Narelle Butt  
Rethink Mental Health Project  
GPO Box 125  
Hobart TAS 7000  

By email: rethink@dhhs.tas.gov.au  

5 March 2015  

Dear Ms Butt  

RE: RETHINK MENTAL HEALTH TASMANIA  

Thank you for the opportunity to comment on the Rethink Mental Health Project: A long term plan for mental health in Tasmania - Discussion Paper.  

MY ROLE AND FOCUS  

As you may be aware, the Commissioner for Children is an independent statutory officer appointed by the Governor pursuant to s78 of the Children, Young Persons and Their Families Act 1997. The Commissioner’s powers and functions are set out in Part 9 of that Act.  

A major focus of the Commissioner’s role is to promote the health, welfare, care, protection and development of children and young people and to provide advice to the Minister for Human Services on policy, practice and services provided to or for children and young people in Tasmania, which may include any laws affecting them.  

My comments are guided by the principles expressed in the United Nations Convention on the Rights of the Child (CRC) which provides an appropriate framework for analysis of policy and legislative proposals which have the capacity to impact upon the rights and wellbeing of children and young people.  

Of particular relevance are Article 6 (Right to life, survival and development and the determinants of children’s health) and Article 24 (Children have the right to the highest attainable standard of health)1.  

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1 Refer particularly to the General Comment on the right of the child to the highest attainable standard of health – No 15 (2013) UN Committee on the Rights of the Child –accessed 5 March 2015.  
Acknowledging that the Articles in CROC are interconnected and that human rights are interconnected, mutually reinforcing and indivisible, other Articles of fundamental importance in this context include:

- The child’s best interests as a primary consideration – Article 3
- Non-discrimination – Article 4
- Assistance to parents and legal guardians in the performance of their child-rearing responsibilities – Article 18
- Children with a disability have a right to special care and support – Article 23.

COMMENT

My submission is substantially contained in the attached paper prepared at my request by Professor Michael Sawyer titled Child and adolescent mental health problems: Prevalence, disability and financial costs. Professor Sawyer is Professor of Child and Adolescent Psychiatry in the School of Paediatrics and Reproductive Health at the University of Adelaide and Head, Research and Evaluation Unit at the Women's and Children's Hospital in South Australia. A short CV for Professor Sawyer is attached to this submission.

The main point I wish to make is that mental illness affects almost every aspect of society and the economy and as such represents a significant public health challenge, however our responses to date have not been effective in reducing the prevalence of mental health problems. In addition, the costs associated with mental health morbidity and mortality continue to grow significantly, with no apparent abatement in sight.

I respectfully submit that there now exists an opportunity to commence a process to address this growing problem, through the Rethink initiative. Whilst the requirement to continue to meet the needs of the acutely unwell population will continue, a process to refocus and strengthen investment in early intervention and prevention should be commenced. Due to the need to “catch up” in this space it will require a longer term strategy with tri partisan support from all political parties.

Substantial evidence shows that resources and interventions must focus increasingly on childhood and adolescence as chronic mental disorders typically have their onset during this critical developmental period.

Although it is acknowledged that early intervention and prevention during childhood and adolescence is the most effective way to address mental health issues, this is not occurring for various reasons, one of which is the tendency to prioritise public spending on interventions that are capable of showing short term improvements for those who are acutely unwell, in particular the adult cohort. Many of these adults could have been prevented from developing these problems with earlier intervention, in particular during childhood and adolescence.

In light of what we know about the importance of addressing mental health issues in childhood and adolescence, Tasmania’s per capita expenditure on child and adolescent
mental services appears to be disproportionately low when compared with expenditure for general adult mental health services.  

The lower expenditure ratio for CAMHS services is not unique to Tasmania, but common across all jurisdictions. It is noted that underinvestment in CAMHS services is not a recent occurrence but one which goes back for a number of decades, across all Australian mental health services.

