Submission to the Health & Ambulance Services Committee with reference to the Mental Health (Recovery Model) Bill 2015 (Private Member's Bill) and Mental Health Bill 2015 (Government Bill)

Abstract (Summary)

This Submission describes an Early Screening System for Children and Youth so that children and young people's mental health disorders, and precursors of these disorders, can be identified well in advance of their appearance later in childhood and early adolescence. Practical prevention measures for mental health problems in young people must be instituted.

Body of Submission

The absolutely essential factor to drive mental health in Queensland is "*prevention"*. See also Intervention Action Plan (2015-17), Queensland Mental Health Commission. This does state, very generally, that "schools" should "strengthen whole-of-system capacity and partnerships to support *early detection* and *intervention* of mental health problems and disorders in children" (p. 30), and the "Ed-LinQ" program … [need] … linkages between the Educational Sectors, Primary Care and Mental Health sectors … to enhance the early detection of … mental health difficulties and disorders affecting school age children" (p. 46). However, these general statements do not concretise the actual early IDENTIFICATION of children with mental health problems. Our Submission, based on 25 years of experimental *and clinical* published research in Queensland, demonstrates how this can be carried out IN PRACTICE. This needs specifying.

This comprehensive screening system, with referrals for further assessment and interventions, MUST be incorporated into the Mental Health Queensland state framework for the prevention of mental health disorders. The background research, screening research, related statistics, and specific Recommendations are contained in the one page Appendix (attached). This Paper was accepted and presented at the International Conference on Mental Health (Gold Coast, 13,14 August, 2015). Key statements include:

1. "The PSILD system … provides for the early identification of mental health disorders – analogous to the *mandatory* system for early child immunisation" (para. "Targeted Teaching: Implications for Child Mental Health"). Thus, if mandatory systems are employed in Physical Health, the same must be provided in Mental Health. (See para. "Targeted Teaching: Implications for Child Mental Health").

2. "It is now essential that Mental Health Commissions and State Education Departments, *in combination*, decide on a system for comprehensively assessing Child Mental Health." (para. "Recommendations").

This information is fully supported by statements issued by Professor Alan Fels, AO, Chair of the National Mental Health Commission, Australia, who emphasised, "early detection", "early identification" and "prevention research" as a "big problem" in his keynote address to the 50th Australian Psychological Society Conference (30th Sep 2015).

It is important to realise that bureaucratic systems are slow to adjust to medical and educational "change", and may, for no good reason, resist the introduction of the above screening approach for ALL CHILDREN and EARLY ADOLESCENTS (ie, Day Care-Pre-school/2-4; School Prep-entry/4-5; Early Adolescence/12-13). The best way to introduce this screening system is to start with 1 or 2 volunteer schools, then develop the approach until it becomes established with a larger number of schools, and is eventually accepted as "Systemic". The "Headspace" system for adolescents and young adults exists as a referral system at these later levels, but, it does not *identify* all persons at these ages. Our PSILD (Parents Screening and Inventory for Learning Difficulties) at the *three age levels*, fulfils the gap before Headspace, and allows for the identification of young people with mental disorders prior to the point at which they reach "crisis" level (Professors Fels' statement, CM, 2013).

I would like to be interviewed concerning this system, since in approaching schools individually (recommended by DETE) I have found School Principals and Prep-teachers do not have a good understanding of early screening. This was also found when I interacted with two DETE officials – who did not reflect, or seem to understand, our approach. See Reddington and Wheeldon (2009) for the validation and reliability of the full screening research.

I ask that the screening Abstract, above, be incorporated specifically into the Mental Health Bills, 2015. Details including the Forms and Administration Guide can be sent on request.

Key References

1. Gleason, M.M., Heller, S.S., Nagle, G.A, Boothe, A., Keyes, A. (2012). Mental health screening in child care: Impact of a statewide training session. *Early Childhood Research and Practice, 14*(2), 1-15. (U.S.).

2. Gutman, L.M. & Feinstein, L. (2008). *Children's well-being in primary school; pupil and school effects. Report No. 25.* London, U.K.: Research Centre for the Wider Benefits of Learning, Institute of Education, University of London (U.K.).

3. Reddington, J.M. (2015). *Screening for Child and Youth Mental Health and Intervention Procedures*. Poster presented at the International Conference on Mental Health, Gold Coast, Queensland. ATTACHED.

4. Reddington, J.M., & Wheeldon, A. (2009). Predicting behaviour and learning problems at school entry: Examining the utility of a parent-, teacher-, and a child-based scale. *The Australian Educational and Developmental Psychologist, 26*(1), 36-62. (QLD).

