OFFICE OF THE PRIME MINISTER'S SCIENCE ADVISORY COMMITTEE

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Speech notes for the launch of *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*

Sir Peter Gluckman

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Today we release a major report on adolescence entitled *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. This report represented the culmination of 18 months of work by a highly involved academic and professional taskforce. The report was commissioned by the Prime Minister essentially on the following premise: there is major and continuing public concern about adolescents and young people in New Zealand; it is clearly a complex problem; and it is not clear what pathways should be followed to address it. Rather than follow the more traditional New Zealand route of setting up a committee with multiple vested interests in it which inevitably produce a report reflecting political, ideological or self-interests, the PM asked me to consider how my Office would address it. I suggested the appropriate route was to establish a panel of academic experts, not to come up with recommendations, but to consider the published literature, interrogate the evidence and by summation provide the basis for policy formation. This was the path that was followed.

I appointed an academic co-chair with expertise in the domain, Professor Harlene Hayne, a developmental psychologist from the University of Otago, and soon to be its Vice-Chancellor. It is unfortunate that she cannot be here today but it is for the best of reasons — she is becoming a New Zealand citizen today. Together with my Chief of Staff, Dr Alan Beedle, we scoped out some general principles and together we identified about 15 other academics and clinical practitioners from across the range of disciplines and invited them to join a taskforce. They all agreed to do so and many have had particularly heavy engagement, all unpaid and entirely voluntary. There have been many meetings and many drafts of various aspects of this report.

We agreed from the outset the following rules: we would only use the peer-reviewed scientific literature, not the grey literature, and the discussion would be kept objective and not biased by value-based outcomes. We decided to take a life course approach — that is, we see adolescence from the perspective of what precedes it and what follows, and we identified a number of chapters that were to be written by experts from within the committee, supplemented by other authors as appropriate and peer-reviewed from within

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the committee. We released some preliminary conclusions about 10 months ago because of the high public interest at that time around teenage suicide, which we reiterate should be handled in a very careful way in the media and we are very concerned at the direction of travel. It is a classical example where people think that common sense suggests a direction, but then the evidence points in another. Indeed the report highlights a number of examples like that, particularly around life skills education, punitive approaches to conduct disorders, where to invest for better outcomes, and cannabis use by teenagers. As gaps were identified more chapters and authors were added. From that a Synthesis Report was written and subjected to external and international peer review. The comment from those experts, including that from Dr Laurence Steinberg, who chaired the recent U.S. Institute of Medicine report on conduct disorders in adolescence, was that this is the most comprehensive discussion of what is a critical issue for all western societies.

The report deliberately does not attempt to make specific recommendations. In general, my view of scientific advice is that it provides base knowledge on which other perspectives need to be overlaid as policy is formed. It is in this spirit that the report is provided. The key element in my mind is to provide a comprehensive summary of the evidence so that the public and policymaker can reach some decisions that need to be made and sustained over several electoral cycles if we are really to have impact on the very high rate of adolescent morbidity faced by New Zealand.

I cannot do justice to a 307-page report in a few minutes. Soon I shall turn the podium over to Professor David Fergusson, of the Christchurch School of Medicine and Health Sciences and one of the taskforce's most active members, to summarise a key finding that reverberates from every page. As summarised on page 1 of the report in bullet point 3, "one dominant message comes through — that application of the international and domestic evidence base to policy formation and programme development in this area will lead to better outcomes for our young people. However, to do so will require a prolonged effort over several electoral cycles and cannot be held hostage to adversarial politics. Our research suggests that many programmes have been introduced, albeit with good intent, that are unlikely to succeed as they are not supported by the evidence base, whereas other approaches likely to be effective have not been implemented. A key challenge is to ensure that all programmes are appropriately monitored to ensure that they are effective and cost effective within the New Zealand context, allowing better use of scarce public resources to support our young people." We think that the failure to use social science evidence properly is a core failing that must be addressed. The funds being wasted on unproven and in some cases harmful programmes can be better used elsewhere. Too many programmes are started on the basis of advocacy, and even if they can work at pilot level, they do not scale, or the success factors enabling them to scale are not understood. Professor Fergusson will take this up in a few minutes.

