THE UNIVERSITY OF SYDNEY
Matilda Centre

Submission in Response to the Australian Government Productivity Commission Mental Health Inquiry Draft Report

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Topics addressed from draft report:

Part II: Healthcare workforce
Part IV: Early Childhood and Young Adults

ABOUT THE MATILDA CENTRE

The Matilda Centre for Research in Mental Health and Substance Use is a multidisciplinary research centre committed to improving the health and wellbeing of people affected by co-occurring substance use and mental disorders.

Established in 2018, the Matilda Centre for Research in Mental Health and Substance Use aims to generate innovative and workable solutions to address substance use and mental disorders, which are currently the leading global causes of burden and disease in young people.

We work closely with research collaborators to share skills, synergise data and harness new technologies to develop and trial innovative prevention and early-intervention programs for co-occurring substance use and mental disorders.

We're committed to;

- bringing together globally recognised researchers with a shared commitment to the prevention, early intervention and treatment of mental and substance use disorders
- leading research to build the evidence base for a thriving and empowered younger generation
- engaging with decision-makers and people with lived experience to enact real change
- acting as a focal point and link between University of Sydney researchers, policy leaders and clinicians.

The Matilda Centre hosts the PREMISE NHMRC Centre of Research Excellence in Mental Illness and Substance Use. Funded in 2018 by the Australian National Health and Medical Research Council, PREMISE aims to provide a world-first synergy of the leading prevention and early intervention research and translation programs in mental health and addiction across five Australian Universities.

EXECUTIVE SUMMARY

We congratulate the Australian Productivity Commission on its draft mental health report.
The report shines a light on the devastating effects of poor mental health and shows that our current mental health system is currently poorly evaluated and dangerously underfunded. Given that the cost to the Australian economy of mental ill-health and suicide is, conservatively, in the order of $43 to $51 billion per year business as usual in no longer an option. The Productivity Commission's report represents a critical opportunity to rebuild Australia's mental health system to ensure that Australian communities can thrive and all of us can lead full and contributing lives[1]. Rebuilding the mental health system will take new investment but the Productivity Commission report is clear that such new investment will lead to a better Australia, especially for our young citizens.

As substance use disorders, depression, suicide, anxiety, and psychosis frequently co-occur, share common risk factors, and interact, an integrated approach to substance use and mental illness is critical[2-5]. The Matilda Centre welcomes the focus on substance use comorbidities (Section 9.2, pg. 323-332) and supports broad systematic funding reforms to break down silos between mental health and substance use. Ambitious structural reforms are required to integrate mental health and substance use prevention and treatment. Many recommendations in the draft report would be strengthened through the explicit inclusion of comorbidity.

Considering 75% of those who develop mental illness, first experience mental ill-health before the age of 25 years, the Matilda Centre enthusiastically welcomes the focus on the delivery of better support for young people through enhanced prevention and early intervention. Australian research has shown world leading innovation in the development of digital responses and investment in the implementation of these responses is critical to ensuring successful translation of effective prevention[6-7].

A thriving mental health and substance use research workforce is also an essential element in creating a world-class mental health system. New, targeted funding is required to 1) increase the evidence base for effective prevention and early intervention in substance use and mental disorders; (2) increase the scientific evidence for knowledge of causes and risks of substance use and mental disorders; and (3) disseminate and implement the science of prevention and early intervention of substance use and mental disorders into practice.

The involvement of people with lived experience of mental health and substance use is essential to improving the mental health system. To ensure we involve young people in our research the Matilda Centre and PREMISE recently established a Youth Advisory Board (YAB). The aim of the YAB is to provide input into our governance and research priorities and to contribute to youth focused mental health and substance use research projects. The YAB comprises a group of 9 young people aged between 16-25 from NSW, VIC, ACT, TAS, NT, QLD and WA. They are an inspiring and culturally, linguistically and gender diverse group with representatives from metropolitan, rural, regional and remote areas of Australia. They are all passionate about mental health and substance use and are extremely well positioned to contribute to our research and national conversations about issues that affect them. The YAB met on three occasions in 2019 and in September they participated in a priority setting workshop. They have asked for the outcome of this workshop to be shared with the productivity commission (see below). Feedback from the YAB has informed this submission.

YAB Priority Setting Workshop

The YAB were asked to identify and discuss the important issues affecting young people in their communities. The following issues were discussed;

- Mental health
    - Links to unemployment
    - Defining what is mental health
- Inter-generational trauma
    - Start of all the other issues discussed
    - Related to who you are and influenced by social determinants of health
    - Drug use/incarceration
- Rural isolation
    - Lower access to services
    - Higher percentage of Aboriginal population in these areas
    - Loneliness - but also in cities as well

From this discussion, the YAB identified three main priority issues;

1. Drugs and alcohol
2. Mental health
3. Intergenerational trauma and disadvantage

These issues are linked and not singular issues. An increased focus on the social determinants of health and the interconnectedness of mental health issues is required.