Submission by

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[redacted]
Daytime [redacted]

(National Organisation: Australian Psychological Society, Membership No. 013063. This Organisation has been fully informed of the details of the above screening research).

Curriculum vitae attached.

NB. Signature will be attached to the copy sent by postal service.

Screening for child and youth mental health and intervention procedures. Dr. John Reddington, Ph.D, MAPS.

Abstract: A comprehensive early screening system is necessary for the assessment and prediction of child and youth mental health. A U.K. study and a Queensland system are compared. The Queensland model describes a validated system at School Entry, with slightly modified screens at Pre-School and Adolescence. These provide coverage of developmental markers to assess and track mental health problems at an early stage. The Queensland model is recommended to provide for the necessary decisions on action for school-based early screening systems.

Keywords: Screening, mental health, prediction, comprehensive, pre-school, school entry, adolescence.

Aim: To recommend a valid, comprehensive, school-based, screening system for the prediction of early mental health, assessed at Pre-School, School Entry and Adolescence.

Introduction: Thompson & Carpenter (2014) stated, "Mental Health is about being able to successfully cope with the stressors and demands of daily life … students with mental health issues will present with academic, emotional and social challenges" (p.154). Gleason et al. (2012) stated, "The first step towards intervention is identification … early childhood experts have called for universal mental health screening in child care" (p.2).

Gutman & Feinstein (2008), U.K., investigated early screening systems.

Table 1. Predictor variables employed by Gutman & Feinstein (2008)

Variables	Age
1. Demographic (Family)	
• Child gender	Birth
• Maternal education	N/A
• Family income	3y11m
• Marital status	3y11m
2. Pupil/Emotional Characteristics	
• Locus of control (External versus Internal)	8
• Child estimates of scholastic comprehension	8
• Depression (feelings the previous 2 weeks)	10
• Peer victimisation (by peers)	8 & 10
• Bullying (victim, or, initiated by child)	8 & 10
• Antisocial behaviour (eg. stealing, fighting)	8 & 10
• Antisocial friends (conduct behaviour of friends)	10
• Talks to teacher (can talk to teacher alone?)	8 & 10
• Likes school?	8 & 10
• Satisfaction with friends (five questions)	8 & 10
3. Academic Areas	
• English Key Stage scores (Stages 1 & 2)	Stages 1 & 2
• Maths Key Stage score (Stages 1 & 2)	Stages 1 & 2
4. School Variables	
• School disadvantage (No. of pupils with free meals – low SES)	7
• School type: State, Faith (aided); Faith (controlled), Foundation.	7
• Parent-Principal disputes (frequency)	7
• Parent involvement (percentage of parents attending parent meetings)	7
• Pupil-Staff ratio (No. of pupils / No. of staff)	7

Table 2. Outcomes of Wellbeing: Predictor levels rated by Gutman & Feinstein (2008)

	Levels 2 – 6 (Low to High) of wellbeing, with related percentages					
Age	Levels	2	3	4	5	6
8	Percent	5	9	18	35	38
10	Percent	2	6	12	28	54

Note. Adapted from Gutman & Feinstein (2008), Figure 1.
In Table 2, there are consistent low levels of wellbeing at age 10 for Levels 2 – 5, but there is an increase of wellbeing at age 10 for Level 6 (achieving children?). Gutman & Feinstein reported a "small subset of – 1 in 5 children – who have declining or low trajectories from 8 to 10 years [see Table 2]. They are likely to be male, low SES and low achieving" (p. 29).

Gutman & Feinstein reported that School Variables "explained only three percent or less of the variance in pupils' mental health and behaviour" (p. i). They refer to SEAL (Social and Emotional Aspects of Learning) intervention. This whole-school approach "teaches children the qualities and skills which promote positive behaviour and effective learning" (p. 30). SEAL is also quoted by Mendoza et al. (2014), who described Queensland "Ed-LinQ Coordinators" who provide "clinical guidance", "… accurate data", and "a school assessment readiness tool" (p. 11) but no specific data or screening tools were reported. Madelaine & Wheldall (2003) found *teacher* identification of children was inaccurate (10% False Positives, 18% False Negatives).

PSILD (Parent Screening Inventory for Learning Difficulties), Reddington & Wheeldon (2009).

