The Winston Rickards Memorial Oration

Child and Adolescent Mental Health

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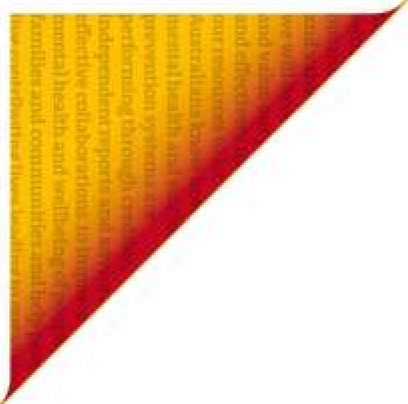

Australian Government
National Mental Health Commission

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The Ella Latham Theatre,
The Royal Children's Hospital, Melbourne

1. Introduction

I acknowledge the traditional custodians of the land on which we meet and pay my respects to their elders past and present.

Let me also acknowledge:

The Rickards family and other distinguished guests. I am honoured, and flattered, to be asked to address you today in this year's Winston Rickards Oration. Dr Rickards devoted his professional life to the care of children, young people and their families, through the integrated application of a multi-disciplinary approach. He enriched the field of mental health immensely and he enriched the lives of the many children and young people he helped immeasurably.

We would also like to pay our respects to people with lived experience of mental health issues, their families and other supporters. Particularly, we commemorate those who have been before us and travelled this journey. Through their courage and efforts, we and others are able to stand here more respected and with a strong voice.

1. How I became involved in mental health

a. Isabella's story

Some seventeen years ago my daughter Isabella, now aged 41, was diagnosed with schizophrenia after a prolonged period of disturbing, distressing, bizarre behaviour.

Her first 18 months of life seemed normal. The period from then to adolescence was worrying. She had many difficulties and much unhappiness during her childhood years. At the age of 18 months she used to tear out her hair becoming bald on certain parts of her head. She did many strange things.

In childhood and throughout her life, she was never able to relate to a peer group, to play with them or to be included in their activities. She depended upon her parents and other adults for her mental stimulus. Her adolescence was tormented and troubled at home, school and everywhere else – and ever increasingly so. An embarrassing obsession with another student led to the first of several changes of school. She did well academically, receiving a Bachelor of Arts degree at Swinburne University, but only after great stress. She received a great deal of psychotherapy from psychiatrists from age 12 until age 26. She also saw some psychologists. However, during all this time she never received any diagnosis of mental illness and the deep fears of her family in that regard were never confirmed, or supported, and indeed to some degree were discouraged.

At the age of 26, Isabella had a full psychotic episode. She heard gunshots and other noises in her head and kept seeing monsters and other frightening images. After receiving a diagnosis and taking medication on a substantial scale, her severe psychotic symptoms were largely removed and she returned home from hospital but she continued to be very obsessive, and had difficulty concentrating.

Eight years ago she was having adverse side effects from her medicine and it was decided that she should change medicine. Unfortunately the new medicine was a failure and she lapsed into an extremely psychotic condition, culminating in a three month stay in a high dependency ward of a public hospital as doctors fought to overcome her difficulties. Eventually she had ECT treatment. Although the severe symptoms were eventually removed and a seemingly appropriate form of medication was applied, she was adversely affected by the episode in terms of obsessiveness and lack of concentration and spent a period living in a community care unit attached to the hospital with a twenty four hour nursing service.

Isabella thus now receives treatment from a psychiatrist, and takes medication which generally relieves her psychotic symptoms. Isabella is a loveable, charming, sensitive, articulate and intelligent young woman but even with medicine her illness can cause serious difficulty in comprehending reality, frequent obsessional behaviour, sometimes socially inappropriate behaviour and lack of motivation. She is rather obsessed about her weight and body. She has quite poor living skills.

One effect of deinstitutionalising those with mental illness since the 1980s has been the greater burden on families. An attempt by Isabella some years ago to live away from home with others in a house (where mental health workers were present but only from 9am to 5pm on weekdays) did not work. She has underdeveloped living skills and her illness is such that she could not live by herself – she basically has depended upon family care and upon a system of accommodation that provides a significant degree of care and support for most of her life.

b. The Haven story

Let me tell you that story briefly. In 2003 following the ABC TV Australian Story program about my daughter's schizophrenia (a factor in my retirement from the ACCC), a group of carers, including my wife, got together concerned about finding secure and stable accommodation for their children, all of whom suffered from high impact mental illness, all very vulnerable, that required them to have support, care and accommodation on a long term basis even beyond the time we could care for them.

We approached the Catholic Parish of South Yarra which had a disused convent. Instead of selling the valuable property for a high price, that parish provided the convent at very low rent as part of its social commitment. These carers (all of them women incidentally) then drew up a model of accommodation, care and support. The process took 8 years to come to fruition.

It is really hard for most people; both to get the resources and to break through the many hurdles there are, to involve families and carers properly.

Most people could not possibly have achieved this outcome yet the outcome has been one that meets a really important unmet need in our community. We have 14 people who would otherwise be in hospital or high intensity care or, at the other end of the spectrum, homeless or in temporary accommodation before relapse and re-entry into hospital, at the Haven. We have a very high degree of family, carer and consumer involvement in the conduct of the management of the unit which we do in conjunction with the Prahran Mission. There is a huge waiting list.

