

**Response to the Productivity Commission's
Draft Inquiry Report
Inquiry into Paid Maternity, Paternity
and Parental Leave**

November 2008

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Introduction

As our previous submission to the Productivity Commission shows, and the Productivity Commission's Draft Inquiry Report acknowledges, there is a significant amount of evidence of the substantial social and economic benefits from a largely Government funded paid parental leave scheme.

We congratulate the Productivity Commission on bringing together the broad scientific evidence on the benefits of paid parental leave to children and families. We are pleased that the Productivity Commission has recognised that enhancing children's health and development should be one of the primary objectives of a paid parental leave scheme. Although the field of research on the impact of parental leave policies is still in its own infancy, we recognise there is a growing body of evidence showing the benefits of parental leave on infant and maternal health, both physical and mental (Lero, 2003; Gregg & Waldfogel, 2005), as well as the flow-on social and economic impacts from these.

In general, we support the design of the scheme recommended by the Productivity Commission. We are pleased that the recommended scheme is not overly prescriptive, allowing families to adapt the scheme to their needs. We strongly support the recommendation of separate leave for fathers and partners. The broad application of the scheme to parents in casual and part-time employment, as well as to self employed parents, is also positive.

However, we are disappointed that the Productivity Commission has not paid sufficient attention to the evidence that a paid parental leave scheme of at least 12 months is needed to provide the best long term outcomes for children's well-being, particularly in terms of mental health and literacy, as well as for the community.

We are equally disappointed that the Productivity Commission has recommended a paid parental leave scheme of only 18 weeks despite acknowledging that the best outcomes for children come from having parents at home with them for at least 26 weeks. Providing payment for only 18 weeks will disadvantage those children of women who do not have access to an employer paid parental leave scheme or other forms of accrued leave in order to co-fund at least eight weeks of leave. We are concerned that vulnerable families, such as those where parents work casually and/or are from lower

socio-economic backgrounds, will be particularly disadvantaged by the Productivity Commission's scheme which relies on co-funding by parents in order to meet the desired leave length of at least 26 weeks.

Why paid parental leave needs to be at least 12 months to benefit children

The many benefits of a longer leave period

In its Draft Inquiry Report, the Productivity Commission acknowledges the body of evidence that parental leave from work for up to 12 months can be beneficial for children's health and development, yet as a 'tradeoff' between these undoubted benefits and the cost, recommends only an 18 week scheme. We consider that a paid parental leave scheme of at least 12 months is not only beneficial but necessary in order to provide children with the best start in life.

Through its recognition of the benefits of breastfeeding and the role of continuous caregiver interactions in healthy brain development the Productivity Commission's Draft Inquiry Report presents a strong argument for at least six months paid parental leave. However, by not focusing on the second six months of life the range of longer term benefits of a paid parental leave scheme in promoting healthy mental functioning and the development of a highly literate workforce are not likely to be fully realised.

A number of studies have now been published indicating that the length of time necessary to recover from childbirth and adapt to the demands of childrearing has been underestimated by policy makers. As the Productivity Commission has acknowledged, it appears that we should be thinking of a minimum of six months for such recovery (Tulman & Fawcett, 1991). There is also data to suggest that the earlier the return to work the greater the stresses for the parent, with an associated higher risk of maternal depression or an anxiety disorder (Hyde et al., 1993).

Longitudinal data from the National Institute of Child Health and Human Development has confirmed that maternal employment in the first year of a child's life is associated with negative risk for the child's school-readiness (Phillips & Adams, 2001). There are also a number of studies indicating that a longer period of leave is associated with children having stronger attachment patterns and greater interactional synchrony with caregivers (Weinraub & Jaeger, 1991). Importantly, researchers have identified a direct association between shorter length of maternal leave time and more maternal negative affect and behaviour in their interactions with their infant. They show there is a greater likelihood of mothers perceiving their infant as having a difficult temperament and to be less responsive and sensitive in their interactions with their infant (Clark et al., 1997). Also noteworthy are those studies that suggest that returning to work within a year of giving birth is associated with lower language and cognitive scores at ages four, seven and nine years (Vandell & Ramanan, 1992; Baydar & Brooks-Gunn, 1991; Belsky & Eggebeen, 1991).

