Submission to the Royal Commission into Victoria's mental health system:

A health economics perspective on mental healthcare for children in Victoria

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Background and context

Childhood is an important opportunity for mental health intervention due to a high prevalence of mental health problems and the opportunity to change life outcomes.

- We welcome the emphasis in the terms of reference on prevention and support early in life. Inherently this means a strong focus on children's mental health since we know that half of mental health problems start during childhood (before adolescence) [1].
- It is well-recognised that early life mental health problems have a substantial impact on wellbeing in childhood, during the time that foundations are being laid in social and emotional development, and investment is made in education. Childhood presents the greatest opportunity for intervening to change life course trajectories and future outcomes.
- Around 1 in 9 children have a mental health problem, and that figure has not shifted in two decades despite increased investment in prevention, destigmatisation, and treatment. [2].
- We therefore need to do better at targeting investment in effective – and cost-effective – interventions and health system reform to support children's mental health care needs.

A failure to address mental health concerns in childhood will lead to health and welfare systems that pay many times over in later life.

- We know that childhood mental health problems are associated with a range of adverse outcomes in education, relationships, employment, criminality, and earnings potential later in life [3-8].
- Childhood mental health problems also carry a substantial burden of financial costs to the healthcare system [9], to families, and to wider society through education, criminal justice, and welfare sectors [10]. The lifetime costs of mental health problems in childhood are larger than the costs for physical health problems in childhood [11].
- Presentations to accident and emergency (A&E) departments among children for mental health problems are rising [12], signalling a failure of the system to adequately provide for these children in the primary care and community sectors.

There is critical underserving of children with moderate to severe mental health needs in Victoria.

- There is under-resourcing in all areas of the children's mental healthcare system, with high levels of unmet need [13]. Many children with mental health problems do not receive any mental healthcare [14], and many more are missing out on adequate levels of treatment [15].
- Resources to provide evidence-based care for those with the most severe problems – tertiary mental healthcare (CAMHS – Child and Adolescent Mental Health Services) – are important. However, CAMHS currently serves 0.8% of Victorian children, comprising only 38% of children with severe mental health problems and 14% of those with moderate to severe mental health problems.
- Families report long delays in this community-based service. Those that are able to access the service feel under-supported with children who are in crisis, leading many families to attend emergency departments for lack of anywhere else to go [16]. Under-resourced community-based care for these children adds to the already over-burdened and expensive tertiary healthcare system.

The financial barriers to accessing children's mental health care services are concerning.

- In many areas of Victoria there are virtually no services that provide care for children with mild-moderate disorder without significant out of pocket costs. The label 'mild-moderate' disorder may be misleading since it still indicates a significant impact on functioning and wellbeing.
- This lack of financially accessible services for children with these high prevalence disorders is particularly problematic for those in low-income groups, who are in fact among the most likely to have these problems.
- So, the system is compounding risk for these children – higher risk of developing a mental health problem plus lower access to care.

Primary care is the most equitable part of the health care system for delivery of care to children, but most children with mental health concerns are not reaching primary care services for that concern.

- Primary care is of key importance to providing adequate mental healthcare for children. Almost all children are in contact with primary care, and often frequently, especially in the early years of life [17-19].
- GPs are the gateway to accessing most other services, including publicly subsidised mental healthcare through the Access to Allied Psychological Services (ATAPS) program.
- Importantly, primary care is an equalising influence, being perhaps the most equitable part of the health care system for children. We see slightly more children from lower income household utilising general practice, which is what a publicly funded healthcare system is intended to achieve (while specialist care shows more children from higher income households accessing care) [20].
- Primary care data obtained through the Longitudinal Study of Australian Children indicates that in a given year only 21.5% of children who reach a level of clinical significance for mental health problems have at least one rebated mental health contact. Of those who have a mental health rebated contact the average number of contacts was 5.2, while the mental health care plan allows children up to 10 rebated visits per year.

Reducing fragmentation of care and improving flow of information between parts of the system offers opportunities to make the most of existing systems of care while improving patient and family experiences of healthcare.

- Fragmentation of health services is an important problem for mental healthcare across the age spectrum, but perhaps more of a problem in children since there are more services and provider types involved in children's care than for adults [21, 22].
- In addition to GPs, psychologists, psychiatrists, and specialist mental health services (CAMHS), paediatricians, school nurses, and maternal and child health services also provide important elements of healthcare for children and are all involved in mental healthcare [14].
- Within this complex network, families are frequently exhausted with the time and effort required to find a suitable clinician or service, with some feeling that accessing private treatment was the only way they could guarantee consistent care for their child [16].