For ease of reference I summarise below some of the key points made by Professor Sawyer which inform my position.

Prevalence of Child and Adolescent Mental Health Problems

The prevalence of mental health problems in children and adolescents is high in Australia and elsewhere.

The national survey of child and adolescent mental health in Australia in 2000 found that 14% of children and adolescents met the criteria for having a mental health problem. In Tasmania, that figure is equivalent to 16,850 children and young people aged 0-18.

The high prevalence of problems is evident across the full age range of children in the study for both males and females.

While it is not clear whether the prevalence of mental health problems in children and adolescents is increasing, there is no evidence that it is declining. Of particular concern is the apparent increase in prevalence of mental health disorders in young women, in particular eating disorders and self harm.

Chronic mental health disorders typically have their onset in childhood and adolescence (eg 50% of all mental disorders have their onset before age 14 and 75% before 24 years). Once established, child and adolescent mental health disorders frequently have a long-term adverse impact in a broad range of areas.

Disability

Professor Sawyer cites epidemiological data and burden estimation methodology used to quantify the burden of health conditions on individuals in the community. In brief, the size of the impact of mental health problems on the health of adolescents in Australia is evident in the observation that the proportion of total disability accounted for by mental health problems is almost twice that of the next ranked health problem (musculoskeletal disorders).

Financial Costs

Professor Sawyer estimates that the cost of supporting children and adolescents in Tasmania with mental health problems is $60,153,000 per annum.

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2 See for more detail the National Mental Health Report 2013  
Mental health problems in children and adolescents have adverse effects on many areas of their lives. The associated financial costs imposed on non-health services (eg education, justice, social services) are high but rarely assessed.

Child and adolescent mental health problems are frequently associated with poor economic outcomes in adulthood such as early termination of education, unemployment and employment in less skilled/lower paid jobs. This issue significantly impacts on state revenue and expenditure. These costs impact on many areas of government service delivery.

Health System Responses

Health systems and governments in Australia and internationally have traditionally struggled to respond to the public health challenge that child and adolescent mental health problems pose.

Resources are finite and it is essential that interventions represent value for money. While many interventions for the prevention of mental health problems and the promotion of mental wellbeing have been found to represent outstandingly good value for money (with payoffs being spread over a number of years), priority is often given to interventions that can achieve benefits in short periods of time (eg crisis responses to existing health problems). As a result:

- There continues to be a mismatch between the size of the social and economic problems associated with child and adolescent mental health problems and the size of the government/service response.
- Specialist CAMHS services are scarce. Services see only a minority of children with significant mental health problems and CAMHS are fully occupied supporting the children that access their services, most of whom have very high level chronic and complex problems.

Attempts to improve the effectiveness of CAMHS should be guided by a strong evidence base. Professor Sawyer suggests three steps that could be taken in this regard:

1. Make greater use of existing data routinely collected by CAHMS and place greater emphasis on collecting data that assesses mental health outcomes.

   - Rapid feedback of good quality data can increase effectiveness of intervention programmes in clinical services.
   - Policy decisions must be based on good quality outcome data rather than on “appealing” ideas
   - Initial benefits should be monitored over time to ensure they associated with better longer term outcomes.

2. Make greater use of pragmatic trials designed to evaluate the effectiveness of the new interventions delivered in routine clinical practice.

   - Only a tiny proportion of children who receive care through CAMHS participate in outcome-oriented trials.
- CAHMS should access funding available to health services research with a view to developing, implementing and evaluating new interventions delivered in clinical practice.

3. **Place greater emphasis on ensuring that evidence-based interventions in all services responsible for the care of children and adolescents with mental health problems are implemented with a high level of fidelity.**

- While CAMHS has a key role, incidence and prevalence of mental health problems in children and adolescents is unlikely to decline unless all services with responsibly for their health, education and welfare implement targeted, universal and clinical cost-effective programs aimed at reducing mental health problems in this cohort.

