Submission
No 52

SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

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1. The NSW Mental Health Commission

The Mental Health Commission of NSW is an independent statutory agency responsible for monitoring, reviewing and improving mental health services and the mental health and wellbeing of the people in NSW. It works with government agencies and the community to secure better mental health and wellbeing for everyone, to prevent mental illness, and to ensure the availability of appropriate supports in or close to home when people are unwell or at risk of becoming unwell.

The Commission promotes policies and practices that recognise the autonomy of people who experience mental illness and support their recovery, emphasising their personal and social needs and preferences as well as broader health concerns. The Commission is guided in all of its work by the lived experience of people with a mental illness.

The Commission works in three main ways:

- Advocating, educating and advising about positive change to mental health policy, practice and systems in order to support better responses to people who experience mental illness, and their families and carers.
- Partnering with community-managed organisations, academic institutions, professional groups or government agencies to support the development of better approaches to the provision of mental health services and improved community wellbeing, and promote their wide adoption.
- Monitoring and reviewing the current system of mental health supports and progress towards achieving the Actions in Living Well: A Strategic Plan for Mental Health 2014 - 2024, and providing this information to the community and the mental health sector in ways that encourage positive change.

Should you wish to discuss any of the issues raised in this submission in more detail please contact Karen Burns, Deputy Commissioner, on 9859 5216 or at karen.burns@mhc.nsw.gov.au.

2. Introduction

Becoming a parent can be an exciting yet challenging time. Helping new parents and babies adjust to this new situation can require a broad spectrum of physical, mental and social supports.

The Commission is pleased that the NSW parliament is turning the spotlight on the health and wellbeing of new parents and babies. The evidence is robust that promoting the mental health and wellbeing of families, and providing early and evidence-based interventions when developmental problems arise (physical, cognitive, emotional, behavioural) for babies, toddlers and preschoolers, is the most cost-effective way of building resilience in young people and preventing the development of mental illness later in life.

Studies have consistently shown that prevention and early intervention in the first five years is likely to save around $7 for every dollar spent. Importantly these savings not only accrue to health services but also to other government services and the community more generally. For example, studies have shown that early intervention in the first five years for children at risk leads to greater school retention in adolescence, less likelihood of engagement with

juvenile justice, greater likelihood of employment as an adult and less likelihood of becoming dependent on social services. This is a whole of population intervention so that opportunities for a healthy contributing life are maximised.

The concept of interventions to support parents, families and infants over the first1,000 days of the infant's life (from conception up to two years old) is an internationally recognised approach to change life trajectories for children born into communities where positive life outcomes are not always achieved. The First 1000 Days Movement was begun internationally with a focus on reducing under nutrition. The model has been adapted for use in Australia with Aboriginal and Torres Strait Islander communities. The Australia model is an indigenous-led initiative, which has been expanded beyond the original focus on nutrition to include comprehensive primary health care with a case management approach.

"*The Australia model is an Indigenous-led initiative which seeks to provide a coordinated, comprehensive intervention to address the needs of Aboriginal and Torres Strait Islander children from (pre)conception to two years of age and their families. It is an engaging model that assists parents to achieve health outcomes for their children by strengthening their extended family and community to realise the potential of all children. It also supports service providers to act on evidence and build service and regional level capacities to respond.*[1]"

Such community based approaches to support resilience and wellbeing from the earliest age are supported by the Commission, especially when we know that 50% of mental health problems will start by the mid to late teens. Growing up strong within resilient families and communities is essential, as is the need for supports to be provided appropriate to the age and stage of the child and their family development.

There are specific areas of disadvantage or challenge in relation to health outcomes for babies, which directly impact the way in which services should be delivered. This submission focuses on two areas in particular, trauma and parental substance use.

As with so many areas, coordinated service delivery is essential for improving the physical, mental and social outcomes for new parents and babies. This submission identifies some core elements for achieving better service coordination.