Routine collection of outcome measures in mental health is a useful first stage but data on mental health care in Victoria are incomplete and underutilised. Improving data collection and use offers potential for substantial advancements in monitoring and evaluation of care quality and effectiveness.

- Along with service fragmentation, data on mental healthcare for children is also fragmented, making it near-impossible to know how well the system is meeting the needs of children in Victoria.
- While delivering the best mental health outcomes through best practice treatment and care is a laudable ambition, with existing data systems we cannot know if this is being achieved. We have arms-length evidence that the system is not achieving its aims in the lack of improvement in prevalence of mental health problems [2], and evidence that many children with mental health problems are missing out on care [13, 15].
- It would be much better if the system allowed for monitoring of vital aspects such as access and quality of care across the full range of healthcare providers.
- A strength of the Australian system is that outcome measurement is routing in tertiary mental health services, including CAMHS, with all patients expected to have outcome measurement at the beginning and end of episodes of care, and at review periods [23]
- However, there are a number of issues with this system.
    - First, it only covers the small proportion of mental healthcare that occurs in tertiary services, so that there is no routine monitoring of outcomes in care provided by GPs, psychologists, psychiatrists, paediatricians, and school-based services. This means that it is difficult to determine whether the majority of publicly subsidised mental healthcare is achieving effective change.
    - Second, the data are underutilised for research and evaluation of mental healthcare due to difficulties in accessing the data.
    - Third, the outcome measures may not capture facets of wellbeing and functioning that are important to patients. Parent-reported outcome measures are not captured for the majority of episodes of care, meaning that the family's perspective on the impact of treatment cannot be evaluated [24].

Addressing comorbidity of mental and physical health in childhood presents opportunities for prevention of later-life comorbidity and reduce the mortality gap for those with mental health problems.

- In adulthood there are well-recognised issues around the physical health of people with mental health problems, including a 10-20 year difference in life expectancy for those with serious mental illness [25]. It is less well-recognised that this association between mental and physical health problems is also present in childhood.
- For example, recent evidence from the Longitudinal Study of Australian Children suggests there are considerable psychosocial consequences of obesity among Australian children [26].
- Mental health problems in children with chronic physical health problems often go undetected or undermanaged, with healthcare providers often viewing one or the other as their main focus.
- One of the main reasons for this underserving is that current funding models (for example for tertiary hospital children's outpatient clinics) do not include resources for concurrent treatment of comorbid mental health concerns.

Actionable suggestions

1. *Fund programs with evidence of cost-effectiveness*

While family and social support/ carers are vital for the wellbeing of people with mental health problems at all ages, these are particularly important for children with mental health problems. Parents play a vital role in recognizing children's mental health difficulties, initiating visits to health services and facilitating professional mental health care. Parenting is a key part of intervention, both in terms of prevention and in management/ treatment of mental health problems in children. Parenting programs can provide a cost-effective means of improving child mental health [27-30].

2. *Make better use of routinely collected outcome measurement data in mental health services and develop a plan for state-level mental health data collection to accurately evaluate the impact of policies*

Monitoring and evaluation of outcome measures in mental healthcare provides an opportunity to improve governance and accountability of services, and to help services to achieve their goals of improving patient wellbeing. To be able to use outcome measurement to assess service quality, it is important to capture outcomes over at least two time periods so that change can be measured, since every patient is different. At present, clinician-rated measures are reasonably well documented at admission and discharge but parent-reported measures are reported much less often [24]. Services may need to be incentivised to improve reporting.

Making outcome measurement data more readily available to researchers, especially if linked to other data on the services provided in specialist care and to other healthcare datasets, would be a significant step forward in improving the evidence base on mental healthcare in Australia.

Patient reported outcome measures (PROMs) provide a platform for discussion between patients and clinicians as to how treatment is working for the patient, and their use as a measure of treatment effectiveness within clinical encounters can improve outcomes in children's mental healthcare [31].

A recent report [32] recognises the important role of measuring and valuing PROMs in moving Australia towards a patient-centred, outcome-focused healthcare system. This shift requires funding systems that incentivise the delivery of high-quality healthcare that meets patient needs, and a system-wide coordinated strategy involving all tiers of government, healthcare providers and consumers. Key enablers of this process are already present in the Australian system (including universal health coverage, support of key stakeholders, and health technology assessment), but a more coordinated effort is required to enable sustained cultural change.

