs of children in out-of-home-care. Journal of Paediatrics and Child Health, 51(S2), 7-8. Available at: http://onlinelibrary.wiley.com/doi/10.1111/jpc.1291324/full)
[33] Price-Robertson,R. (2010). 'Supporting Young Parents'. *Child Family Community Australia,* Australian Institute of Family Studies.
[34] Antii,K. & Hiilamo,H. (2017). 'Children in OOHC as young adults: A systemic review of outcomes in Nordic countries'. *Children and Youth Services Review,79,* 107-14.

If you have any questions or would like more detailed information on any of the issues raised in this submission, please do not hesitate to contact the PACYPC on (02) 6205 2222.

Regards,

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