**CONCLUSION**

Of all the diseases and challenges faced by the Tasmanian community, the mental health of children and young people poses one of the most prevalent and challenging situations. The Rethink initiative provides a watershed opportunity to reconsider how our services are delivered and how these scarce resources are best targeted in order to deliver the most effective programs in terms of much improved human and fiscal outcomes.

In essence, investing earlier in the life course, in particular children and young people’s mental health services is also a sound financial decision.

Thank you again for the opportunity to contribute to the Rethink consultation process.

I wish to commend the Government for undertaking the Rethink Mental Health Tasmania review.

I trust that my comments contribute to ongoing efforts to improve Tasmania’s mental health service system.

I would appreciate the opportunity to meet with the Minister for Health to provide a personal briefing on the matters I have raised in my submission.

I am of course available should my comments require clarification or if I can further contribute in any way to this important discussion.

Yours sincerely,

Mark Morrissey
Commissioner for Children

Attachments:

2. Sawyer, Prof MG - Short CV.

cc Minister for Human Services
CHILD AND ADOLESCENT MENTAL HEALTH PROBLEMS: PREVALENCE, DISABILITY AND FINANCIAL COSTS

Professor Michael Sawyer
March, 2015

Children and adolescents aged 0-18 years represent approximately 24% of the population in Tasmania\(^1\). Furthermore each year, approximately 6,000 infants are born to families living in Tasmania. Good health among young people and their families is an essential prerequisite to achieving and maintaining a well-educated, self-sustaining and productive society. As such, all communities have to consider carefully the best ways to promote the health of their young people and minimize the adverse impact of health problems on young people’s development, education and subsequent employment.

Over the last 20 years recognition of the importance of good health for economic productivity in particular, has encouraged substantial research aimed at identifying health conditions that have the greatest adverse impact on individuals, families and communities. To do this, the impact of different health problems on communities is compared on the basis of their frequency (i.e., the prevalence of the conditions in the general population), the level of disability associated with different health problems, and the cost of health problems in both human and fiscal terms\(^2\). This work has consistently shown that on all three dimensions, child and adolescent mental health problems rate extremely highly\(^2\).

Prevalence of Child and Adolescent Mental Health Problems

What are mental health problems and mental disorders?

Terms such as mental health problems and emotional and behavioural problems do not have exact definitions. They are commonly used to describe alterations in thinking, mood or behaviour that are associated with distress or impaired functioning. In the Australian national child and adolescent mental health survey\(^3\), children and adolescents were considered to have a mental health problem if the number of emotional and behavioural problems they were experiencing was in the range typically reported for children and adolescents attending mental health clinics\(^3\). The survey assessed the prevalence of mental health problems among
4-17 year olds and problems were identified by parents and adolescents who completed questionnaires asking about a large number of emotional and behavioural problems that can occur in childhood and adolescence\textsuperscript{4, 5}.

*Mental disorders* are conditions characterised by clinically significant sets of symptoms or emotional and behavioural problems associated with personal distress and impaired functioning, as defined in the *Diagnostic and Statistical Manual of Mental Disorders (4th edition)*\textsuperscript{6} or the *International Statistical Classification of Diseases and Related Health Problems (10\textsuperscript{th} revision)*\textsuperscript{7}. In the Australian national child and adolescent mental health survey, three child and adolescent mental disorders were studied: Depressive Disorder, Conduct Disorder and Attention-Deficit/Hyperactivity Disorder. These disorders were included because they were known from previous studies to be prevalent in the community and because of their significance for child and adolescent health in Australia. Mental disorders were identified using face-to-face interviews conducted with parents by trained interviewers using the Diagnostic Interview Schedule for Children Version IV\textsuperscript{8}. Mental disorders among children aged 4-5 years could not assessed because the interview assessment technique used in the survey had not been validated for this age group (4-5 year olds were assessed using questionnaires\textsuperscript{5}).