3. *Build evidence on the socioeconomic inequalities in accessing children's mental health care services*

A key consideration of new programs to improve childhood mental health should be the impact on reducing socioeconomic inequalities in mental ill health.

Recent evidence from the Longitudinal Study of Australian Children suggests that mental health difficulties for children from the lowest income quintiles are less likely to be recognised by parents [33]

Greater monitoring of children's mental health and access to mental health care services over time by socioeconomic disadvantage is needed to understand how new government policies and programs alleviate socioeconomic inequalities in mental health care use.

4. *Strengthen the capacity of primary care to provide mental health care for children and explore further implementation of an integrated GP-Paediatrician model of care to manage children with mental health concerns*

Access to primary care in general for children is one of the best functioning parts of the health system in Australia so perhaps the statistics are telling us that the type of care available in general practice is not meeting the mental health needs of children. While funding of GP services is a federal matter, there are state-level interventions that can improve the ability of primary care to support the mental health of children. Work to upskill and support GPs to manage children's mental health has been researched with Better Care Victoria through an integrated care model with GPs and Paediatricians. The Strengthening Care for Children Project demonstrated positive outcomes of co-consultation and case management in terms of increased GP confidence, increased quality of care and family satisfaction. Rotating paediatricians through primary care could form part of the solution. Costs indicate a sustainable model suitable for implementation [34].

5. *Consider ways to reduce care fragmentation and to improve flow of information between parts of the system to assist coordination of care.*

Supporting parents to navigate care and empowering them to seek appropriate and high-quality care can mitigate against fragmentation of care. Current research is investigating a patient navigator role working alongside primary care to help patients to access care that fits their needs and preferences. This type of support for parents is highly valued and can help to alleviate the burden of providing care for a child with mental health problems as well as promoting the sharing of information and experience to facilitate help seeking [35].

6. Promote the joint management of mental and physical health in children

Better equipping generalists such as GPs, paediatricians, maternal and child health nurses, and school healthcare services to manage mental health problems could improve the capacity of the healthcare system to provide mental healthcare, but these providers are also experts in physical healthcare and can manage comorbidity. This important role needs to be recognised in funding mechanisms to encourage cohesive management of children's problems rather than promoting a siloed approach to physical and mental healthcare. Recognised training in children's mental health with accreditation for clinicians such as GPs and paediatricians could provide a means to increase capacity in the generalist workforce.

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2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Dr Jemimah Ride

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
N/A

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"Childhood is an important opportunity for mental health intervention due to a high prevalence of mental health problems and the opportunity to change life outcomes. We welcome the emphasis in the terms of reference on prevention and support early in life. Inherently this means a strong focus on children's mental health since we know that half of mental health problems start during childhood (before adolescence) [1]. It is well-recognised that early life mental health problems have a substantial impact on wellbeing in childhood, during the time that foundations are being laid in social and emotional development, and investment is made in education. Childhood presents the greatest opportunity for intervening to change life course trajectories and future outcomes. Around 1 in 9 children have a mental health problem, and that figure has not shifted in two decades despite increased investment in prevention, destigmatisation, and treatment. [2]. We therefore need to do better at targeting investment in effective ? and cost-effective ? interventions and health system reform to support children's mental health care needs. A failure to address mental health concerns in childhood will lead to health and welfare systems that pay many times over in later life. We know that childhood mental health problems are associated with a range of adverse outcomes in education, relationships, employment, criminality, and earnings potential later in life [3-8]. Childhood mental health problems also carry a substantial burden of financial costs to the healthcare system [9], to families, and to wider society through education, criminal justice, and welfare sectors [10]. The lifetime costs of mental health problems in childhood are larger than the costs for physical health problems in childhood [11]. Presentations to accident and emergency (A&E) departments among children for mental health problems are rising [12], signalling a failure of the system to adequately provide for these children in the primary care and community sectors. References: 1.Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. JAMA Psychiatry. 2005;62(6):593-602. 2.Sawyer MG, Reece CE, Sawyer AC, Johnson SE, Lawrence D. Has the Prevalence of Child and Adolescent Mental Disorders in Australia Changed Between 1998 and 2013 to 2014? Journal of the American Academy of Child & Adolescent Psychiatry. 2018;57(5):343-50. e5. 3.Altszuler AR, Page TF, Gnagy EM, Coxe S, Arrieta A, Molina BS, et al. Financial dependence of young adults with childhood ADHD. Journal of abnormal child psychology. 2016;44(6):1217-29. 4.McLeod JD, Kaiser K. Childhood emotional and behavioral problems and educational attainment. American sociological review. 2004;69(5):636-58. 5.Clark C, Smuk M, Lain D, Stansfeld SA, Carr E, Head J, et al. Impact of childhood and adulthood psychological health on labour force participation and exit in later life. Psychological Medicine. 2017;47(9):1597-608. 6.Colman I, Murray J, Abbott RA,