There are a number of other significant factors involved in all of these correlations, such as the child's biological constitution, the parents' mental health, family dynamics, availability of quality childcare and flexible working hours. However, the available body of evidence suggests that, at least up to 12 months, the longer the leave the greater the benefits for the child's mental health, as well as their language and cognitive development.

Giving consideration to the longer term impacts of paid parental leave

In order to assess the full cost-benefits of a 12 months scheme we must carefully consider how children are cared for in their second six months of life and the impacts this care can have on their long term well-being, including their mental health and literacy.

Recent neuroscientific advances have confirmed that the second six months of life constitutes one of the most important opportunities that we have to mitigate and possibly prevent a broad range of developmental, psychological and behavioural disorders. It is an opportunity that we should embrace in Australia given recent reports by the ABS (2008) that one in five Australians aged 16–85 years had a mental disorder in 2007 and earlier reports nationally and from Western Australia of a prevalence of mental health problems in non-Aboriginal children and young people of around 14-20 per cent (Sawyer et al., 2001; Silburn et al., 1996). This period also provides an opportunity to lay the cognitive and communicative foundations necessary for a child to flourish in school (Shanker, 2008). So important is this period that scientists are now able to make important predictions about a child's development simply on the basis of the joint attentional skills that a child demonstrates at nine months (see Tomasello & Todd, 1983).

Brain maturation: 4½ to 12 months

The importance of the early years for healthy brain development is now well-known (see Mustard, McCain & Shanker, 2007). However, the key issue often not recognised or understood is the role of the ongoing caregiver-infant interactions for a child's mental health and literacy. The fundamental issue that arises in considerations over the appropriate length of parental leave is whether these long-term caregiver-infant interactions are critical to the developmental milestones that occur between the ages of four and half to 12 months.

Joint attentional frames (six to nine months)

There are a couple of key 'maturational phases' in child development in which a sharp jump in brain development correlates with a transition in a child's cognitive and communicative development. One of the most important of these phases occurs at roughly six to nine months. Not only does a child begin to show important advances in their working memory (Nelson et al. 2006), but perhaps even more important, at least in regard to their development of language, is their ability to engage in *joint attentional frames*, in which the child looks where their caregiver is looking and imitates their caregiver's actions (Tomasello, 2003). Typically, this ability emerges by the age of eight months. Studies show that the more time a child spends in joint

attentional engagement with their caregiver during this time the better their ability to understand and produce language over the next year (Tomasello, 2003).

Joint attentional frames are not a fixed cognitive event. A joint attentional frame is an ongoing communicative process that is established and sustained by back-and-forth affective gesturing involving a number of modalities including facial expressions, hand and arm gestures, tones of voice, posture, etc. In the context of the sustained back-and-forth exchanges with their caregiver the child is not simply 'reading' a caregiver's intentions and imitating her actions. In these exchanges the child is engaged in a co-regulated activity that shapes her actions and her emotional understanding.

For a joint attentional frame to occur, a baby needs to have been wooed into a warm pleasurable relationship with one or a few caregivers, so that there is another human being toward whom they experience deep emotions and, therefore, with whom they want to communicate. A baby also needs opportunities to act intentionally, to express an emotion or need by making a sound, using a facial expression or making a gesture with their arm, and to have their efforts become part of a co-regulated interaction. It is only on the basis of these affective experiences that a child is able to establish and maintain joint attentional frames.

A baby's life is filled with sudden and urgent needs for food, to be dry, to go to sleep, or simply to be cuddled. Recent studies have reported that the effect of touch on lowering a baby's response to stress remains with them throughout the course of life. A baby who experiences being soothed by their caregiver when they're feeling distress goes beyond simply having her cortisol levels lowered, she is building the foundation for her subsequent capacity to experience empathy. That is, *predicting* what someone else is thinking or feeling is quite different from sharing what someone else is thinking or feeling. The ability to empathise is not the result of inference, as some early social psychologists speculated but rather, a consequence of the experience of being soothed in the early stages of life. The neural network to support this capacity is formed as a result of these early calming experiences.