3. Specific issues

3.1. Trauma

The intergenerational impact of trauma is well known. Parents' lives clearly affect their children's lives and patterns of disadvantage can become entrenched. If we are able to improve the outcomes for parents who experienced childhood trauma, the consequent benefits to their children will have long term and far reaching social and economic benefits. The findings of the Royal Commission into Institutional Child Sexual Abuse will be illustrative in this respect.

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[1] Arabena, K, Ritte, R and Panozzo, S, *The Australian Model of the First 1000 Days*, Australian Institute of Family Studies, Knowledge Circle, accessed via https://www2.aifs.gov.au/cfca/knowledgecircle/discussions/children-and-young-people/australian-model-first-1000-days

A critical aspect in ensuring appropriate responses are provided to those who have experienced childhood trauma is recognising the complexity that arises and designing systems and services that are responsive to this, rather than re-traumatising. The complexity of unresolved trauma and subsequent mental illness has important implications for the way in which all support services are delivered and the way in which people engage with those services.

Likewise it is essential that programs and supports to reduce the incidence of experiencing childhood trauma and exposure to traumatic events (such as witnessing domestic violence; neglect; physical, emotional or sexual abuse) are in place for children, parents and families/communities.

In NSW there have been some significant advances in recent times in ensuring that services are trauma informed. In particular, there have been notable advances in the response to the complex issues around borderline personality disorder and eating disorders. These can be drawn on when designing other support services.

Given what we now know about the prevalence of trauma it is safer for services across the full range of health and human services to assume a history of trauma than not. For this reason it is essential that all social services, and not only health/ mental health services, are designed to respond appropriately.

3.2. Parental substance use

It has been reported to the Commission that a significant area of co-morbidity in relation to maternal and early childhood mental health is maternal substance misuse.

In the 2017/18 Budget, the NSW Government announced the Drug and Alcohol Package, which included $24.5 million over four years directed to families:

- $15 million to expand substance use in pregnancy services. Eight Local Health Districts are being funded to develop and expand ‘Substance Use in Pregnancy and Parenting Services’ to provide specialist medical and nursing throughout pregnancy and post-delivery, including a plan for appropriate support up to two years.
- $8 million to increase residential rehabilitation and on-going care for women and parents with dependent children
- $1.5 million to boost support for families and carers by providing access to information including de-escalation strategies, parenting programs and understanding relapse[2].

The Commission welcomes this investment. However, anecdotally, this has not been uniformly aligned with Sustaining NSW Families (this program is discussed in more detail below). Further, it has been reported to the Commission that these resources were not well linked in with tertiary services. What is needed is a state-wide, combined alcohol and other drug and mental health, sustained home visiting program, which is well linked with secondary and tertiary services for mothers and their babies up to pre-school age.

[2] NSW Health, Centre for Population Health (28 June 2017), “Alcohol and Other Drugs – About Us”, accessed via http://www.health.nsw.gov.au/aod/Pages/about.aspx

In respect of new mothers who were substance using prior to, during pregnancy and after the birth of their baby, better understanding of the support needs of the mothers and their babies is needed.

While there is good care for babies with neonatal abstinence syndrome (NAS) and their mothers for the first three months, support – physical, mental and social – needs to actively continue beyond that point. There is a need for longer term monitoring to identify opportunities for early intervention and for research into the long term consequences for these babies.

Babies with NAS are often temporarily placed in out-of-home-care, when parents' ongoing substance misuse means they cannot care for the baby. Reportedly, temporary carers have little or no training in terms of what to expect from a baby with NAS, such as difficulties with feeding, sleeping and settling and how to manage these. That said, there have been good models of collaboration between Family and Community Services and Health to improve the health outcomes of children in out-of-home-care and to better support carers in this respect. One example is the out-of-home-care-clinic jointly funded by the Department of Community Services (as it then was) and Health, based out of Redbank House at Westmead Hospital as well as the Reparative Foster Parenting Program.