Matilda Centre Key Recommendations

Part II: Healthcare workforce

- Training for co-occurring mental health conditions should become a core part of **a new National Minimum Qualifications Framework for AOD workers**.
- We support the Rebuild Model as well as the establishment of Regional Commissioning Authorities (RCAs). It is essential that RCAs hold funding for, and commission, AOD services and they have an opportunity to **make comorbidity training a mandatory requirement for all staff commissioned under their AOD services**, effectively setting a national comorbidity training standard for the AOD workforce.
- If the commission's preference of RCAs commissioning AOD services is implemented, we recommend a **National Workforce Development Strategy that is consistent with this integrated approach.** This strategy should include the entire mental health and alcohol and other drug workforce including mental health nurses and the peer workforce.
- The healthcare workforce needs specific, ongoing support to become 'digitally capable' and 'digital capability' should be a core requirement within national minimum qualifications frameworks for AOD and mental health workers.

Part IV: Early Childhood and Young Adults

- We strongly support the implementation of **national strategies supporting schools and educators to deliver prevention programs that have been rigorously evaluated** and found to decrease risk of mental disorders, and harms relating to drug and alcohol use.
- Specifically, it is recommended that that schools be supported to develop a sustainable structure to implement evidence-based, curriculum-aligned universal and selective prevention programs, through;
    - Provision of **funding to support school licences for evidence-based prevention programs**;
    - Provision of **professional learning activities, online resources and training modules** to empower school communities to implement evidence-based drug prevention principles and practices tailored to their school and local environment;

      Support to **co-ordinate across and integrate mental health and substance use prevention** initiatives;

Part IV: Early Childhood and Young Adults (continued)

- Support for high-risk young people and communities through a **coordinated approach between schools and established services and programs addressing mental health and substance use issues** and that leverages technology to provide a wraparound support service for at-risk young people.

- Tertiary institutions should support wellbeing and productivity among young adults by;
  - **Increasing mental health literacy** and awareness of the services available to support wellbeing among young adults, including online programs,
  - **Promoting evidence-based online services** via organisational websites and through student support and counselling services,
  - **Providing students with licences to facilitate free or subsidised access** to evidence-based programs.

eHealth has enormous potential to provide a scalable and sustainable prevention and intervention strategy that can be rolled out nationally to reduce the burden of mental and substance use disorders among young people.

In the following sections of this submission we provide more detailed responses to Part II: Mental Health Workforce and; Part IV: Early Intervention and Prevention.

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Part II: Mental Health Workforce

THE COMMISSION'S VISION: AN INTEGRATED, PEOPLE ORIENTED SYSTEM WITH NO WRONG DOOR

- Section 4 of the draft report emphasises that the commission's overarching goal is a stepped model of care within a mental health system that is integrated, people-oriented and truly representative of a 'no wrong door' approach. We greatly encourage and support this vision.
- Multiple sections of the report (in particular sections 4-10) state the importance of ensuring that no matter how consumers initially engage with this mental health system, consumers will have confidence that they will be referred to the right service provider for their needs.

ACHIEVING THIS VISION: AN UPSKILLED, COORDINATED MENTAL HEALTH WORKFORCE

- Section 11 acknowledges that a key component to achieving this is upskilling the mental health workforce to close existing service gaps and siloes. In particular, allocating skills more efficiently to roles that are being underutilised is recognised as vital (pg 370).
- The integrated, people oriented system proposed cannot exist without *all* health and social workers who work with people who may have mental health conditions being trained in the identification of these conditions, not just those working within the mental health system. Without this, appropriate referrals will not be made, and many of the recommendations in sections 4-10 will fall short.
- Despite the availability of evidence-based digital programs that address mental health and alcohol and other drug use problems, mental healthcare providers underutilise digital tools in their practice[1]. This is in contrast to almost every other sector in Australia, especially the commercial/corporate industries[2]. A critical step in achieving the reform outlined by the draft report is to facilitate a cultural shift in the role and benefits of digital tools in mental healthcare

practice through training, structural improvements, and including digital capability in the minimum workforce standards for all mental health professionals.

- Considering this, it is very concerning that the alcohol and other drug (AOD) workforce are not considered in the workforce development section, and noticeably absent from the key health professions most relevant to people with mental ill-health (pages 368-369).