In short we have an innovative model that provides accommodation, care and support in a setting that provides independence for residents but also an opportunity for them to live as a community. An especially innovative feature is that families and carers as well as residents play a very substantial role in the project, trying to overcome some of the problems that often arise in such settings when mental health workers do not engage with families and carers. There has been an evaluation conducted by Monash University and it has found that there has been a considerable improvement in the lives of residents including Isabella. This confirms our own observations.

Isabella was lucky. But that is a one off solution and not a system wide option. Housing authorities and governments need to do more than provide indifferent hostels where people languish without hope.

Having a home where one feels safe, stable and secure, is in the Commission's sights as a core right and a critical foundation for recovery.

c. Chair of the National Mental Health Commission

So my involvement with mental health began with my daughter's experience, continued through my involvement with the Haven project, and now continues as Chair of the National Mental Health Commission.

Today I am going to talk to you about the role of NMHC, but since it is certainly not usual for an economist to Chair bodies of this kind – it is usually the province of psychiatrists, psychologists or social policy experts – in the remainder of the lecture I will devote considerable attention to some economic questions in the field of mental health including child and adolescent mental health, most especially in investing in good mental health.

I believe that economics has a great deal to offer our understanding of mental health services – and if you don't believe me now, perhaps you will by the time I finish. It is especially important for the mental health community to engage with Treasuries and the Finance Departments as well as with business. Economics is also relevant to what should be an ongoing dialogue between these groups.

At the end I will spend some time on some specific issues on early child and adolescent mental health.

3 The National Mental Health Commission

a. Its role

The National Mental Health Commission was launched by the Commonwealth Government in 2012. We are an independent body, and our role is to report to the public and to hold governments to account for their commitment to improve outcomes for countless number of Australians and their families and reveal the full truth about the provision and delivery of mental health services in Australia. We exist because the mental health community has, for some time, felt that neither of these two things has been happening.

We provide evidence-based strategic and practical advice to Government on mental health reform. Working across all states and territories, and all sectors not just health – government and non-government, service providers, organizations, institutions and professionals in a range of fields – we see our job as to *report* on mental health in Australia, to *advise* honestly and independently on what can be done better, and to *collaborate* with others across all sectors to help bring about those positive changes.

Our composition is broad. We have two carers, including myself, and one person with lived experience of mental illness, a housing and social welfare provider, an indigenous psychologist, a psychiatry specialist, a distinguished general practitioner professor, a business woman, and a former state health minister

b. The significance of its location in the Prime Minister's portfolio

The NMHC is located in the Prime Minister's portfolio and reports directly to her, not through her department. We hope this is a sign of how seriously the government takes mental health. We also believe that this reflects an understanding, both within government and within our Commission, that mental health issues are a whole of government issue. Consider the fact that nearly every department one can think of, at federal or state or even local government level, has some interest in mental health. At a federal level, that applies to health, to aging, to families, indigenous matters, community matters, immigration, defence, education, housing, employment, veteran's affairs, treasury and finance – virtually all departments. The same applies at state and local levels.

c. Its views and philosophy

The Commission believes that mental health needs to be a much higher and continuing priority for governments and the communities. Too often there is a momentary surge of interest in mental health with a few accompanying measures and then it drops off the agenda as a priority for another few years. We want it to be a continuing priority. Part of that is that we must continuously work to reduce discrimination and stigma in the community. I believe that the community attitude to mental illness have improved, but there is still a long way to go.

More basically, Commissioner Janet Meagher puts our guiding aim very simply when she says that 'people with mental health problems want the same thing as everyone else. Even the most disadvantaged should be able to lead a contributing life'. This can mean many things. It can mean a fulfilling life enriched with close connections to family and friends, good health and wellbeing to allow those connections to be enjoyed, having something to do each day that provides meaning and purpose – whether it be a job, supporting others or volunteering, and a home to live in, free from financial stress and uncertainty. *

At the Commission we believe that everyone has a right to lead a contributing life. All of us, not just governments, can play a part in enabling those living with and recovering from mental health difficulties to achieve the life they want.

When people with mental health conditions are able to lead 'a contributing life', it benefits them, their community, and the economy.

d. Its first report

We released our first National Report Card on Mental Health and Suicide Prevention in November last year.