PSILD Scales

- **Parent Screen (Reddington, 1999):** The PSILD Parent screen (Mean Age 5.9, N = 215) at School Entry (12.7 minutes) employed eight sub-scales: SES, Medical (Genetic and Perinatal), Speech-Language, Motor, Resilience, Central Auditory Processing Disorder (CAPD) (embedded in Speech-Language and Inattention), Behaviour (Internal, External and Inattention), Early Education, Parent comments and PIPS (Tymms, 1999) (Reading, Maths and Phonics), optional, at school entry and after 6 – 9 months of schooling.
- **Teacher Screen (Reddington & Wheeldon, 2009):** The PSILD-T matching Teacher screen (3.0 minutes) assessed children after 6 – 9 months of schooling (Mean Age 5.5, N = 78). Sub-scales: CAPD (9 items: Memory, Discrimination, Attention); Child Characteristics; Behaviour (Internal, External, Inattention); Teacher Future Risk Estimation (1 - 9 scale); Ability (5 levels)?; Is Behaviour different from home to school?; Is Risk developmental or behavioural?
- **Feedback Sheet:** (Computer scored). Developmental (all areas), Behaviour (Overall), Academic (PIPS) (Reading, Maths, Phonics). Scored: 1 – 9 scale. Sub-scales (in pairs): Early Education/Language, CAPD/Inattention, Hyperactivity/Conduct Disorder, Withdrawal/Anxiety-Depression, Motor (Gross/Fine), Resilience, Social Strength/Ability. Scored: Risk, Borderline, No Risk. Ancillary factors: Giftedness?, Behaviour at Home vs. School?, Handicap?, Behaviour: Developmental vs. Behavioural?, Key Comments? Interventions (Referrals by Parent and Teacher); Learning Support, Professionals, KidsMatter, Triple P.

Validation

- Of 215 children (one-third upper SES, two-thirds lower) 16.23% were predicted as At Risk. (Increases in low SES and Indigenous areas). Reddington & Wheeldon (2009).
- **Parent Screen:** Predictive validity was achieved from the combination of Parent sub-scales, and the Auditory Comprehension and Memory sub-scale of the Pupil Rating Scale (CAPD) (Myklebust,1981), the Clay Letter Identification Test, and C.A. These obtained an Odds Ratio of 12.6, Hit Rate 92%, and Sensitivity and Specificity of 77% and 94% respectively against WIAT Reading. Reliability was .83 (test-retest).
- **Teacher Screen:** The Teacher and Parent Behaviour sub-scales, combined, achieved concurrent validity against the Personal-Social sub-scale of the Pupil Rating Scale, Revised (Myklebust, 1981). CAPD predicted Reading better than Phonological Awareness (PIPS Phonics), and obtained significant correlations with the Teacher-based Future Risk (.79), Overall Behaviour (.78), Inattention (.69) sub-scales, and Reading Benchmarks (.50). PIPS, after 6 - 9 months of schooling, significantly predicted Reading at two years without help from other variables (Reddington & Wheeldon, 2009).
- **Reliability:** PSILD-T Behaviour, Future Risk and CAPD sub-scales were .80, .76 and .71 respectively (test-retest).
- **PSILD Items:** Items were validated by item to total sub-scale correlations, and factor loadings. The item weights (1 – 9 scale) were used to calculate all PSILD sub-scales. A combination of Teacher CAPD, Teacher Overall Behaviour and Future Risk Estimation accounted for 49% of the variance in predicting Reading, *without the inclusion of PIPS*. Thus comorbidity contributes to the overall evaluation of child mental health. Behaviour alone is not an acceptable predictor. Prediction must be achieved, *comprehensively*, by combining all variables to address the large ability range found in inclusion classes (see Masters, 2013c).
- **Modifications:** PSILD Parent and Teacher forms were modified for Pre-School (Early Education markers reduced) and Adolescent levels (Behaviour markers added: self-harm, suicidal ideation, eating disorders, drug and alcohol abuse etc). These require validation.
- **Interventions:** PSILD interventions are *individual* and are referred *jointly* by parents and teachers to Learning Support; Professionals (eg. Speech-Pathologists), KidsMatter (a school-based mental health program, Graetz et al., 2008), and Triple P (parenting, Prinz et al., 2009).
- **Replication:** Reddington (2010) replicated the PSILD-T scale sub-sections with 123 school entry children. The correlations confirmed the validity of the PSILD-T Screen.

Table 3. PSILD-T Sub-scale correlations (Spearman). Reddington (2010).