So what are some of the key messages?

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Certainly New Zealand has an unacceptably high rate of adolescent morbidity, although about 80% of our young people safely transition this phase without long-term consequences affecting the rest of their lives. Prolonged adolescence is a new phase in the life course, not seen until perhaps 50 years ago. This reflects the declining age of physical maturation, itself a reflection of better health, and a delayed age of acceptance as an adult for a mixture of biological and social reasons. Brain maturation is a long process and the period of adolescence is characterised by a phase in which risk-taking behaviour is more likely due to immature impulse control systems. As such the young person is naturally more likely to engage in risk-taking behaviours, and alcohol and cannabis can put the young person at particular risk. The immature brain is far more likely to suffer long-term adverse effects of these toxins, and society needs to develop strategies to reverse the increased use of these toxins by young people. Beyond that, the changed social milieu of young people in a highly wired and connected society is having effects on the young person that we still do not fully understand; the data on the impact of a more explicit media is not well understood. However what we cannot deny is that the changed sexuality of young people is inevitable given their earlier sexual maturation.

Deficient self-control, which is common in young people for biological reasons and is aggravated by social and developmental factors, is at the heart of the problems many young people face and the behaviours they exhibit from bullying through to binge drinking. The research shows that the best way of advancing self-control and protecting the young person in their transition to adulthood lies in focusing on the preschool years. Quality early childhood environments and education, targeted as appropriate to the most disadvantaged and with specific success criteria underpinning the programmes offered, offer the best chance of reducing adolescent morbidity; economic analyses show the cost-benefit ratio of doing so. Such approaches in general are likely to be more effective than remediation, but where remediation is necessary the evidence suggests that punitive approaches are not effective; this report has reviewed the more effective remediation approaches.

There is a gross under-recognition of depression in adolescents and this is an area requiring health professionals, teachers and parents to be more aware and better services to be made available.

The report is broad in its perspectives. It considers the particular issues of Māori, Pasifika and Asian children. I acknowledge the contributions of Dr Chris Cunningham from Massey University and Mr Philip Siataga from Christchurch, who are here and who, along with Professor Shanthi Ameratunga from the University of Auckland, have addressed these issues. There is an extensive discussion of the need to find general solutions to the issues of adolescent morbidity but to acknowledge that the context many young Māori and Pasifika find themselves in puts them at particular risk. Accordingly, while the issues are not ethnic-specific the solutions must be contextually and culturally relevant to be likely to succeed.

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The report does not pretend there is any magic bullet — there is none — rather it points out that a holistic approach, taking a life course investment focusing on the earlier phase of development, is likely over a decade or so to pay real dividends for our young people. There will always be a tension between targeted interventions and universalism, and the data points to the benefit of both approaches. The policy issues of targeted interventions are complex but there can be no doubt that for young people in situations of disadvantage from early life, different levels of intervention can be shown to have long-term benefit and to be highly cost-effective.

The taskforce is of the view that a knowledge- rather than a dogma-based approach offers much more even within the available spend. We have not really answered the question of what makes New Zealand do so poorly. Hints are found in several chapters within the report but the lack of trans-national evidence makes any conclusion supposition, and therefore to highlight it would break our own rules. But New Zealanders as a whole seem to have low self-control for reasons you can speculate upon.

Finally on behalf of the taskforce we would like to thank the Prime Minister for his patronage of this exercise. The report pulls no punches; it evaluates the evidence and avoids partisan politics. It states it as we see the evidence. There will be places where it cuts across ideology. This made the Prime Minister even more determined that we proceed and he has bugged me for the release virtually every month for the last year, but the amount of evidence we have reviewed is enormous, hence the time taken to produce what we hope is useful product for the public and policymaker to consider and see a way ahead to do much better for our young people.

Before taking questions I would like to turn the floor over to Professor David Fergusson.

-ENDS-

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