**What is the prevalence of mental health problems and mental disorders in Australia?**

During the last two decades a high prevalence of child and adolescent mental health problems has been found in many countries around the world. Consistent with this pattern, 14% of children and adolescents in the Australian national survey were found to meet the criteria for having a mental health problem (equivalent to 16,850 young people aged 0-18 years in Tasmania\textsuperscript{1}). Furthermore, this high prevalence of problems was evident across the full age range of children in the study, and for both males and females.

The prevalence of the three mental disorders assessed in the Australian national survey is shown in Table 1. It can be seen that Attention Deficit/Hyperactivity Disorder (ADHD) was the disorder most frequently identified, followed by Depressive Disorder and Conduct Disorder. ADHD and Conduct Disorder were more frequently identified among males than females. It should be noted that the survey did not have the resources to assess the prevalence of anxiety disorders which have been identified in other surveys as having a high prevalence in children and adolescents.
Is the prevalence of mental health problems changing?

There is some evidence that the prevalence of problems among adolescents is increasing. For example, Collishaw et al.\(^9\) compared the prevalence of problems experienced by 15–16-year-olds in 1974, 1986, and 1999. Results showed a substantial increase in adolescent conduct problems over this 25-year period for both males and females across all social groups and family types. More recently the same group of investigators have compared the prevalence of emotional problems experienced by 16-17-year-olds living in England in 1986 and 2006\(^10\). For males and females in all social groups it appeared that emotional problems, including depression, had increased markedly. In an extensive review of studies examining the prevalence of mental health problems over time experienced by 0-18 year olds, Bor et al. concluded that “in children and toddlers, recent cohorts did not exhibit a worsening of mental health symptoms”\(^{11(p.613)}\). Among adolescents the prevalence of externalizing problems appeared to be stable. However the majority of studies reported an increase in the prevalence of emotional problems among female adolescents, while mixed results were reported for male adolescents.

Although studies have varied in the extent to which they have reported an increase in the prevalence of child and adolescent mental health problems, what is important is the absence of any evidence suggesting that the prevalence of problems in this age group is declining. The findings suggest that current approaches being used to address child and adolescent mental health problems are not reducing the prevalence of problems in the community. As such, new efforts are needed to identify more effective methods to address the major public health problem posed by child and adolescent mental health problems.

At what age do mental health problems have their onset?

A high proportion of all mental health problems, including those experienced by adults, have their onset during childhood and adolescence. For example, Kessler et al.\(^12\) have shown that 50% of all mental disorders have their onset before the age of 14 years and 75% before 24 years. Kessler et al. reported that the median age of onset for anxiety disorders and impulse-control disorders reported is 11 years\(^12\). As noted by Kessler et al.\(^13\), in contrast to the situation with chronic physical disorders which typically have their onset later in life, chronic mental disorders typically have their onset in childhood and adolescence. This finding has profound implications for interventions designed to reduce the incidence (i.e., number of new
cases) of mental disorders in the community. If they are to be effective in achieving this goal, interventions must focus their endeavours on childhood and adolescence.

**Do mental health problems persist over time?**

Once established, child and adolescent mental disorders frequently have a long-term adverse impact in a broad range of areas. For example, Farrington et al.\(^{14}\) found that 40\% of 8 year olds with conduct disorder subsequently had repeated convictions for crimes such as theft, vandalism, and assault in adolescence. They are also at increased future risk for poor educational outcomes, drug and alcohol abuse, unemployment and criminal behaviour as adults. The mechanisms by which this problem recurs across generations can be understood when it is recognised that conduct disorders occur four times more often in families with unskilled occupations than in professional families and also in families where conflict is common. In the absence of effective interventions that can break these cycles, it is inevitable that subsequent generations in the same families will experience conduct problems over many years.