THE BLINDSPOT: NO WORKFORCE DEVELOPMENT RECOMMENDATIONS FOR AOD WORKERS

- Section 1 (page 124) acknowledges that substance use disorders are not only within the scope of the inquiry, but among the most prevalent conditions across the lifespan. In particular, they impact two priority groups for the commission; young people (page 141) and those at risk for suicide (page 142). Substance use is also identified as a key consideration for prison and homeless populations, who are the sole focus of sections 15 and 16.
- As acknowledged in Section 9, co-occurring (or comorbid) mental health and substance use conditions are extremely common. Prevalence rates of mental health conditions in Australian substance use treatment settings range from 47% to 100%[3]. Those affected by substance use also have more complex presentations, experience greater harm and poorer long-term outcomes[4-8].
- Section 9 also acknowledges a consensus among submissions that the AOD workforce have been chronically undertrained in the identification and management of mental health conditions despite a high demand for such training.
- Section 9.3 then recommends ‘specialised workforce development’ (pg 330) and refers to section 11 for details (pg 331). Unfortunately, section 11 then excludes the AOD workforce entirely.
- This is despite the draft report formally acknowledging in section 9 that AOD workers often manage the mental health of hundreds of thousands of Australians with minimal mental health training. As previously stated, consumers whose mental health is being informally managed by AOD staff are also more likely to be part of the commission’s high priority groups including youth, those at risk of suicide, homeless and prison populations.

THE OPPORTUNITY: ‘REBUILD’ AND ESTABLISH A NATIONAL COMORBIDITY TRAINING STANDARD THROUGH REGIONAL COMMISSIONING AUTHORITIES (RCAs)

In our original submission, we suggested training for co-occurring mental health conditions become a

core part of a National Minimum Qualifications Framework for AOD workers, which is acknowledged in section 9 (pg 327). This recommendation has not been prioritised by the Commission, however, an exciting opportunity exists to mitigate the issues outlined above via making such comorbidity training a focus within the 'rebuild' model described in section 23. We have outlined our response to the information request below.

INFORMATION REQUEST: RESPONSE

23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

It is essential that RCAs hold funding for and commission AOD services.

We support the 'rebuild' recommendation, including the establishment of RCAs that pool funds from all tiers of government and commission. These commissioning bodies stand to offer less siloed funding and service delivery for both mental health and AOD, which were two primary issues reported by participants at the First National Primary Health Networks (PHN) AOD Workshop (delivered by the Matilda Centre in November 2019). This support for integrated funding and service delivery alongside the high prevalence of comorbid mental health and substance use disorders presents a strong case for RCAs to hold funding for, and commission, AOD services. Encouragingly, this is in line with the commission's views (pg 956).

RCAs have an opportunity to make comorbidity training a mandatory requirement for all staff commissioned under their AOD services, effectively setting a national comorbidity training standard for the AOD workforce.

As AOD workforce development recommendations are not made in section 9 of the draft report, we strongly recommend they be integrated into policy when establishing RCAs under the 'rebuild' proposal. When commissioning AOD services, these centralised RCAs would hold an unparalleled opportunity to implement a national comorbidity training standard for the AOD workforce. If training for co-occurring mental health conditions was a made a requirement for all AOD staff commissioned by all RCAs, the mental health skill shortage identified in section 9 would be greatly lessened.

RCAs have an opportunity to choose cost-effective, evidence-based comorbidity training through the Australian Department of Health-funded National Comorbidity Guidelines Online Training Program.

As outlined in our original submission, our online training program provides evidence-based training on the identification and management of comorbid mental health and substance use conditions.

INFORMATION REQUEST: RESPONSE (CONTINUED)

— ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

The training program is based on the second edition of the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*[9], which were developed by researchers from the Matilda Centre in consultation with a panel of experts, drawing on the experience and knowledge of clinicians, consumers, carers and researchers.

Since the online training program launched in November 2017, over 3,000 health workers have registered for training, and registration grew by 50% from 2018 to 2019. An evaluation study of the training program showed that over 90% of participants who completed training agreed/strongly agreed that it helped improved their confidence, skills, and capacity to respond to co-occurring mental health and substance use conditions.

The program is also highly cost-efficient; training takes approximately 10 hours to complete online and is freely available. More information about the Guidelines and their accompanying resources can be found at our website; https://comorbidityguidelines.org.au/

OTHER OPPORTUNITIES IN CURRENT WORKFORCE DEVELOPMENT RECOMMENDATIONS

Draft recommendation 11.1 – The National Mental Health Workforce Strategy.

If the commission's preference of RCAs commissioning AOD services is implemented, **we recommend a National Workforce Development Strategy that is consistent with this integrated approach**. Currently, the inaugural *National Mental Health Workforce Strategy* proposed by the commission and the existing *National Alcohol and other Drug Workforce Development Strategy*[10] are two separate federal policies. Similar to Western Australia's integrated *Mental Health, Alcohol and Other Drug Workforce Strategic Framework (2018–2025)*[11], we recommend an integrated federal policy with a strong focus on comorbidity training.