In that Report Card, we highlighted the need for a better understanding, a more complete picture, of mental health in Australia. There are over 75 national mental health indicators, but their focus on health services obscures the other factors that have a direct impact on mental health and on the lived experience of Australians with mental health problems – factors like community support, the role of families and carers, and interaction with employment or housing services. We, collectively, gather a lot of data, but all too often it doesn't tell what the NMHC considers to be the key part of the story: whether people's lives are improving, whether they are able to live a contributing life. The data we collect tells us about what has been spent, and what treatment or support has been given, but it doesn't tell us what the result was. There is very little about the actual experience of persons with lived experience of mental health, sometimes called 'consumers', and carers and families, and this is significant in the light of the low satisfaction levels of people interacting with the mental health system. The NMHC believes there should be a shift in focus on collecting data to tell us more about what's really happening for people in Australia with poor mental health.

e. Its recommendations

The National Mental Health Council made 9 recommendations in our 2012 Report Card. Although these recommendations are general, many of them are particularly relevant to issues concerning early childhood and adolescent mental health matters. Our overarching view is that governments need to make mental health a higher priority. Specific recommendations are:

1. Nothing about us, without us – there must be a regular independent survey of people's experiences of and access to all mental health services to drive real improvement.
2. Increase access to timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population.
3. Reduce the use of involuntary practices and work to eliminate seclusion and restraint.
4. All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness.
5. Include the mental health of Aboriginal and Torres Strait Islander peoples in 'Closing the Gap' targets to reduce early deaths and improve wellbeing.
6. There must be the same national commitment to safety and quality of care for mental health services as there is for general health services.
7. Invest in healthy families and communities to increase resilience and reduce the longer term need for crisis services.

8. Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.

9. No one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness. Access to stable and safe places to live must increase.

You can see from these recommendations that as well as a better measurement of outcomes – not just inputs! – and thus more accountability, the NMHC is also very serious about taking not just a whole-of-government but a whole-of-life approach to mental health. People with poor mental health do not live their lives in silos with their mental health over here, their housing over there, their physical health somewhere else. Like us, their entire lives affect and are affected by their mental and emotional wellbeing, and at the NMHC we strongly believe that our goal of a contributing life can't be reached without an integrated approach that embraces that complexity. The involvement of persons with lived experience of mental illness and carers and families in the NMHC keeps us focused on this aim.

Some of our recommendations relate to child, adolescent and youth mental health in much the same way as they relate to other age groups – a national commitment to safety and quality of care, for example, and a reduction in the use of involuntary practices.

One of the most startling findings of the report was the poor life expectancy of people with severe mental illness. Their life expectancy is about 20 to 25 years less than the rest of the population. It is lower on average than that of the indigenous population. That's not a fact that a recently diagnosed young person wants to face.

We know that there are several reasons for the poor physical health of those with severe mental illness. Some antipsychotic medications prescribed to manage mental illnesses such as schizophrenia also contribute to the likelihood of developing chronic physical disorders. Smoking, poor nutrition and physical diseases have a major bearing on physical health – and their incidence is high amongst people living with severe mental illness. Suicide contributes to the worst death rate of those with severe mental illness.

Physical health and mental wellbeing are woven intricately together and they need to be treated as such. It highlights that mental health practitioners and GPs must work very closely together, and as part of a team with the person, and their family.

Some of the Report's recommendations, though, have a particular relevance to younger Australians, such as the need to invest in healthy families and communities; and some look a little bit different when viewed through the lens of their particular needs, such as the first recommendation highlighting the need for the voices of people with lived experience of poor mental health to be heard. For adolescents and young people, the problem of being discharged from care into homelessness or insecure housing has particular characteristics. I will talk about those recommendations and the way they interact with the needs of children, adolescents and young people a little later on.

f. Its role in relation to the COAG

The National Mental Health Commission is encouraged by the outcomes of the Council of Australian Governments (COAG) meeting, held on Friday 7 December.

COAG is made up of the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association. COAG's role is to initiate and monitor the implementation of nationally significant policy reforms that require cooperative action by all Australian governments. COAG has responded favourably to the first Report Card. They have put it on their agenda. We are pleased that Australia's political leaders are directly considering our recommendations rather than shunting them off to be a part of the agenda of health departments. However, we await the details of that response.

COAG has released a Ten Year Roadmap for National Mental Health Reform 2012-2022. The COAG communique points to a new approach and a new process to develop a set of national targets and indicators for mental health reform focussed on a whole of life – a contributing life – view. This may hold more hope for the establishment of genuine and meaningful targets and reporting than other processes have yielded to date.

COAG has set up a new working group on Mental Health Reform co-chaired by the Commonwealth Minister for Mental Health, Mark Butler, and a Minister appointed by the states and territories, in this case Ms Mary Wooldridge, Victorian Minister for Mental Health. An Expert Reference Group, which I have been asked to chair, has also been formed.

Informed by input from consumers, carers, NGOs, researchers and academics, the ERG's task is to provide independent advice to governments on a set of national indicators and targets that will drive system reform, improve lives and that the community will understand. Notwithstanding this ERG process and what it produces, we will not be captured by the process. The Commission retains its independent right to report against performance indicators and targets that it believes will make the biggest difference.

g. The next report

The Commission announced its focus topics for the 2013 Report Card following a recent meeting in Cairns. The 2013 Report Card will take up issues such as problems of dual diagnosis and difficulties with alcohol and drug use; working to improve community understanding of mental health; developing approaches that support recovery including through peer support; transitioning from education to independence; the justice system and mental health; what works in suicide prevention.

The Commission will look to use new and unreported data in future Report Cards, which will include research and data we commission, to enable reporting on action and progress against our recommendations.

h. The views of the NMHC on the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is long overdue and very welcome. I welcome the bipartisan support for it. I'm sure you'll be interested in the Commission's views on it.