**Disability associated with Child and Adolescent Mental Health Problems**

During the last two decades the Global Burden of Disease Studies have used epidemiological data and burden estimation methodology to quantify the impact of a wide range of health conditions on individuals in the community\(^ {15,16}\). The size of the impact is described using three metrics: (i) ‘years of life lost due to premature mortality’ (YLLs), (ii) ‘years lived with disability’ (YLDs), and (iii) ‘disability-adjusted life years’ (DALYs). The latter is a composite of the other two metrics with one DALY effectively representing one lost year of ‘healthy’ life. Globally, it has been found that mental and substance abuse disorders are the leading cause of disability among children and youth (0-24 years), accounting for 25\% of YLDs. They also ranked 6\(^{th}\) for DALYs in this age group, accounting for 5.7\% of all DALYs\(^ {16}\).

At a global level among 0-24 year olds, Erskine et al.\(^ {16}\) reported that Major Depressive Disorder is the leading contributor to YLDs and DALYs among both males and females. Other mood disorders, anxiety disorders, and eating disorders were important contributors to burden in females while conduct disorder, attention deficit/hyperactivity disorder, autism spectrum disorders, and substance use disorders contributed more to burden among males.
In Australia, among 1-14 year olds, mental and substance abuse disorders are ranked 1st for both YLDs and DALY, accounting for 20.5% of YLDs and 16.7% for DALYs\(^7\). In each case, these disorders lead chronic respiratory diseases, which rank 2nd and account for 20.1% and 16.6% of YLDs and DALYs respectively\(^7\).

Among 15-19 year olds in Australia, mental and substance abuse disorders also rank 1st for YLDs and DALYs, accounting for 36.5% of all YLDs and 29.0% of all DALYs. In this age range, musculoskeletal disorders rank 2nd, accounting for 19.1% and 14.7% of all YLDs and DALYs respectively\(^7\). The size of the impact of mental health problems on the health of adolescents in Australia is evident in the observation that the proportion of total disability accounted for by mental health problems is almost twice that of the next ranked health problem (musculoskeletal disorders).\(^3\)

**Financial Costs of Child and Adolescent Mental Problems**

In a recent review, Beecham\(^8\) summarized key findings from studies examining support and treatment costs of child and adolescent mental health problems, and the economic impact of these problems in adulthood. Average estimated costs in a pan-European study were 3,595 per child per annum\(^9\) while analysis of the national British Child and Adolescent Mental Health Surveys identified the mean cost for children with a psychiatric disorder to be £1,803 per child per annum of which 75% was absorbed by additional education services\(^10\). It is possible to estimate the costs of supporting children and adolescents with mental health problems in Tasmania by multiplying these cost estimates by the estimated number of children with mental health problems in the State (e.g. 16,850 X £1,803 = £30,380,550 or approximately A$60,153,000 per annum).

Other key findings from the review were:

- The financial costs imposed on non-health agencies such as education, social services, and justice, and also on individual families are high but rarely assessed. This is consistent with mental health problems having adverse effects on many areas of the lives of children and adolescents.
- Child and adolescent mental health problems are frequently associated with poor economic outcomes in adulthood including early termination of education, unemployment and employment in less skilled and lower paid jobs.
Health System Responses

Internationally and in Australia, governments and health systems have struggled to respond to the public health challenge posed by child and adolescent mental problems. In Australia and overseas there have been numerous “reviews”, “reforms” and “reorganizations” of child and adolescent mental health services with the goal of reducing the incidence and prevalence of mental disorders in this age group. However as noted, there is little evidence that these changes have achieved their goals with recent studies showing no reduction in the prevalence of child and adolescent mental health problems\textsuperscript{9-11}.