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What is already working well and what can be done better to prevent suicide?
N/A

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"There is critical underserving of children with moderate to severe mental health needs in Victoria. There is under-resourcing in all areas of the children's mental healthcare system, with high levels of unmet need [13]. Many children with mental health problems do not receive any mental healthcare [14], and many more are missing out on adequate levels of treatment [15]. Resources to provide evidence-based care for those with the most severe problems ? tertiary mental healthcare (CAMHS ? Child and Adolescent Mental Health Services) ? are important. However, CAMHS currently serves 0.8% of Victorian children, comprising only 38% of children with severe mental health problems and 14% of those with moderate to severe mental health problems. Families report long delays in this community-based service. Those that are able to access the service feel under-supported with children who are in crisis, leading many families to attend emergency departments for lack of anywhere else to go [16]. Under-resourced community-based care for these children adds to the already over-burdened and expensive tertiary healthcare system. The financial barriers to accessing children's mental health care services are concerning. In many areas of Victoria there are virtually no services that provide care for children with mild-moderate disorder without significant out of pocket costs. The label mild-moderate' disorder may be misleading since it still indicates a significant impact on functioning and wellbeing. This lack of financially accessible services for children with these high prevalence disorders is particularly problematic for those in low-income groups, who are in fact among the most likely to have these problems. So, the system is compounding risk for these children ? higher risk of developing a mental health problem plus lower access to care. Primary care is the most equitable part of the health care system for delivery of care to children, but most children with mental health concerns are not reaching primary care services for that concern. Primary care is of key importance to providing adequate mental healthcare for children. Almost all children are in contact with primary care, and often frequently, especially in the early years of life [17-19]. GPs are the gateway to accessing most other services, including publicly subsidised mental healthcare through the Access

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What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"Reducing fragmentation of care and improving flow of information between parts of the system offers opportunities to make the most of existing systems of care while improving patient and family experiences of healthcare. Fragmentation of health services is an important problem for mental healthcare across the age spectrum, but perhaps more of a problem in children since there are more services and provider types involved in children's care than for adults [23, 24]. In addition to GPs, psychologists, psychiatrists, and specialist mental health services (CAMHS), paediatricians, school nurses, and maternal and child health services also provide important elements of healthcare for children and are all involved in mental healthcare [14]. Within this complex network, families are frequently exhausted with the time and effort required to find a suitable clinician or service, with some feeling that accessing private treatment was the only way they could guarantee consistent care for their child [16]. Suggestion: Build evidence on the socioeconomic inequalities in accessing children's mental health care services A key consideration of new programs to improve childhood mental health should be the impact on reducing socioeconomic inequalities in mental ill health. Recent evidence from the Longitudinal Study of Australian Children suggests that mental health difficulties for children from the lowest income quintiles are less likely to be recognised by parents [25] Greater monitoring of children's mental health and access to mental health care services over time by socioeconomic disadvantage is needed to understand how new government policies and programs alleviate socioeconomic inequalities in mental health care use. References: 23.Boulter E, Rickwood D. Parents' experience of seeking help for children with mental health problems. Advances in Mental Health. 2013 2013/02/01;11(2):131-42. 24.Shanley DC, Reid GJ, Evans B. How Parents Seek Help for Children with Mental Health Problems. Administration and Policy in Mental Health and Mental Health Services Research. 2008 2008/05/01;35(3):135-46. 14.Johnson SE, Lawrence D, Hafekost J, Saw S, Buckingham WJ, Sawyer M, et al. Service use by Australian children for emotional and behavioural problems: Findings from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Australian & New Zealand Journal of Psychiatry. 2016;50(9):887-98. 16.Hiscock H, Conolly A, Dunlop K, Perera P, O'Loughlin R, Brown S, et al. Parent perspectives on child mental health services in Victoria ? what's wrong and how to fix it: A multi-site mixed-methods study. . Work in progress. 2019. 25.Huang L, Hiscock H, Dalziel KM. Parents' perception of children's mental health: seeing the signs but not the problems. Archives of disease in childhood. 2018:archdischild-2018-315829. "

What are the needs of family members and carers and what can be done better to support them?