Mental health problems and associated physical health problems can lead to lifetime impacts that are just as disabling as sensory, intellectual or physical disabilities. Our Report Card stated clearly that there must be no competition: disability is disability, whatever the cause. Any systemic response to disability must include consideration of the impact of mental illness upon some people's ability to participate in education, the workforce and other activities that support a 'contributing life'. This includes recognising that circumstances, impact and severity can alter between individuals and across the lifespan.

The National Disability Insurance Scheme adopts a key economic idea. Under the NDIS, funds will be made available to individuals with lifelong disabilities. In broad terms, it will be up to them as to how they spend the money. This idea of personal budgets, vouchers, or whatever has had strong in principle support from the world of economics. It's a favourite idea of economists and I shall come back to economics later. It empowers consumers, gives them choice and can lead to competition for their funds from suppliers rather than a kind of monopoly approach. It will be extremely interesting to see how this part of the experiment works and to see how personal budgets and the like work in the field of mental health.

I have however a few points to make.

First, it is critical that it not only applies to persons with physical disability but also to persons with significant and enduring psycho social disability arising from their mental ill health. After some debate, the Productivity Commission recommended this and I believe the Government supports this. It is a key need for the mental illness agenda. We are conscious there will be pressure to reduce costs by restricting the scope of the program. The NMHC will closely watch to ensure that current policy is maintained.

Second, it is essential that the NDIS Rules which sit underneath the scheme's legislation and determine how it will be used, interpreted and rolled out do not disadvantage people with psycho social disability.

The language of the Rules is pertinent to their understanding, implementation and compliance. It is important that wording, such as the use of the term ‘impairment’, is audited for eligibility against disability definitional parameters that include psychosocial disability associated with mental health conditions. There is a need to ensure the Rules are consistent with a whole of life, whole of person, disability responsive approach.

The NDIS should support the inclusion of people with psychosocial disability associated with a mental health or psychiatric condition. As the National Mental Health Consumer and Carer Forum pointed out in their Position Statement *‘Unravelling Psychosocial Disability’*, traditional assessments of people with a disability can often fail to identify the most disabling aspects of psychosocial disability, and are therefore limited in relevance for identifying the necessary supports. For example, the use of the term “irreversible” in Division 2, Clause 5.5 of the Rules to describe the relative permanency of impairment could create perverse incentives and detract from the potential improvement in people’s lives.

Third, the NDIS at best covers only a small proportion of the population with mental illness. There are many other persons with mental illness outside the proposed NDIS who need care, treatment, support, accommodation, employment and other services. We must not forget about them

i. Some economic matters

As I have mentioned I am an economist, and I would like to talk about some economic issues tonight.

a. The questions that concern economists

Economists are concerned with such questions as:

- How to allocate scarce resources in the best possible manner?
- How to evaluate the benefits and costs of government and other interventions and actions?
- What is the role of government and what is the role of the market?
- What is the role of the individual as opposed to the role of government?
- What role do incentives play in influencing behaviour?

In the field of mental health, everywhere I look there is a set of very substantial economic questions. To name a few:

- What is cost to society as well as to the individual of mental illness?
- How much should be spent on it compared to other spending?
- Could we improve the allocation of the limited resources made available for mental health?

- What are the costs and benefits of current and prospective government (or other) mental health policies and programs?
- What is the role of markets, governments and individuals and what is the interrelationship?
- Can we observe the role played by incentives, especially economic incentives in various parts of mental health and are we structuring the approach to mental health in such a way that the available incentives for consumers, carers, suppliers of services and governments work to the maximum good of society rather than to its harm or to its very limited benefit?
- What are the best methods of funding mental health services?

None of this is to say that economics should be the prime determinant of our approach to health care. Even if there is no economic benefit to society in investing in care or in an individual person, we still have a moral and social obligation.

b. Costs to the economy

One of the things that economics does is teach us is the costs to the economy of illness, including mental illness.

Here are some examples.

Ernst & Young, in a study for the Inspire Foundation titled *Counting the Cost: The impact of young men's mental health on the Australian economy*, found that mental illness in young men aged 12-25 costs the Australian economy $3.27 billion per annum or $387,000 per hour across a year in lost productivity. Australia loses over 9 million working days per annum to young men with mental illness, and the OECD report *Sick on the Job* points out that further productivity loss occurs through underperformance. This is an excellent example of the kind of analysis that economics can bring to the questions around mental health – when government and the private sector look at spending and investment, economic analysis can show them the costs of *not* spending, of *not* investing.

In Australia, the 2010 'Suicide and Suicide Prevention in Australia: Breaking the Silence' report quantified the financial cost to Australia as a result of suicide and suicidal behaviour at $17.5 billion. At the time of publication this represented 1.5% of Gross Domestic Product, or $795 per person, per year. While not all of this cost is attributable to mental illness, mental health is a key contributing factor to this cost.

The presence of mental illness has a significant influence on an individual's productivity, with a close association between productivity and the presence of mental illness in adolescence.