Knapp, McDaid and Parsonage\textsuperscript{21} note that the goal of health systems is to improve the health and health-related well-being of individuals. However all health services are constrained by the resources available to them. As such, it is essential to assess whether interventions represent a good use of available resources. In their review of interventions for the prevention of mental health problems and the promotion of mental health and well-being, Knapp et al.\textsuperscript{21} conclude that even though their economic modelling was based on conservative assumptions, many interventions represent “outstandingly good value for money”\textsuperscript{21}(p. 43). Furthermore, many interventions have a broad range of pay-offs, both within the public sector and more widely (such as through better educational performance, improved employment/earnings and reduced crime). However Knapp et al.\textsuperscript{21} note that in the case of programs dealing with child and adolescent mental health problems, these payoffs are spread over many years.

The need to accept that important benefits of interventions for child and adolescent mental health problems may be spread over several years can be an impediment for program implementation in an era when priority is given by governments and health systems to interventions that can achieve benefits in short periods of time. This priority has led to an emphasis on programs designed to treat existing health problems, particularly problems that are in crisis. A much lower priority has been given to the development and implementation of programs that focus on prevention or health promotion where benefits are spread over longer time periods. Given this approach to priority setting, it is not surprising that the resources provided to address child and adolescent mental health problems are substantially less than would be warranted by an objective assessment of the fiscal and personal impact of these problems.
A further challenge is that the full extent of the public health problem posed by child and adolescent mental health problems has only become evident in the last 30 years. As well, such problems continue to attract social stigma and they are more commonly experienced by young people living in families with limited financial and emotional resources, and where parents may themselves have experienced mental disorders and social adversities. As a result, despite all the evidence highlighting the major public health challenge posed by issues in this area, advocacy for children and adolescents with mental health problems has been weak. As such, there continues to be a major mismatch between the size of the public health and economic problems posed by child and adolescent mental health problems and the size of the government/service response.

Specialist services available to support children and adolescents with mental health problems continue to be scarce. Two findings are evident in this area. First, only a minority of children and adolescents with mental health problems attend specialist mental health services (Figure 1). Second, a large proportion of children and adolescents who attend mental health services have a very high level of problems (Table 2). This is a major challenge for Child and Adolescent Mental Health Services (CAMHS). On the one hand, mental health services are only seeing a minority of all the children in the community with significant mental health problems. However on the other hand, the resources of CAMHS are fully occupied supporting children and adolescents who have accessed their programs, the vast majority of whom have a very high level of problems.³

A significant weakness of previous attempts to improve the effectiveness of CAMHS has been the lack of a strong evidence base to guide the change process and reluctance by governments to commit sufficient resources to deal with the major public health problem posed by child and adolescent mental health problems. As a result, reforms and reviews repeatedly focus on general issues such as how to reorganize existing services and how to improve clinical governance and care pathways. While it is important to monitor and review service issues such as quality of service coordination, clinical governance and care pathways, it is also important to acknowledge the very limited evidence that improvements to such “systems of care” produce better outcomes for children and adolescents with mental health problems.²²

A key piece of work examining the effect of improving systems of care on outcomes was undertaken several years ago by Bickman et al.²² This large-scale evaluation has been
subject to extensive reviews and re-analyses but the results remain firm. In brief, the
evaluation showed that improving systems of care in a large mental health service (US$17M
per year) resulted in improvements in areas such as parent satisfaction and use of services but
no improvement in mental health outcomes as compared to a service with poorer systems of
care. The most likely explanation is that programs provided in CAMHS have only modest
effectiveness. As such, organizing these programs into a coherent system or continuum of
care, while an appealing idea, does not result in improvement to the mental health outcomes
for children and adolescents.23

