Productivity Commission Mental Health Issues Paper Submission
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Mental illness has always been a common human experience but in the past few decades rates of mental illness have soared to alarming levels globally, with mental health problems and illness now "among the greatest causes of disability, diminished quality of life and reduced productivity" (Australian Human Rights Commission 2014). The World Health Organisation estimates that depression is set to outpace ischemic heart disease as the be the number one health concern globally by 2030 (WHO 2008). Black Dog Institute director Helen Christensen believes mental illness is "one of the biggest challenges of the 21st century" (Browne 2017) and George Monbiot (2016) calls the current "plagues of anxiety, stress, depression, social phobia, eating disorders, self-harm and loneliness" a global public health crisis.

In Australia, almost half the population (45%) will experience a mental illness over their lifetime. Not only will one in five (20%) Australians aged 16-85 experience a mental illness in any year but 8.5% of them will have two or more disorders (ABS 2009). Of particular concern is that young Australians (18-24 years old) have the highest prevalence (26%) of mental illness of any age group, that is 1 in 4 (AIHW 2018). The most common mental illnesses in this age group are: anxiety disorders (14%), depressive disorders (6%) and substance use disorders (5%)—though these statistics are oversimplified, because someone with an anxiety disorder could develop depression, and/or a person with depression might misuse alcohol or drugs, in an effort to self-medicate (Black Dog 2012). Even among school-aged children (12-17 year olds), 10% have reported self-harming, 7% have an anxiety disorder and 5% have a major depressive disorder andmany more experience symptoms that do not meet the threshold for clinical diagnosis (Lawrence *et al* 2015). Even more alarming is that suicide is the leading cause of death for young people aged 15-24 (34%), greater even than road accidents (21%) (AIHW 2018: 89).

There are multiple biopsychosocial reasons for 18-24 year olds having the highest prevalence of mental illness. In terms of underlying physiological causes, we know that structural changes in the brain during adolescence are associated with mental health conditions. For instance, increased activity in the amygdala and ventral prefrontal cortical areas during adolescence have been linked to anxiety and mood disorders in young people (Miguel-Hidalgo 2013). Significant psychosocial factors are also at play. Adolescence (10-18 years old) and emerging adulthood (19-24 years old) are developmental phases characterised by challenging developmental tasks like: role experimentation, identity consolidation; achieving emotional and economic independence from parents; and establishing adult relationships outside the family, including sexual relationships and being part of a peer group (Arnett 2000). Thus during the transition to adulthood, young people experience rapid physical, social and emotional changes, all of which are affected by broader sociological factors, such as economic, environmental and technological influences (AIHW 2015). It is therefore unsurprising that mental illness typically starts in mid-to-late adolescence, with 75% of mental health conditions emerging by the age of 24 (Kessler *et al* 2005).

However, biological and psychological factors alone cannot explain why the rate of mental disorders has skyrocketed worldwide to epidemic proportions, particularly among young people. For instance, the proportion of young Australians (15-19) likely to have a serious mental illness has increased from 18.7% in 2012 to 22.8% in 2016, with 18 to 19 year olds at higher risk (27.4%) than younger teens (20.8%) (Mission Australia & Black Dog 2017). Guy

McCulloch, a teacher at Burwood Girls' High School and Coordinator of the Mindmatters mental health program reports: *"There is a tidal wave of mental health issues in schools... Teachers are spending more time helping students through mental health crises, particularly in Years 11 and 12, where they can just crash and burn"* (Browne 2017).

Evolution is too slow for physiological changes to have occurred in just a few decades, suggesting the current mental health crisis is indicative of wider social phenomena or cultural change. Monbiot (2016) argues that decades of neoliberalism have created a culture of individualism and competition, leading to high levels of stress and social alienation and, ultimately, an epidemic crisis of mental health problems. There is increasing evidence to link competitive mindsets to stress, anxiety and depression. For instance, a recent longitudinal meta-analysis based on surveys with 41,641 American, Canadian and British college students over a 27 year period, found increasing levels of socially prescribed perfectionism in young people between 1989 and 2016 (Curran & Hill 2017). It is argued this might be symptomatic of the internalisation by younger generations of neoliberalism's culture of competitive individualism which results in the development of "a sense of self overwhelmed by pathological worry and a fear of negative social evaluation, characterized by a focus on deficiencies" (Curran & Hill 2017: p 412-3). Unsurprisingly, socially prescribed perfectionism is positively associated with anxiety, depressive symptoms, and suicide ideation (Curran & Hill 2017: p 411).