Finally, mothers who are addicted to prescription or over-the-counter drugs are a hidden problem. There is a real lack of information about women of reproductive age using over the counter and prescription drugs and they are not generally catered for by typical alcohol and other drug programs.

4. Coordinated service delivery

The best support models, and especially for new parents and babies, are those that are integrated to enable a person's (or whole family's) physical, mental and social support needs to be provided in a coordinated way. Integrated models are well recognised as affording improved outcomes. In many respects, NSW is on the right track in this regard, however, there are still significant gaps between services.

In 2011 the NSW Ombudsman commissioned a report from the Social Policy Research Centre (UNSW) looking at why child welfare agencies fail to coordinate with each other, despite the wealth of best practice literature outlining how to do this and why it is important. In that report, SPRC concluded:

"*Integrated service delivery cannot remedy entrenched social problems, nor solve institutional ones such as limited system capacity, ineffective services, and inadequate funding. It is a strategy which requires policy and resource support, implementation planning, and practitioner commitment to overcome barriers to success*[3]."

Leadership is required to drive cultural change within services; to facilitate collaboration between services; and to maintain the momentum once a collaborative culture is established.

[3] Valentine, K and Hilferty, F (2011), "Why don't multi-agency child welfare initiatives deliver? A counterpoint to best practice literature', prepared for NSW Ombudsman, Social Policy Research Centre, University of New South Wales, Sydney, p iii

For service coordination to be effective, a significant amount of time and with some financial support needs to be dedicated to coordination activities. This can be difficult in resource constrained environments, where coordination is not seen as an outcome in and of itself.

Finally and crucially, service coordination requires clear pathways of care so that effective referrals can be made to either ‘step-up’ care where risks are identified, or to ‘step-down’ care as support needs decrease.

An example of a good program is the universal health home visiting in the weeks after birth. Under the banner of the Maternal and Child Health Primary Health Care Policy, NSW Health delivers a universal health home visiting program, which dovetails with the SAFESTART model, designed to provide early identification of, and access to support, for new parents and babies (up to two years old) who are experiencing psychosocial risk and depressive symptoms.

There is a lot of evidence for the long term effectiveness of universal post-natal home visiting programs, so the introduction of Families First (as it was initially named) was much welcomed[4].

The Commission understands that the program's roll out was affected by variability in resourcing between the local health districts, the reliance upon redirection of existing staff roles, inconsistent co-ordination efforts and program activities and inconsistent strong leadership, so that the opportunities from the program were not fully achieved. Based upon this advice, it appears that while the program has many strengths, there is also a missed opportunity for prevention and early intervention in the course of childhood psychiatric disorders – such as disruptive behaviour disorders and severe anxiety disorders – which can be very much positively influenced by appropriate parenting and especially the treatment of parental mental illness and/or substance use disorder.

Conversely, the Sustaining NSW Families program, is a good example of a sustainable and coordinated service model. Specially trained child and family health nurses, supported by a social worker and allied health workers, follow a structured program of at least 25 home visits, starting in pregnancy and continuing up to their child’s second birthday. The target group for this intervention is families with social and economic disadvantage who are vulnerable and have associated psychosocial distress. Eligible families are identified through the SAFESTART assessment and pathway.

The issue in relation to this program raised with the Commission, is bringing it up to scale for state-wide implementation. Sustaining NSW Families is currently available in nine sites across NSW. This is despite positive program evaluation conducted by KPMG which recommended the option of a state-wide rollout of the program be explored[5].

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[4] See for example, NSW Department of Community Services (2005), “Families First delivers better outcomes for children” in *Inside Outside*, accessed via http://www.families.nsw.gov.au/docs_menu/about_us/news_and_publications/community_services_news/archives/families_first_delivers_better_outcomes_for_children.html

[5] KPMG (2015), *Evaluation of the Sustaining NSW Families Program: Final Report*, for NSW Kids and Families accessed via http://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Documents/sustaining-nsw-families-kpmg.pdf, p 8