"Suggestion: Fund cost-effective parenting programs While family and social support/ carers are vital for the wellbeing of people with mental health problems at all ages, these are particularly important for children with mental health problems. Parents play a vital role in recognizing

children's mental health difficulties, initiating visits to health services and facilitating professional mental health care. Parenting is a key part of intervention, both in terms of prevention and in management/ treatment of mental health problems in children. Parenting programs can provide a cost-effective means of improving child mental health [26-29]. References: 26.Mihalopoulos C, Vos T, Rapee RM, Pirkis J, Chatterton ML, Lee Y-C, et al. The population cost-effectiveness of a parenting intervention designed to prevent anxiety disorders in children. Journal of Child Psychology and Psychiatry. 2015;56(9):1026-33. 27.Sampaio F, Enebrink P, Mihalopoulos C, Feldman I. Cost-effectiveness of four parenting programs and bibliotherapy for parents of children with conduct problems. Journal of Mental Health Policy and Economics. 2016;19(4):201-12. 28.Sampaio F, Barendregt JJ, Feldman I, Lee YY, Sawyer MG, Dadds MR, et al. Population cost-effectiveness of the Triple P parenting programme for the treatment of conduct disorder: an economic modelling study. European Child & Adolescent Psychiatry. 2018 July 01;27(7):933-44. 29.Bonin E-M, Stevens M, Beecham J, Byford S, Parsonage M. Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: a modelling study. BMC public health. 2011;11(1):803. "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"Routine collection of outcome measures in mental health is a useful first stage but data on mental health care in Victoria are incomplete and underutilised. Improving data collection and use offers potential for substantial advancements in monitoring and evaluation of care quality and effectiveness. Along with service fragmentation, data on mental healthcare for children is also fragmented, making it near-impossible to know how well the system is meeting the needs of children in Victoria. While delivering the best mental health outcomes through best practice treatment and care is a laudable ambition, with existing data systems we cannot know if this is being achieved. We have arms-length evidence that the system is not achieving its aims in the lack of improvement in prevalence of mental health problems [2], and evidence that many children with mental health problems are missing out on care [13, 15]. It would be much better if the system allowed for monitoring of vital aspects such as access and quality of care across the full range of healthcare providers. A strength of the Australian system is that outcome measurement is routing in tertiary mental health services, including CAMHS, with all patients expected to have outcome measurement at the beginning and end of episodes of care, and at review periods [30] However, there are a number of issues with this system. oFirst, it only covers the small proportion of mental healthcare that occurs in tertiary services, so that there is no routine monitoring of outcomes in care provided by GPs, psychologists, psychiatrists, paediatricians, and school-based services. This means that it is difficult to determine whether the majority of publicly subsidised mental healthcare is achieving effective change. oSecond, the data are underutilised for research and evaluation of mental healthcare due to difficulties in accessing the data. oThird, the outcome