Moreover, although perfectionists have an excessive need for the approval of others, they feel socially disconnected and such alienation renders them susceptible to profound psychological turmoil (Hewitt cited in Curran & Hill 2017: 420). As Monbiot explains:

> *The latest, catastrophic figures for children's mental health in England reflect a global crisis. There are plenty of secondary reasons for this distress, but it seems to me that the underlying cause is everywhere the same. Human beings, the ultra-social mammals, whose brains are wired to respond to other people, are being peeled apart. Economic and technological change play a major role, but so does ideology. Though our well-being is inextricably linked to the lives of others, everywhere we are told that we will prosper through competitive self-interest and extreme individualism* (Monbiot 2016).

Quite simply, because humans have evolved as a social species, meaningful social relationships are essential for both mental and physical wellbeing. Loneliness and social isolation can lead to various psychiatric disorders like depression, alcohol abuse, sleep problems, personality disorders and Alzheimer's (Mushtaq, Shoib, Shah and Mushtaq 2014). For instance, an Australian study found student depression was linked to lack of 'belonging' and 'connectedness' to their school (Shochet, Dadds, Ham and Montague 2006). It can also lead to physical disorders like diabetes, rheumatoid arthritis, lupus, coronary heart disease, hypertension, obesity, physiological aging and cancer (Mushtaq, Shoib, Shah and Mushtaq 2014). Indeed, findings from a recent meta-analysis of more than 200 studies showed that a lack of social connection increased the risk of premature death by 26%, making loneliness deadlier than obesity (Holt-Lunstad *et al* 2015).

In a neoliberalised society, students are not only encouraged to compete with one another for marks in a schooling system increasingly characterised by teaching-to-the-test but they then need to compete for jobs and housing after school. Many of the 15-19 years old respondents to Mission Australia's 2018 Youth Survey, felt that lack of skills/experience (14.5%), lack of jobs (12.2%), transport (11.7%) and job requirements (9.6%) were barriers to finding work

and that housing costs (70.1%), financial stability (62.8%) and availability of housing (41.7%) would be a future barrier to moving out of home (Carlisle *et al* 2018). It is little surprise that 14% of 18-24 year old Australians have anxiety disorders, given they are plagued with high levels of insecurity about climate change, the changing workforce, insecure work and unaffordable housing.

In such an uncertain and competitive world, transitioning to adulthood increasingly involves higher education for more and more young Australians. As a mental health survey of over 6,000 Australian university students indicates, university students are a particularly high-risk group for mental health problems, with 84% suffering psychological distress and 19% showing signs of mental illness—five times higher than the general population (Stallman 2010). The survey identified the most common causes of psychological distress as: financial issues; inability to cope with frustration and disappointment; and perfectionistic thinking due to self-worth being tied primarily or solely to academic performance (Stallman 2010). At the University of Sydney, students with a mental health condition currently make up 60% of students registered with Disability Services (2019). In a recent survey conducted by the University of Sydney's Disability Action Plan Committee, 58% of all student respondents with a disability reported experiencing a mental health condition in the last 12 months, 45% reported that a mental health condition was their primary disability and 35% reported that having a mental health condition was an additional disability.