During this critical stage of development, a baby reacts with different emotions and responses to their caregivers. As the baby reacts to these enticing emotional experiences, she gives a big smile as she reaches for the funny rattle on mum's head, and then a back-and-forth interactive rhythm begins to happen. The baby starts to initiate more and to entice her caregiver into these interactions.

Different textures of emotions are seen as these capacities are formed. The baby is differentiating as part of two-way communication and the brain is forming the pathways that make this possible. Not only are inter-regional interactions between sensory, emotional and motor processes being forged, but pathways that have to do with initiative, planning, and coordinating are also becoming integrated. At this stage a significant sharpening in the functioning of neural regions begins as they become increasingly restricted to

a narrower set of circumstances, which is a consequence of activity-dependent interactions.

Caregiver-infant synchronicity (six to 12 months)

More and more synchronicity develops between the baby and caregiver's actions during the ages six to 12 months. This occurs both in the same modality, for example vocalising, and cross-modally, for example, where the baby moves her arms in synchrony with the caregiver's vocalisations (see Fogel, 1993). Most importantly, the baby is beginning to initiate more and more. When these efforts are positively reinforced by the caregiver, and this requires effort on the baby's part, then the brain pathways that support and enable all of this strengthen.

However, when this doesn't happen, either for biological reasons, which requires an even greater effort than usual from the baby, or because the caregiver is not available or cannot reinforce these efforts, the sensory-affect-motor pathways do not adequately develop. This impacts on children's language development and therefore long term literacy skills.

As the baby progresses through this stage of emotional signaling and two-way communication, new mental capacities are forming for pre-verbal communication and joint goal-directed behaviour. The stronger these pathways form the better the baby is able to engage in shared social problem-solving with their caregiver. This is demonstrated when the infant takes mum's hand and places it on the toy, then looks up at mum, down to the toy and solicits mum's help in making the toy work with a yearning look and vocalisation.

The baby at this stage is also developing her will and sense of intent. Problems arise in the development of this capacity if caregivers are not available for shared social problem solving. This is evident in babies who spend a large part of their waking time in a busy group-setting where there is too much noise or bustle for the baby and not enough personalised attention. In such situations it is common for a child who, say, is hyper-sensitive to sounds to become overloaded and retreat to the corner of the room rather than engage in social problem solving. Conversely, a baby who is under-reactive to visual or auditory stimuli and thus requires their caregiver to take the time to help energize and encourage them to engage in shared social problem-solving might also retreat into withdrawal. Furthermore, in stressful situations, such as in some of the low-quality child care services, many babies display higher levels of the stress hormone cortisol at the end of the day, whereas in a soothing environment the stress hormone levels of these children can be expected to go down at the end of the day. In these circumstances a lack of attention by a caregiver strengthens the stress pathways as opposed to the shared problem-solving pathways, which has negative impacts on a child's long term well-being.

During this critical stage of development the baby is also learning the significance of affect patterns in their caregivers, that is learning the significance of a certain facial expression or vocalisation in terms of mum or

dad's behaviour, and thereby learning to signal when they themselves are angry or happy. Recent findings indicate that these vital elements of social cognition are being wired into the limbic system and in connections being formed between the limbic system and the prefrontal cortex. The resulting connections will have a profound influence on all of the child's interactions in life, beginning with these earliest interactions with their primary caregivers. The baby is learning to woo her caregivers, rather than just grab at them, through a series of gestures or vocalisations. The better she learns to read her caregiver's emotions for example when dad is tired or overwhelmed or when mum is receptive to a playful overture, the better she can regulate herself, be less demanding, and even, remarkably, be a soothing comfort for her caregiver. For the baby who has experienced empathy is already learning when their caregiver is the one who needs comforting.