	ATT	CAPD	F RISK	EXT	INT	BEH	HYP	COD	SW	ANX
ATT	1.0									
CAPD	.69 (.69)	1.0								
F RISK	.59	.70 (.79)	1.0							
EXT	.51	.39	.56	1.0						
INT	.05	.24 (a)	.52	.09	1.0					
BEH	.62	.59 (.78)	.84	.71	.62	1.0				
HYP	.54	.38	.51	.88	.01	.64	1.0			
COD	.31	.26	.48	.83	.15	.61	.59	1.0		
SW	.17	.23 (c)	.47	.25 (b)	.71	.60	.18	.37	1.0	
ANX	.05	.17	.38	.05	.83	.42	.12	.07	.31	1.0

Note. Adapted from Reddington (2010). N = 123 school entry children.
$p < .001$ for all correlations except, (a) and (b) = .005, (c) = .01. Correlations < .22 are not significant.
ATT=Inattention, CAPD=Central Auditory Processing Disorder, F RISK=Teacher estimate of Future Risk, ANX=Anxiety, EXT=Externalised Behaviour, INT=Internalised Behaviour, BEH=Overall Behaviour (EXT+INT), HYP= Hyperactivity, COD=Conduct-Oppositional Disorder, SW=Social Withdrawal. Where a second correlation is designated in parenthesis, this replicates the equivalent correlation in Reddington & Wheeldon (2009, Tables 2 and 5). All these correlations are significant.

Targeted Teaching: Implications for Child Mental Health

Goss et al. (2015) stated, "Teachers need … fine-grained baseline data to identify where each student is starting from" (p. 11), and, "analyse evidence to identify students' needs" (p. 22). This has implications for Teacher Training. The PSILD system provides, comprehensively, for academic data, besides developmental markers establishing a baseline screening tool. CAPD and Medical (Genetic, Perinatal) sub-scales are unique to PSILD. Mares et al. (2011) stated, "Physical and mental health are not separable" (p.44). The CAPD screen was created after Reddington & Cameron (1991) found a significant difference in speech discrimination between dyslexic and normal readers at *threshold*. Reddington (2010, 2011) found 16% of on-entry children at risk for CAPD. The PSILD system enables teachers to identity *all* children at risk, and gifted children, and track their progress. It also provides for the early identification of mental health disorders - analogous to the mandatory system for early child immunisation.

Recommendation

It is now essential that Mental Health Commissions and State Education Departments, *in combination*, decide on a system for comprehensively assessing Child Mental Health. School-based identification should start at day care or pre-school, then school entry and adolescence. One approach might be to trial the system initially with volunteer schools and gradually increase the sample size to become systemic. The objective would be to identify problem children and adolescents, so that the emergence of psychological or psychiatric disorders, can be recognised and children can be referred for therapy at an early life stage.

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Curriculum Vitae.

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Qualifications
Ph.D (QUT), M App Psych (Qld.), Dip Psych (Qld.)(4th Year Hons.),
BA Hons (Psych) (Wales), Dip Educ Therapy (Calif.), Tchrs Cert (London)
(Previously Psychologist, Registered Australia, No. PSY0001364126)
(Previously Registered Medicare Allied Health Professional, No. 2817591F)
(Retired as a Registered Psychologist, 2014, after 24 years).

Professional Experience
Psychologist in Private Practice (focus children and adolescents) (24 years)
Senior Lecturer, Griffith University, Psychology and Special Education (19 years)
Teacher, Primary (Disadvantaged), Special Needs, Learning Support (7 years)

Memberships (current)
The Australian Association for Infant Mental Health
The Australian Psychological Society (including Perinatal, and Psychoanalytically Orientated, Interest Groups).
The Concerned Psychologists for Children's Rights, Queensland (Convenor).
Learning Difficulties Australia.

Award
Research Award of the Dyslexia Research Foundation of Australia (Perth) 1987.
"In recognition of a significant contribution to knowledge and practice in the area of learning disabilities".

Publications and referenced research data

1. Reddington, J.M. (1999). Involving parents in screening children for learning difficulties at school entry. Upgrading teacher knowledge of children's academic and behaviour problems in the first school year. In P. Westwood, & W. Scott (Eds) *Learning disabilities: Advocacy and action*. (pp. 129-144). Parkville, Australia: Australian Resource Educators Association Inc.

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Conference Presentations

1. *Early screening for Mental Health for 3 and 5 year old children: Early identification, early intervention*. 3rd Mental Conference, Logan, Queensland. (Sep, 2011).

2. *A Central Auditory Processing Disorder (CAPD) Scale for classroom screening of school entry children: Validity and reliability*. Conference of the Australian Educational and Developmental Psychologists, Melbourne, Victoria. (Nov, 2011).

3. *Predicting behaviour, auditory processing and learning problems at school entry: Screening by parent, teacher and child based scales*. International Congress of Applied Psychology, Paris, France (10 Jul 2014).

4. *Early screening for child and adolescent mental health*. 15th International Mental Health Conference, Gold Coast, Qld. (25 Aug 2014).

5. *Screening for child and youth mental health and intervention procedures*. 16th International Mental Health Conference, Gold Coast, Qld. (13/14 Aug 2015).

6. *The validation and reliability of child screening for central auditory processing disorder at school entry*. 50th APS Conference, Broadbeach, Qld. (2 Oct 2015).