measures may not capture facets of wellbeing and functioning that are important to patients. Parent-reported outcome measures are not captured for the majority of episodes of care, meaning that the family's perspective on the impact of treatment cannot be evaluated [31]. Addressing comorbidity of mental and physical health in childhood presents opportunities for prevention of later-life comorbidity and reduce the mortality gap for those with mental health problems. In adulthood there are well-recognised issues around the physical health of people with mental health problems, including a 10-20 year difference in life expectancy for those with serious mental illness [32]. It is less well-recognised that this association between mental and physical health problems is also present in childhood. For example, recent evidence from the Longitudinal Study of Australian Children suggests there are considerable psychosocial consequences of obesity among Australian children [33]. Mental health problems in children with chronic physical health problems often go undetected or undermanaged, with healthcare providers often viewing one or the other as their main focus. One of the main reasons for this underserving is that current funding models (for example for tertiary hospital children's outpatient clinics) do not include resources for concurrent treatment of comorbid mental health concerns. Suggestion: Promote the joint management of mental and physical health in children Better equipping generalists such as GPs, paediatricians, maternal and child health nurses, and school healthcare services to manage mental health problems could improve the capacity of the healthcare system to provide mental healthcare, but these providers are also experts in physical healthcare and can manage comorbidity. This important role needs to be recognised in funding mechanisms to encourage cohesive management of children's problems rather than promoting a siloed approach to physical and mental healthcare. Recognised training in children's mental health with accreditation for clinicians such as GPs and paediatricians could provide a means to increase capacity in the generalist workforce. References: 2.Sawyer MG, Reece CE, Sawyer AC, Johnson SE, Lawrence D. Has the Prevalence of Child and Adolescent Mental Disorders in Australia Changed Between 1998 and 2013 to 2014? Journal of the American Academy of Child & Adolescent Psychiatry. 2018;57(5):343-50. e5. 13.Johnson SE, Lawrence D, Sawyer M, Zubrick SR. Mental disorders in Australian 4-to 17-year olds: Parent-reported need for help. Australian & New Zealand Journal of Psychiatry. 2018;52(2):149-62. 15.Sawyer MG, Reece CE, Sawyer AC, Hiscock H, Lawrence D. Adequacy of treatment for child and adolescent mental disorders in Australia: A national study. Australian & New Zealand Journal of Psychiatry. 2018:0004867418808895. 30.Burgess P, Coombs T, Clarke A, Dickson R, Pirkis J. Achievements in mental health outcome measurement in Australia: Reflections on progress made by the Australian Mental Health Outcomes and Classification Network (AMHOCN). International Journal of Mental Health Systems. 2012 May 28;6(1):4. 31.Burgess P, Pirkis J, Coombs T. Routine outcome measurement in Australia. International Review of Psychiatry. 2015 2015/07/04;27(4):264-75. 32.Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. British Journal of Psychiatry. 2011;199(6):441-2. 33.Black N, Kassenboehmer SC. Getting weighed down: the effect of childhood obesity on the development of socioemotional skills. Journal of Human Capital. 2017;11(2):263-95. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"Suggestion: Make better use of routinely collected outcome measurement data in mental health services and develop a plan for state-level mental health data collection to accurately evaluate the impact of policies Monitoring and evaluation of outcome measures in mental healthcare provides an opportunity to improve governance and accountability of services, and to help services to achieve their goals of improving patient wellbeing. To be able to use outcome measurement to

assess service quality, it is important to capture outcomes over at least two time periods so that change can be measured, since every patient is different. At present, clinician-rated measures are reasonably well documented at admission and discharge but parent-reported measures are reported much less often [31]. Services may need to be incentivised to improve reporting. Making outcome measurement data more readily available to researchers, especially if linked to other data on the services provided in specialist care and to other healthcare datasets, would be a significant step forward in improving the evidence base on mental healthcare in Australia. Patient reported outcome measures (PROMs) provide a platform for discussion between patients and clinicians as to how treatment is working for the patient, and their use as a measure of treatment effectiveness within clinical encounters can improve outcomes in children's mental healthcare [34]. A recent report [35] recognises the important role of measuring and valuing PROMs in moving Australia towards a patient-centred, outcome-focused healthcare system. This shift requires funding systems that incentivise the delivery of high-quality healthcare that meets patient needs, and a system-wide coordinated strategy involving all tiers of government, healthcare providers and consumers. Key enablers of this process are already present in the Australian system (including universal health coverage, support of key stakeholders, and health technology assessment), but a more coordinated effort is required to enable sustained cultural change. References: 31.Burgess P, Pirkis J, Coombs T. Routine outcome measurement in Australia. International Review of Psychiatry. 2015 2015/07/04;27(4):264-75. 34.Knaup C, Koesters M, Schoefer D, Becker T, Puschner B. Effect of feedback of treatment outcome in specialist mental healthcare: meta-analysis. British Journal of Psychiatry. 2009;195(1):15-22. 35.Woolcock K. Based Health Care: Setting the scene for Australia. : Deeble Institute for Health Policy Research.; 2019. "

Is there anything else you would like to share with the Royal Commission?

"This submission represents the views of health economists from different academic institutions in Victoria. All of us conduct research in the area of children's mental health with the purpose of informing policy and improvement of health and healthcare. We would strongly urge the Commissioners to make children's mental health care a priority, for all the reasons that we outline in our submission. Thank you for the opportunity to bring these issues to your attention. This submission is made by and on behalf of: Dr Jemimah Ride, Associate Professor Kim Dalziel, and Dr Li Huang Health Economics Unit, Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne. Associate Professor Nicole Black Centre for Health Economics, Monash Business School, Monash University Ms Rachel O'Loughlin Health Services, Murdoch Children's Research Institute Health Services Research Unit, The Royal Children's Hospital "