What is really happening here is that the baby is developing a sense of their own self and a sense of the "other" as a separate reality. That is, the baby is progressing from a sort of 'global consciousness' to a sense of 'me' and 'you'. Not only does the baby recognise how her caregivers' movements, vocalisations and facial expressions all work together, but through her developing kinesthetic awareness – which is itself strengthened by these interactions – she is better able to 'feel' when she is mirroring these patterns. Research over the past decade in language acquisition has targeted this developing capacity as a critical element in the child's earliest efforts to learn the sound system of their culture's language. This has significant implications for the development of a child's long term literacy skills.

The promotion of healthy mental functioning and literacy

Measuring benefits in dollar costs alone, the work of James Heckman shows that the return for every dollar invested in early child development programs is about eight to one. This is in contrast to the return on investments in education, where the dollar return is about three to one (Heckman, 2006). Notably, Heckman's calculation does not include the effects of early child development on mental health and literacy in adult life, which if included would be likely to further increase his estimates.

Healthy mental functioning

It is always challenging trying to come up with reliable population estimates of the number of children who are struggling with a mental health issues. There are problems in diagnostic categories and practice (Kirk & Kutchins, 1992), problems in factoring in co-morbidities and problems raised by trying to estimate the percentage of children not seen by medical professionals who might also be suffering from such issues. At the end of the day, however, our primary concern should not simply be with the number of children who are 'diagnosable' but those who are displaying common symptoms of mental health issues. Is a child who is getting by in school with C- grades, has no close friends and no interests other than video games, is overweight and subdued, but is not difficult to handle at home or in the classroom, *thriving*?

We need to factor in the number of children who, while they may not have a diagnosed mental health disorder, cannot be said to be mentally healthy

either. To develop such a broad-based approach to child development, we need a model of the core capacities underlying mental health rather than a simply symptom-based classification of children. For example, the capacity for healthy relationships, characterised by warmth, intimacy, stability and flexibility, can be limited with challenges involving constrictions (the individual who is aloof) or deficits (the individual who is completely withdrawn). Similarly, the healthy capacity for experiencing, comprehending and expressing a range of age-appropriate emotions can be contrasted with the maladaptive patterns of only experiencing a few selective emotions, such as anger and suspiciousness, or being unable to experience deep feelings of love or trust.

Literacy development

The same point applies when we're looking at language development, which so many theorists have treated as a maturational phenomenon (Chomsky, 1980). We have developed sophisticated tools for comparing children's mastery of vocabulary and grammatical constructions according to 'language milestones'. However, when we come to look at the child's functional use of language we need to consider things like how well the child can communicate what they are thinking or feeling in different emotional states, how well they know 'how to do things with words', how well they can absorb what another is saying and how receptive they are to what others are saying.

Taking a preventative approach

In recent years a number of powerful studies have documented why it is so strongly in a society's interests to intervene as early as possible in developmental and social disorders before they become intractable (Farrington & Welsh, 2007). There is strong evidence on why an intransigent problem like poverty can best be addressed with a universal early child development program (Heckman, 2006) and why efforts to enhance the overall literacy and physical health of a population must begin at the moment of birth, or indeed, at the moment of conception (Mustard, McCain & Shanker, 2007). All of the current research tells us that it is extremely difficult, and costly, to alter the outcome of a child who has entered the school system with a developmental, psychological, or social challenge or constriction (see Shanker, 2006).

There has also been a dramatic advance in the science of preventative mental health, including the emergence of *pathways models* of developmental, psychological and behavioural disorders. The basic principle of these models is that initial neurobiological deficits, which might be the result of genetic and social-environmental factors, including a lack of positive continuous interactions with the one caregiver, can strongly influence the kinds of interactive experiences that a child seeks out or to which the child is receptive. This in turn can have a dramatic impact on the development of increasingly specialised neural systems such as reading emotions, social orienting and social motivation. A child's capacity to engage in these very social interactions has other measurable effects on brain development (Segalowitz & Shmidt, 2007).