A recent Foresight Mental Capital and Wellbeing Project (2008), commissioned by the Government Office for Science, London highlighted the strong link between mental health and wellbeing and the production of capital, the role of mental health in national prosperity, and the development of mental wealth.

The OECD report Sick on the Job estimated that the employment rate for people with mental health disorders is 10 to 15 percentage points lower than for people without.

The unemployment rate for people with mental health conditions is 2.8% higher than for those without. According to a US study, workers with a mental disorder have a 50% higher likelihood of losing their job, and also a 30% increased likelihood of quitting. People with mental illness have lower levels of education than those without, and they earn less: young men with mental illness have a 4.7% lower hourly rate than young men without, even when level of education, unemployment history, experience and physical health are taken into account.

c. What Australia spends on mental health

Medibank Private has just released a study showing that, surprisingly, Australia spends at least $28.6 billion per year, excluding capital expenditure, supporting people with mental illness. This is far higher than has been previously estimated.

Direct health expenditure is at least $13.8 billion, mainly by state governments. Federal funding is now approaching $3.5 billion, from under $2 billion in 2007-8.

In addition to the costs associated directly with specialist mental health care, the government also bears a broad range of costs required to support people with mental illness - including income support, housing services, domiciliary care and employment and training opportunities. Direct non-health expenditure is at least $14.8 billion.

The total expenditure of $28.6 billion is equivalent to 2.2% of Australia's Gross Domestic Product. This excludes indirect costs, such as lost productivity.

Despite that, outcomes are not improving – there is an underlying structural problem, of fragmentation, and insufficient co-ordination both within the health care system and between the health care system and social services.

What stands out rather strikingly is that very little assessment has been done on whether we spend these resources well but on the face of it we do not. For example, there is only a relatively smaller part of the population that has access to mental health services compared to other medical services. Also the general incidence of mental health problems shows that the spending may not be either adequate or appropriately targeted. To judge from the amount of mental illness in the community, one is aware of some economic inclusions, problems and dilemmas. Would it pay to spend more? Is it that we do not spend the money well? Is it that we spend the money well in the circumstances but the solutions are not available or are imperfect at this stage? Is the balance right between prevention and care? Is the balance right between clinical (or hospital) spending and spending in the non-clinical and/or non-hospital area? Whatever the case, this is not a reason for disinvestment.

d. The current health reforms

One thing that economics teaches you is to look out for incentives within any policy or program – and to be aware that sometimes those incentives can be what we economists call 'perverse'. That is, they create a situation where it makes sense for people or organisations to do exactly the opposite of the intent of the policy or the program.

When it comes to the current health reforms, there are a number of incentives we can see. They operate largely at a State rather than an individual level, and some of them are *quite* perverse.

For example, the National Health Reforms, chiefly the Activity Based Funding one.

Under the reforms the Commonwealth would soon be paying 50% of the increase in state and territory hospital expenditure. This will give states major incentive to move mental health services from the community into hospitals. This reverses the work of many years in which we have been trying to keep people with mental illness out of hospitals wherever possible and supported to stay well in the community. Years of effort in moving to contemporary and innovative practice threaten to be undone.

We believe it is better for people to be treated in their community, very often by excellent non-government organisations, with links to services such as rehabilitation, housing and employment, rather than in hospital beds in a clinical or hospital setting except in acute cases. They can also be with or near their families and friends. Costs are usually lower. This is a people centred approach that considers their whole life, not just health aspects.

The ABF focus on public hospital services also artificially slices up an ideal system of integrated, cross sector, community based support which should focus on what the person wants and needs, not where the money comes from.

Moreover, there are claims in the mental health community that mental health spending already has an undue bias towards hospital spending. Especially where there are expenditure cuts, many believe the first thing to go is community services and the last thing to go is hospital services, causing further imbalance. All of this makes the reforms of great concern.

Our concerns are compounded by the national pricing system reforms.

Under Activity Based Funding, funding flows to hospitals on the basis of the average cost of each service. This works well for many health “transactions” such as a standard knee operation, where operating theatre and bed times and other costs are often standard and undebatable.

While the Commissioners broadly support the pricing reform agreed by the Council of Australian Governments – COAG – which tries to match dollars to need and demand and outcomes, the application of what is basically a good economic idea to mental health is extremely problematic.

First, it is unpredictable as to how long treatment can take. It may take a day, it may take 6 months. It is difficult to run an average costing system in this setting with such wide variation. In addition, although a pricing system provides some powerful incentives for hospitals to work efficiently, there can also be some undesirable effects – undue pressure to get patients out of hospital quickly, even in standard clinical matters, gaming, and so on. Those undesirable side effects can be magnified with patients with mental illness.

If governments get the design of Activity Based Funding and its associated pricing wrong for mental health, it could seriously undermine effective and efficient care.

This, I believe, isn't consistent with the spirit of the COAG agreement; with evidence based best practice models or the most efficient use of highly sought after mental health funds.

The Independent Hospital Pricing Authority has issued their pricing framework and do seem to have heard us, as have the Government, which is very gratifying and we are pleased to be on their mental health working group.