The problem, however, is far greater than these statistics would suggest due to the persistent problem of under-diagnosis, denial and/or refusal to seek help. A recent systematic review found only 16% of medical students who screened positive for depression sought professional help (Rotenstein, Ramos & Torre 2016). This is because, despite the increasingly high prevalence of mental illness, mental health remains surrounded by misconceptions, stereotypes and stigma. As Goffman (1963) famously noted, people whose illness makes them different from a socially constructed ideal or expectation of bodily appearance or function are "no longer perceived by others as an individual but becomes the illness. The stigmatised individual then becomes vulnerable to social condemnation and categorisation as somehow 'less than human.'" (Habibis 2014: 271). It is therefore unsurprising that 54% of people with mental illness do not access any treatment (AIHW 2014), a rate much higher than that of people with physical disorders (Commonwealth of Australia. 2010). The issue of stigmatization of mental health issues is particularly problematic for young adults, who are still in the process of developing an identity and for whom peer approval and social inclusion are particularly important (Arnett 2000). In the words of a 19-year-old art student from Chippendale, diagnosed with depression, anxiety, post-traumatic stress disorder and dissociation: *"You couldn't talk about this stuff with your friends for fear of being labelled weird or strange and being bullied. That needs to change. Mental health problems affect so many young people. It needs to be something we talk about."* (Browne 2017).

As well as negatively affecting student wellbeing, undiagnosed and unmanaged mental disorders are increasingly common hurdles to student success. Indeed, 86% of students who suffer a significant mental health issue are likely to drop out from university (Stallman 2010). It is not uncommon for mental disorders not to come to the attention of the student themselves, their teachers, year coordinators or student services until after one or more failed units, an academic honesty report, withdrawal from university and/or the development of more serious mental health conditions. One reason for this is that conditions like high-functioning depression and anxiety, which are increasingly common in teens and young adults, often go undetected by family, friends, co-workers, medical professionals and even the

young people themselves (Kordana, 2016). Their "normal" levels of functioning are deceptive. Despite excelling in their studies, being dependable friends and family members and appearing calm on the surface, a person with high functioning anxiety or depression might be plagued with persistently negative, fearful and often debilitating thoughts, such as: "I'm a bad student/friend/person" or "I'm not good at study" (Fox 2016). Thus, improving mental health literacy among young people, parents and university staff is essential to the early recognition of mental health issues and in developing help seeking behaviour (Kelly, Jorm, Wright 2007).

Recommendations

Mental health problems and mental illness "are among the greatest causes of disability, diminished quality of life and reduced productivity" (AHRC 2014). The annual cost of mental illness in Australia, including the cost of loss of productivity and workforce participation, is estimated at $20 billion (ABS, 2013). It is simply too expensive (economically and socially) not to tackle. Given the rise in mental illness to epidemic proportions, a strong preventative stance is required alongside existing curative approaches. Counseling, therapy and medication are critical in helping the growing numbers of people who already have a mental illness to enable them to participate in society. Thus it is crucial that existing services are not cut—particularly Mental Health Care Plans because they make mental health services more affordable to those with limited disposable income. This is particularly important given that the mental health of marginalized groups is poorer, due to their social exclusion, than that of the general population (Sawyer & Savy 2014: 248).

However, the dominant medical model leads us to think there is something inherently wrong with people who have a mental illness, resulting not only in stigma but a tendency to treat mental illness at a personal level via various types of drugs, mental health services and interventions. Prevention, on the other hand, requires a focus on broad psychosocial factors that need addressing at a societal, rather than individual, level. Thus, alongside the traditional biomedical approach, a preventative biopsychosocial approach is required, which means taking into account how broader cultural factors and social structures impact mental health. For instance, 90% of suicides of Australian children under 14 years of age so far this year have been Indigenous children and nearly all suicides of Indigenous Australians are people living below the poverty line whilst the suicide rates of Indigenous Australians living above the poverty line are lower than that of non-Indigenous Australians (Allam 2019). Clearly, the disproportionately high suicide rates of Indigenous children and teens needs to be seen (and tackled) in the context of their marginalisation from mainstream Australian society/economy and the simultaneous disconnection of many Indigenous children from their own culture. Gender is another social structure which shapes both the exposure to, and experiences of, mental illness. Young women are around twice as likely as young men to meet the criteria for having a probable serious mental illness and the increase in their rates of mental illness have been much more marked, increasing from 22.5% in 2012 to 28.6% in 2016, compared to a rise from 12.7% to 14.1% for males over the same period (Mission Australia & Black Dog 2017). However, young women are much more likely than young men to seek help, due to the incompatibility of help-seeking with masculinity (Courtenay 2000), which helps explain why in 5 of 6 suicides each day in Australia are men (Beyond Blue). Men are more likely to try to deal with their problems themselves rather than disclose to a friend or seek help (Courtenay 2000). Men are also more likely than women to self-medicate, which explains their higher rates of alcohol abuse (AIHW 2018). Again, these are sociological, rather than individual, factors which require addressing.