If a child is to thrive in the busy and challenging world in which they are going to grow up they need a number of capacities including to relate to others, to care about others, have an inquiring mind, use language in a meaningful way and feel good about themselves. For these capacities to develop robustly in the latter half of the child's first year of life, the child has to continue the endless interactions with their caregivers that were so pivotal in the first six months of their life. Evidence shows that many children who, at age six months, were thriving because of having received such close nurturing interactions, go into something of a tailspin as they are suddenly transitioned to an institutional setting (Baker & Milligan, 2006).

Of course there are some children who can make this transition smoothly at the age of six months, but as the Productivity Commission emphasises, we are talking about the mean response here, and for the average child these further six months are absolutely critical for their long-term mental health and higher reflective capacities. Careful analysis has also established that these problems occur in all sectors of society and are not just confined to the lowest socio-economic stratum. Although, the incidence rates of these problems is highest in the lowest socio-economic stratum (Willms, 2002), the numbers of children affected are actually greater in the larger numbers of the population in mid to higher socioeconomic groups.

Studies of children whose early development has been compromised show that these children manifest a continuum of problems in their capacity to process different kinds of stimulus, to integrate the information coming from different senses or to join the information coming from their senses with emotional and motor response (Cordero et al., 2006). Recent studies indicate that half of all children entering kindergarten are not ready for school (Kauffman, 2002). That is, they score poorly on tests measuring their social, emotional, language, and cognitive development. These problems range from the very severe to the very mild, but even a mild biological constriction can constrain a child's capacity to flourish in school.

How providing only 18 weeks of paid parental leave will disadvantage many families

The Productivity Commission's Draft Inquiry Report itself is telling us that we need to provide a paid parental leave scheme of at least six months unless we want a society in which only the well-off can afford what is important for all children.

We consider that the goal in designing a paid parental leave scheme is to provide sufficient support so that parents can take leave from work to care for their newborn child for an appropriate length of time, that is, at least 12 months. A scheme should not be developed based on the assumption that parents will have other forms of their own leave available in order to reach the optimal period of leave. For many parents who do not have access to other forms of leave this is just not possible. As evidence from other countries shows, parents will only participate in a parental leave scheme if they can afford it (Lero, 2003). If parents are unable to take additional leave, the

scheme will not have the desired benefits for children's health and development. As Tanaka's (2005) cross-country study found, making unpaid leave available did not have a significant effect on improving children's health.

Surveys concerning the reasons why women return to work following birth repeatedly show that a significant proportion of women return because of financial reasons (see ABS, 2005; Whitehouse, Baird & Diamond, 2006). In the ABS Pregnancy and Employment Transitions Survey (2005) financial reasons were the main reason cited by women for returning to work, regardless of socio-economic background.

To be maximally effective, any preventative approach to mental and physical healthy must be universal (Mustard, McCain & Shanker). Accordingly, we recommend that young parents who are earning below the adult minimum wage should receive the same payment rate as all other parents eligible for paid parental leave. Regardless of what the young person is earning, they need a sufficient payment in order to be at home and care for their baby.

Many parents do not have access to other forms of leave

In designing its scheme, the Productivity Commission assumes that many parents will have access to other forms of leave in order to self fund a paid parental leave scheme of at least six months. However, we believe that many parents do not have access to such leave and will not be able to afford to take leave from work to care for their child at such a critical time.

Because of the nature of their employment women who work part-time, casual, are self-employed or in areas such as sales or services are unlikely to have access to either paid parental leave or other forms of leave, such as annual or long service leave.¹ This is a significant proportion of working women, given that the number of women in part-time work has increased to 45,000 and around two thirds of part-time jobs are casual positions (ABS, 2008b). The current economic situation is likely to increase the number of casual and part-time employees, as well as unemployment. The number of part-time jobs has grown 4.5 per cent over the past year, outstripping growth in full-time jobs of 1.2 per cent. This reverses a trend in recent years of stronger growth in full-time employment (ABS, 2008b). The *Australia at Work* study (van Wanrooy et al, 2008) found that of the 1,300 working women aged 25-44 years surveyed, 20 per cent had changed employers in the previous 12 months. As the Draft Inquiry Report states, the likelihood of mothers returning to paid work in the first six months after childbirth is associated with casual employment, low incomes, self-employment and changing employers in the 12 months prior to childbirth.