But we are still concerned about how this will roll out and will continue to be an active participant so that good decisions are made.

e. Accessibility of services

There is another perverse incentive that affects accessibility of services. Under the our provider number system and the fee for service system in Medicare, any qualified psychiatrist or psychologist can set up a practice wherever they like and, based on their provider number, will receive payment based on fee for service. Psychiatrists and psychologists tend to live in better off areas. There is as a result an abundance of services in those areas. There is a relative scarcity of services in other parts of Australia where they do not live. This distortion is the result of incentives created under the Medicare scheme.

Despite what I have said, I am sure there will be many people who are somewhat sceptical of the contribution which economics can make in these areas. And this is where I'd like to shift the focus of this oration specifically to children and young people. There is one contribution economics has made that I don't think anyone can question, and it has to do with early childhood. I am talking of the work of Professor James Heckman of the University of Chicago who won the Nobel Prize for his extremely influential work on the economic benefits of policies which promote early childhood development. This has been one of the most important contributions in economics to society in recent decades, a contribution that recent developments in neuroscience have explained from a scientific perspective.

5. Early Childhood

a. James Heckman and early childhood investments.

One of the NMHC Report recommendations was to increase investment in healthy families to build resilience, and this is why.

Professor Heckman established that investing in high-quality programs targeting very young children, and their families, to assist in the development of emotional and social skills, have proven, substantial economic returns.

Heckman's special contribution was to show through a series of empirical studies that the economic return of investing in high-quality early childhood programs consistently far exceeds that of other social investments. The benefits consistently exceeded 3 to 1: that is, for every one dollar spent, there a three dollar return, which is well above the return of most other investments by government.

These programs, Heckman argues, have a much higher return than later interventions, but, significantly, programs aimed at older age groups show more return for children who have already had the benefit of interventions in pre-school years. That is, the efficacy and efficiency of help and support for school age children and adolescents is increased by investment in high-quality early childhood development.

Heckman argues that programs targeting the early years, with home visits to affect the lives of the parents and create a permanent change in the home environment that supports the child even after that part of the program delivered through childcare or community centres ends, have the most promise, as do programs that don't focus exclusively on academic or cognitive abilities but more generally on building emotional and social skills.

One example is the US Perry Preschool program, which ran for two years, for disadvantaged children initially aged 3 to 4, and involved morning preschool programs and afternoon visits to the child's home by the teacher. In follow-ups to age forty, those children had higher rates of educational achievement, higher earnings, higher rates of home ownership, and lower rates of government assistance and arrests than the control group. The return on investment of the Perry program was in excess of 14%.

Let me tell you, as an economist, if I could find an investment with that kind of return I'd grab it with both hands!

Heckman suggests these are in fact underestimates of the true rate of return because they ignore the economic returns to health and mental health.

b. The scientific basis

We've been able to see for some time the economic effects of investing in early childhood, but the more we learn about the brain and how it works, the more we come to understand *how* that investment pays such huge dividends. The science of early childhood development is now showing the impact of experience and environment on young children, not just at the time but throughout their subsequent lives. As young children's brains develop their neural networks, which lay the foundation for such essential socio-emotional skills as language, self-regulation, social skills and compassion, the shape and strength of this development depends heavily on environmental input. Over time, the brain becomes less adaptable, less flexible – the effects of early childhood, good or bad, are then much harder to undo.

Prevention during the early years, prior to the onset of a problem, can have a far greater effect than intervening later, after a problem has become established.

Early experiences can significantly influence later life, starting a developmental trajectory which leads to susceptibility to conditions such as mental health problems but also including family violence and anti-social behaviour; participation in crime; poor literacy, early school leaving and subsequent poor skill levels; welfare dependency; substance abuse; and obesity and its associations.

High-quality early childhood and family support programs can do much to prevent this happening. These interventions include early childhood education and intervention programs as well as parenting and family support programs. High quality programs not only improve cognitive and especially socio-emotional functioning but have also been shown to be cost-effective, particularly with children from disadvantaged backgrounds.

This is a multi-faceted issue: appropriate support in early childhood encompasses educational goals, but also social and emotional ones. In fact, 'children's mental health is even more closely related to the concepts of healthy social and emotional development than adult mental health' (Miles et al. 2010, p.21). There are well-established risk factors for children, which can interfere with the development of a healthy brain, including the long term stress of poor relationships with their primary carers. Well-known risk factors for children's mental health include social adversity, poor parenting, family dysfunction, abuse and neglect, as well as biological predispositions.

These risk factors increase the likelihood of poor mental health in later life. There is significant evidence that health promotion, prevention and intervention in the earliest years, beginning with a future mother's health, pregnancy and early childhood, can have lifelong consequences and lay the groundwork for both physical and mental wellbeing of children.

Supporting families, enhancing their capacity to raise their children well is a key investment in good mental health – both the science, and the economics, tell us so.

c. Some examples

We already know, from the research on what works, what that would look like. It would involve a population health approach as well as a clinical one.

It would have interventions to promote attachment and development – effective universal programs for all families such as maternal, infant and child health services, and high-quality education and care, as well as targeted programs for those with greater vulnerability such as intensive home visiting, parenting programs and supported playgroups. Through these programs, we would see the early identification of emerging and established problems, and more seamless integration with other levels of mental health care and support, from assistance in managing developmental and behavioural issues, to referrals to age-appropriate services for more serious problems.