Wealth Redistribution – There is now compelling evidence that one way to radically reduce high rates of mental illness is by decreasing levels of inequality, for example, via the tax system, cutting middle- and upper-class welfare to increase lower-class welfare (Anglicare 2018) and the reigning in of CEO salaries. Among wealthy countries, those with greater levels of income inequality have a higher prevalence of mental illness and drug misuse, an association most likely mediated not just by the quality of social relationships but also by the impact of inequality on the scale of status differentiation (Pickett & Wilkinson 2010). Indeed, we know that "individuals across the industrialized world have become preoccupied with upward social comparison, experience considerable status anxiety" (Curran & Hill 2017: p 412). Comparing mental health survey data from Australia, New Zealand, Canada, the USA, the UK, Spain, Belgium, France, Germany, Italy, The Netherlands and Japan revealed that a much higher percentage of the population had a mental illness in countries where income less equally distributed. In Germany, Italy, Japan and Spain, fewer than 1 in 10 people had been mentally ill within the past year; in Australia, Canada, New Zealand and the UK it was more than1 in 5 people and in the USA more than 1 in 4. Anxiety disorders represented the largest subgroup in all these countries, and the percentage of all mental illnesses that are anxiety disorders is itself significantly higher in more unequal countries (Pickett & Wilkinson 2010: 426). This approach would have many other flow-on benefits, not least of all to the physical, as well as the mental, health of the nation. We now have decades of research showing an incontrovertible relationship between where we stand in the social hierarchy and our health and longevity (Marmot 2015), along with a meta-analysis of multilevel studies including 60 million people which, even after taking account of the effects of individual socioeconomic characteristics, showed health is better in more equal societies (Kondo *et al* 2009).

Tackling Loneliness, Disconnection and Social Isolation - As Professor Patrick McGorry of Youth Mental Health at The University of Melbourne points out, because depression is a biopsychosocial problem we need to widen our attention to view depression as "socially produced" (Adler-Gillies 2018). Johann Hari (2018) argues there is scientific evidence for nine causes of depression and anxiety, only two of which are biological. He argues that, like our physiological need for food, shelter and water, humans also have essential psychological needs to: feel they belong; have a community; have meaningful values; have meaningful work; be in contact with the natural world**;** feel they are respected; and have a secure future. Many of these needs are increasingly no longer being met in our competitive, meritocratic, individualistic neoliberalised society. Cultural change is required to reconnect people with one another and re-engage them in their communities. In the UK, where social isolation is an official health priority, a Minister for Loneliness was appointed in 2018 and some GPs now practice 'social prescribing,' to improve patients' health by connecting them with others with shared interests, with promising outcomes emerging already (Monbiot 2018). As with wealth redistribution, social connectedness and community, also have a positive effect on the physical, not just mental, health of the nation. For instance, a review of 148 studies, involving 300,000 people, found those with strong social relationships had a 50% lower chance of death than those with weak connections, an effect comparable with quitting smoking (Holt-Lunstand, Smith & Layton 2010).

Rethinking our Education System. Given the high levels of stress among Australian high schools students, particularly during Years 11 and 12, (along with Australia's poor ranking internationally) a rethinking of our education system is recommended. One suggestion is to look towards Finland's education system which is routinely at the top in global education

ranking systems because it has the smallest gap between the weakest and strongest pupils in the world, has no banding system and only has one mandatory test, occuring at age 16.

Improving Mental Health Literacy – Where prevention is not possible or unsuccessful, early intervention is critical. Improving mental health literacy among young people, parents, school and university staff is essential to the early recognition of mental health issues and encouraging help seeking behaviour (Kelly, Jorm, Wright 2007).

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