In its Draft Inquiry Report, the Productivity Commission states that 45 per cent of women were entitled to paid maternity leave in 2007. However, other sources show that only one-third of working mothers access paid parental leave (Whitehouse, Baird & Diamond, 2006). The ABS Pregnancy and

¹ However, we were unable to source any data on the amount of leave employees have accumulated in Australia.

Employment Transitions Survey (2005) shows that 28 per cent of women working while pregnant reported they were not eligible for paid maternity leave. This survey also shows that of those women who took no paid maternity leave only 18.7 per cent took some other form of leave, with the majority of these women taking six weeks or less (ABS, 2005).

Families who already have children are less likely to have access to other forms of leave

Women who have previously had children are also less likely to have other forms of leave available to them. This may be because they are working part-time or casual to balance caring for their children, or they have used their entitlements. Women with only one young child are more likely (64 per cent) than those who had additional children (48 per cent) to have leave entitlements in their job (ABS, 2005).

In order to take prenatal leave women reduce their post-birth leave

Very few women are able to continue working right up until the birth of their child. In fact, in some industries employers require women to leave work up to six weeks prior to the expected date of birth. If they take this time away from work prior to birth women must take their own accrued leave or go without pay. This period can be extended up to an additional two weeks if a woman is overdue.

In addition, many women use any accrued leave they have to attend antenatal appointments. This means they then do not have as much leave available to take once their baby is born. The need for women to take leave prior to birth also raises concerns about the availability of paid parental leave at this time.

Other supports and programs for families with young children

To provide the best support for families any investment in paid parental leave must be coupled with other supports and programs designed to enhance children's early development. As a policy to improve children's well-being, paid parental leave should be clearly linked to other national policies on early childhood.

In particular, consideration should be given to the likely impacts of a paid parental leave scheme on other aspects of early childhood policy and practice. Having more parents who are at home with their babies for longer may lead to an increase in the demand for services and activities during the day that can support parents in raising their children.

Universal home visiting schemes

We recommend that free sustained home visiting by a child and family health nurse should be offered to families who need additional support for up to two years. Home visiting is an effective strategy to support families with newborn children as it can be tailored to each family's needs. Home visiting has been

found to be most effective where staff are trained and when linked to centre based programs (Gomby, 2005).

Integrated early childhood and parenting centres

We support the Australian Government's announcement to establish early childhood and parenting centres that will provide integrated services to families, particularly those most disadvantaged. We consider that these centres have the potential to play a key role in supporting parents to be parents. There is much evidence that the most effective way to promote children's healthy development through programs is to adopt a multi-component approach so that both parents and children are targeted (Gomby, 2005). We envisage that parent and child centres will be able to best support parents with newborn children through the provision of professional support and information, home visiting support programs, playgroups and quality early childhood education and care. While such an approach should aim to be universal, the needs of disadvantaged children and their families should be prioritised for these centres.

Conclusion

Universal paid parental leave represents one of the most important and cost-effective investments we can make in children's healthy brain development, and in turn Australia's productivity. However, if paid parental leave is not provided for a sufficient duration, that is at least 12 months at a sufficient rate of pay, we may prevent some harm but we will not get the optimum outcomes for children's long term well-being, in particular, the promotion of mental health and children's literacy.

Given the benefits of paid parental leave, we cannot rely on a public information campaign to create enough of an incentive that families will 'top up' the 18 weeks provided for with their own funds. For many families, particularly those who are already financially disadvantaged, this is just not possible, which means that their children are likely to become even more disadvantaged. So great are the potential cost-benefits of a paid parental leave scheme of at least 12 months that they far outweigh the additional costs of extending the scheme beyond 18 weeks.

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