It is also important to note that mental health interventions demonstrating good outcomes in
efficacy trials (i.e., trials designed to examine whether an intervention works under optimal
conditions such as university-based research programs) typically achieve much poorer
outcomes when delivered in routine clinical practice – the big “research translation” problem.
This is an important issue for child and adolescent mental health services. The best work in
this area has been undertaken by Weisz et al.23,24 The likely explanation for this repeated
finding is the very different circumstances in which new interventions are developed and
evaluated (i.e., university-based research settings), and those in which they are subsequently
deployed (i.e., community-based child and adolescent mental health services). In university-
based research settings where new interventions are commonly developed and evaluated, a
homogeneous group of participants can be selected to participate in the evaluation, staff
delivering the intervention can be specifically chosen to deliver the program, substantial time
can be spent training staff to a high level of expertise with the intervention, and the fidelity of
(typically manual-based) interventions is closely monitored throughout the trial. In clinical
settings where interventions are deployed, staff are expected to provide help to children and
adolescents with a broad array of different problems, the time available to train staff in new
treatment models is limited, and greater emphasis is placed on adapting interventions to the
individual circumstances of children and adolescents than maintaining the full integrity of
interventions upon which the evidence of their effectiveness was based.

A further challenge for service improvement is that few CAMHS systematically collect
information about the mental health outcomes their programs achieve. Instead, most service
data systems utilised by CAMHS collect data about process issues such as the number of
children who attend, the nature of children’s problems, the cost of services provided, and the
type of work undertaken by staff. Furthermore, except at a very simple level, few CAMHS
have the capacity to analyse available data and feedback results to their staff. Given this, it is
not surprising that changes to service delivery often grow out of clinical experience and opinion rather than empirical data.

There are three steps that CAMHS could take to address these issues:

1. **Make greater use of existing data routinely collected by CAMHS and place greater emphasis on collecting data that assesses mental health outcomes**

As noted, CAMHS typically have little ability to utilise the extensive data they collect about patient activity. This is an important issue for two reasons. First, there is evidence suggesting that rapid feedback of good quality data describing the extent to which a treatment program is improving a child/adolescent’s mental health problems can increase the effectiveness of intervention programs in clinical services. Second, in the policy area a failure to base decisions on good quality outcome data risks the adoption of appealing ideas that are subsequently found to be flawed\(^{23,25}\). Furthermore, unless initial benefits are monitored over time, it may be assumed that short term benefits are associated with better longer term outcomes when this is not actually occurring\(^{26}\).

2. **Make greater use of pragmatic trials designed to evaluate the effectiveness of new interventions delivered in routine clinical practice**

Pragmatic trials are designed to evaluate the effectiveness of interventions in real-life routine practice conditions. In the case of CAMHS, such trials have the potential to generate new knowledge and importantly, to improve both service outcomes and the quality of organizational culture. The latter is important in mental health services due to the evidence that it may influence service outcomes\(^{27}\). The health field which has the strongest history in this area is childhood cancer. For many years, a large proportion of all children treated in oncology units have participated in ongoing trials, often coordinated across multiple different services. In contrast, only a tiny proportion of children who receive care through CAMHS participate in outcome-oriented trials\(^{28}\). Given this, it is not surprising that oncology services have achieved much better improvements in their outcomes than CAMHS. There is substantial grant-funding available for health services research at a national level in Australia and it is important that CAMHS access this funding with a view to developing, implementing and evaluating new interventions delivered in routine clinical practice with the goal of reducing the incidence and prevalence of child and adolescent mental health problems at a population level.
3. Place greater emphasis on ensuring that evidence-based interventions in all services responsible for the care of children and adolescents with mental health problems are implemented with a high level of fidelity.

CAMHS have a key role to play in supporting children and adolescents with mental health problems. However, the high prevalence of mental health problems, their multifactorial aetiology, and their broad impact means that a reduction in the incidence and prevalence of problems is unlikely to occur unless all services with responsibility for the health, education and welfare of children and adolescents implement targeted, universal and clinical cost-effective programs aimed at reducing child and adolescent mental health problems. Importantly, it is unlikely that education services will be able to improve learning outcomes at a population level as long as a large proportion of children and adolescents are experiencing a high level of mental health problems. All child and adolescent services need to consider carefully how they can effectively implement and evaluate best practice interventions, appropriate to their circumstances, with the aim of reducing child and adolescent mental health problems.