For slightly older children, starting school is an important platform from which we can reach almost all Australian children. It can be a challenging transition, and supporting children, parents and teachers through it is a crucial factor in promoting resilience. The development of good mental health through the promotion of social and emotional learning should be part of the educational curriculum, and should be promoted in family-friendly schools and in the community. Strong links between schools and community services would allow for the early identification and management of emerging poor mental health. A good example in Victoria is the inclusion of Child and Adolescent Mental Health Services into schools at grade 3 – called the CASEA program – which stands for CAMHS and Schools Early Action. The program means that problem behaviours are identified early and CAMHS get in quickly to deal with the problems in a school setting.

6. Adolescents

Ladies and gentlemen, just as we now have an increasingly sophisticated understanding of the significance of the first years of life in the development of a healthy mind, we also know more and more about the implications of continuing brain development through childhood and into the key transitional years of adolescence and early adulthood. These years, 12 to 24, see the emergence of mental health symptoms for 75% of people who will experience poor mental health throughout their life. Puberty seems to be an important time which triggers a significant increase in mental health problems in young people. It is also an opportunity to try and ameliorate the problems which arose earlier in life as young people are able to embrace more abstract thinking. What is clear is that environmental experiences continue to shape brain development and ultimately influence long- term emotional health.

For young people without strong family and educational connections, puberty can be a high risk period which can mark the beginning of a fast-track to adulthood ranging from an increase in risk behaviours and early transitions into sexual activity and school leaving, to the development of psychiatric and substance use disorders. The health consequences for high-risk or vulnerable groups, such as young offenders as one example, may be devastating.

Although there is a perception that young people are reluctant to seek help for mental health problems, adolescents and young people themselves say that they have sought information and help, and want access to more. The barriers they identify include cost and availability, with the fear of being stigmatized and "shamed out" a substantial obstacle as well.

The first recommendation of the NMHC's Report Card states "Nothing about us, without us." When it comes to children, adolescents and young people, their involvement is critically important.

Many mental health professionals, government representatives, and indeed National Mental Health Commissioners like me, live on the other side of the generational digital divide. We can see, but not quite grasp, the increasingly fluid distinction between online and off-line life for the generation of Australians who don't remember life before smartphones. At the same time, our traditional models of consumer activism, like peak lobby groups and advocacy organisations, seem out-dated and lumberingly slow to the twitter generation, proficient in quick and effective social media campaigns and networked engagement.

Children, adolescents and young people are under-represented in mental health care consumer and advocacy groups and in survey responses – except where those surveys are carried out through social media.

We need to engage with young Australians on their own terms – including through the use of peer researchers, a technique which can provide different and important perspectives. It is our responsibility to make our feedback and data collection processes accessible and engaging.

It is our responsibility to listen to what young Australians have to tell us about what they need and what they want from mental health care and support – not only when they speak through channels we are comfortable with.

The Commission acknowledges the importance of engagement with young Australians in our work. In 2012 we commissioned a report into how we as a Commission, can engage with young people in the development of the National Report Card. Today we are delighted to announce the release of the report on our Commission website. Many thanks to Batyr CEO, Sebastian Robertson, Young and Well-CRC CEO, Dr Jane Burns and Dr Michelle Blanchard, Head of Projects and Partnerships at the Young and Well CRC, who are here this evening - we thank you for your work in developing this informative report. The report is an early step and sets the scene for the involvement of young Australians in informing the development of the Commissions work and future Report Cards.

It is important to realise that children, adolescents and young people engage with help, support and care differently to older adults. While a GP might be the first port of call for an older person seeking help, young people see that as a less desirable option. A mental health care system designed around the preferences of the older members of our community, and designed in the previous century at that, is not meeting the needs of younger Australians.

Just as young Australians have different preferences for communication and interaction with government agencies and other organisations to older generations, they also have different preferences for engaging with services, with help, care and support. We need to listen to young people's perspectives on the type of information, help, support and care they are able to access and willing to engage with. Information and resources need to be accessible and engaging for young Australians, using input *from* them in designing material and programs *for* them.

A key gateway for young people seeking help and information about mental health issues is online. Indeed, many young people prefer to access help, support and care through digital mediums – and for those living outside major metropolitan centres, often online access is the only access. In addition, it provides privacy for those concerned about stigma, and through forums and networks, a community of shared experience. The over-whelming preference for young people we surveyed is to get information on mental health from another young person with lived experience of mental health issues.

The NMHC Report Card's second recommendation is to "Increase access to timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population."

That is a low target and I emphasise, it is a starting point.

For children, adolescents and young people, increasing access to 'timely and appropriate' care and support is not simply a question of more funding for more services. We need to listen to young people's perspectives on the type of information, help, support and care they are able to access and willing to engage with.