In conclusion, as highlighted by Insel, Collins and Hyman\textsuperscript{29}, “in countries of all levels of wealth and development, mental illness affects almost every aspect of society and the economy”\textsuperscript{29(128)}. Despite this, mental illness continues to be viewed as a problem affecting individuals and families rather than “a policy challenge with significant economic and political implications”\textsuperscript{29(128)}. The early onset of many mental disorders during childhood - with approximately 50\% of disorders on-setting before 14 years\textsuperscript{12}, their chronic course, and their broad impact means that if they are to overcome this challenge, governments must focus their endeavours on childhood and adolescence. If they don’t, they may be too late!


17. Institute for Health Metrics and Evaluation. GBD Compare. Published 2103.


<table>
<thead>
<tr>
<th>Disorder</th>
<th>All Children &amp; Adolescents</th>
<th>Males</th>
<th>Females</th>
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<tr>
<td></td>
<td>% Population Estimate³</td>
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<tr>
<td>Depressive Disorder</td>
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<td>3.2  1,032</td>
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<td>1.6  596</td>
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<td>7.0  5,361</td>
<td>9.5  3,737</td>
<td>4.3  1,602</td>
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³Estimated number of children and adolescents aged 6-17 years with a mental health problem in Tasmania, based on Total Population 6-17 years = 76,587; Males = 39,339; Females = 37,248 and prevalence estimates for each disorder¹,³
Figure 1. Percentage of children & adolescents scoring in the clinical range of the Child Behaviour Checklist\(^3\) attending each service\(^3\)
Table 2. Percentage of children and adolescents with a “very high” level of mental health problems in health and education services\textsuperscript{3}

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Private Psychiatrist or Mental Health Clinic or Hospital-Based</td>
<td>75%</td>
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<tr>
<td>Department of Psychiatry</td>
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<tr>
<td>Other Hospital-Based Outpatient Service or Other Community Health Services</td>
<td>65%</td>
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<tr>
<td>Family Doctor</td>
<td>63%</td>
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<tr>
<td>Private Paediatrician</td>
<td>60%</td>
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<td>Special School or Class</td>
<td>60%</td>
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<tr>
<td>Private Psychologist/Social Worker</td>
<td>60%</td>
</tr>
<tr>
<td>Other School- or Education-Based Service or Counselling</td>
<td>41%</td>
</tr>
</tbody>
</table>

Note: a “very high” level of mental health problems was defined as a score greater than the 90\textsuperscript{th} percentile on the Child Behaviour Checklist Total Score across all the scores reported for children and adolescents in the Australian national mental health survey\textsuperscript{3}(p. 15)
Professor Michael Sawyer - Short CV

Michael Sawyer, OAM, MBBS, PhD, Dip Child Psych., FRANZCP, FRCPC is Professor of Child and Adolescent Psychiatry in the School of Paediatrics and Reproductive Health at the University of Adelaide and Head, Research and Evaluation Unit at the Women's and Children's Hospital in South Australia. He is currently the Honorary Medical Advisor for Australian Rotary Health. Prior to this appointment he was Chair of the Australian Rotary Health Research Committee and a Director on the Australian Rotary Health Board. He has also previously been Head, Department of Paediatrics and Associate Dean (Research) in the Faculty of Health Sciences at the University of Adelaide. In 2008, Professor Sawyer was awarded the Medal of the Order of Australia for services to the field of child and adolescent mental health as a researcher and educator.

Professor Sawyer completed his undergraduate medical education at Monash University and his post-graduate training in psychiatry at McMaster University and the University of Toronto in Canada. Professor Sawyer's research has focused on the quality of life of children with chronic illness and the epidemiology of child and adolescent mental disorders. Professor Sawyer was the lead investigator in the Child and Adolescent Component of the National Survey of Mental Health and Well-Being in Australia and the beyondblue Schools Research Initiative.