Of young adults, 93% go online and 33% of them look for mental health information online. Given that half of mental health problems are evident before 15 years of age, e-health technologies are familiar and easily accessible to young people. A recent study showed that 85% of young adults diagnosed with serious mental illness looked up mental health information online and 44% did this at least once a month. These technologies may also lead to appropriate referrals to face to-face primary and secondary mental health interventions.

Web-based intervention programs are currently being developed that work in partnership with primary health care workers such as general practitioners. As noted by Christensen and Hickie there is increasing evidence that internet-delivered treatments are effective, efficient and cost effective for anxiety, depression, post-traumatic stress disorder, and a range of other conditions.

Peer-help and self-help resources are often a critical first step for children, adolescents and young people. Australia has some outstanding and ground-breaking programs that combine the potential of digital delivery with the preference for independent access to information and resources – the Inspire Foundation's 'Reachout' being one of the first in the world, and now being used as a model around the world. 'Headspace' provides both online and offline help and support and has particular, and remarkable, success in engaging young men – who are much less likely to seek mental health help than young women.

Both of these continually engage with the young people they serve and are responsive to their feedback, stressing relevance and accessibility for their target base. Both also serve as an access point for information on, and help for, a wide range of mental health concerns and a wide range of issues that can have a negative impact on mental health.

For children, adolescents and young people experiencing distress and poor mental health, with what may be emerging mental health conditions, the ability to independently access resources or 'self-refer' to a 'headspace' centre, without needing to meet specific clinical thresholds, increases the likelihood they will access timely care. 'Headspace' centres are an example of the provision of integrated, face-to-face services in an accessible setting which reflects the preferences of adolescents and young people.

At the same time, one common comment from young people who have sought out and engaged with mental health services is that the initial decision was sparked by someone else suggesting they might need help, and young people tell us that they urgently need more information and more support on how to talk to and help their peers who are experiencing difficulties.

The report card also recommended that “No one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness. Access to stable and safe places to live must increase.”

Adolescents and young people who don’t, or can’t, live with their families, face the same ‘revolving door’ of crisis care or imprisonment, unstable housing, homelessness and so on ad infinitum as older people. They also face the same difficulties in securing housing when their disorder is too disruptive for housing services to be willing to deal with but not yet severe enough for mental health professionals to consider ‘crisis’. A complicating factor is that adolescents and young people naturally desire housing choices that are age and peer appropriate, and some supported housing options, framed in terms of an older age group, place restrictions on residents that young adults, seeing their peers entering into an independent life, find unreasonable.

In addition, lack of alternate arrangements means the parents of young people with mental illness often feel there is no choice but to have their child living in the family home, even when this is not the preference of the young person or when it is not a suitable arrangement.

We also need to be aware that youth homelessness can be disguised by the often-transitional nature of accommodation arrangements for young people. There is a big difference between an eighteen year old couch-surfing their way around Australia between the HSC and the start of university, and an eighteen year old sleeping in friends' living rooms because they have nowhere else to go.

For children, being part of a homeless family can lead to increased vulnerability: the stresses on a family on insecure and unstable housing are themselves a risk factor. Many children also become homeless as the consequence of circumstances that in and of themselves lead to increased vulnerability, such as family violence.

7. Conclusion

Ladies and gentlemen, the NMHC's recommendations are informed by a holistic, person and family-centred approach across the whole life course, similar to that informing the NDIS. People with mental health difficulties do not live their lives in distinct segments with mental health care in one box, education in another, housing in third, and employment in yet another. In addition, there are complex issues such as people who have both a mental health problem and an intellectual disability, and for children and young people, situations where a child comes from a home with a parent or caregiver suffering mental illness.

Nor do they live their lives in compartmentalised developmental stages, with a calendar birthday bringing a comprehensive change in support needs or in abilities.

A whole-of-life approach means not only on the horizontal plane, but also vertically. I have talked today about age cohorts today, as do the academics I have referred to, but those age cohorts are not neatly segregated from each other and their needs are complementary, not competitive – because they are, of course, made up of the very same people as they transit through life.

A whole-of-person approach also demands a whole-of-government approach; and more than government. Our approach must include the non-government sector, business, and the community as a whole.

For children, adolescents and young people, it is about getting access to the right clinical care when they need it, to the right support and help. But just as importantly, it is also about developing good mental health from childhood through the development of resilience and positive social and emotional health; it's about staying engaged in learning and not missing out on the critical transition to post-compulsory learning or work; it's about family support and support for families in an even more acute way than for adults; it's about the network of government and non-government agencies that may, and should, provide the right help at the right time.

We need to critically examine the way existing services meet these needs and identify both gaps and duplication: and we need to measure their effectiveness.

Government agencies and levels of government need to co-ordinate services and funding. Institutions and organizations need to co-ordinate, not just with carers but with each other; the provision of services in housing, education and employment support, physical health all have an impact on the ability of a young person to stay on track to lead a contributing life.

This is by no means to suggest that child and youth services and programs are the only place we should be putting our attention and our resources, but rather that, as an economist, I can see that these key developmental stages are currently a missed investment opportunity.

Developing a comprehensive, population-based approach to promoting good mental health and addressing poor mental health which integrates with clinical services where necessary will not be an easy task. But, ladies and gentlemen, it is in my opinion an essential one.