Draft recommendation 11.3-11.4 – More specialist mental health nurses, strengthen the peer workforce.

Recommendation 11.3 proposes the design of a new three-year direct-entry (undergraduate) degree in mental health nursing. **We strongly recommend that co-occurring mental and substance use disorders become a core subject in this new curriculum,** as many mental health nurses will be identifying and managing these comorbidities. We suggest the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*[9] become a recommend text for this degree. We also encourage the accompanying online resources, including the online training program, be suggested to educators delivering this curriculum. Our resources are currently being utilised by educators at 23 VET institutes or Universities delivering training under the Community Services (CHC) training package and we have further resources available for educators on request.

Similarly, recommendation 11.4 recommends the development of guidelines for mental health peer workers. Here we also **strongly recommend that training in co-occurring mental and substance use be encouraged**, as this workforce is also highly likely to be responding to both. Again, we recommend the Guidelines and their resources be suggested as a training resource for peer workers.

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Part IV: Early Intervention and Prevention

Almost half of all Australians will experience a diagnosable mental disorder in their lifetime[1] with the majority of mental disorders emerging during adolescence[2-3]. Therefore, the focus of activities to prevent mental disorders should be on the first few decades of life, although they need to continue across the lifespan.

Early Childhood

Draft recommendation 17.3 – social and emotional learning programs in the education system

THE COMMISSION'S VISION: IMPOVED MENTAL HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE DELIVERED THROUGH THE EDUCATION SYSTEM

Curriculum-based, skill-building programs are essential to building resilience and preventing mental disorders among young people. School-based prevention programs for depression, anxiety, suicide and substance use do exist and their efficacy (and in some cases cost-effectiveness), has been demonstrated in well-designed randomised controlled trials[4-5]. For example, the universal Climate Schools program[6] and the selective Preventure program[7] have demonstrated behavioural impacts across multiple randomised controlled trials, with effects persisting over the longer-term (i.e. >24 months post-intervention[*].

In addition to preventing the development of mental and substance use disorders, which have a well-documented impact on absenteeism and workplace productivity, there is evidence that school-based prevention programs can directly improve rates of school attendance and that integrated approaches to the prevention of mental health and substance use can have beneficial effects over 2.5 years in reducing anxiety and alcohol use[8-9]. It is strongly recommended that the Australian Government invest in implementation of evidence-based, scalable, school-based programs to prevent mental and substance use disorders.

[*] Maree Teesson and Nicola Newton have a patent issued for Climate Schools Pty Ltd.

INVESTING IN EVIDENCE BASED PLATFORMS FOR EDUCATORS

Australian Government Initiatives such as the *Positive Choices* (positivechoices.org.au) portal for drug education, and the *BeYou* (https://beyou.edu.au/) portal for mental health promotion, provide platforms for educators and practitioners to access up-to-date evidence-based information and resources for the prevention of mental and substance use disorders. Continued investment in, and up-keep of, these portals is critical to ensuring successful translation of effective prevention.

WELLBEING LEADERS IN SCHOOLS (DRAFT RECOMMENDATION 17.5)

Although an array of school-based prevention programs exist, many show minimal effects in preventing mental health problems and reducing substance use. In some cases, this is because the program lacks essential effective components and is not supported by scientific evidence for effectiveness. For example, the most widely disseminated drug education program in Australian schools is a private program developed in the late 1970s. Despite the popularity of *this program*, there is little evidence to support its effectiveness, and in fact some evidence to suggest the program increased alcohol and tobacco use compared to standard drug education[10]. When evidence-based programs are implemented by schools, effectiveness may be comprised by failure to implement the program as intended. Implementation failure is often a result of schools not having resources to support educators to implement such programs effectively.

There is a critical need to implement national strategies aimed at supporting schools and educators to deliver prevention programs that have been rigorously evaluated and found to decrease risk of mental disorders and harms relating to drug and alcohol use. It is recommended that schools be supported through a national framework to develop a sustainable structure to implement evidence-based, curriculum-aligned universal and selective prevention programs, (i.e. *Climate Schools* and *Preventure*) through:

- **Provision of funding to support school licences** for evidence-based prevention programs;
- **Provision of professional learning activities**, online resources and training modules to empower school communities to implement evidence-based drug prevention principles and practices tailored to their school and local environment;
- **Support to co-ordinate across and integrate mental health** and substance use prevention initiatives;
- **Support for high-risk young people and communities through a coordinated approach between schools and established services and programs addressing mental health and substance use issues** and that leverages technology to provide a wraparound support service for at-risk young people.

VITAL SUPPORT FOR YOUNG ADULTS AS THEY TRANSITION OUT OF SCHOOL

Emerging adulthood, typically defined as 18–25 years, is a critical developmental period when young people have increased exposure to risk behaviours, such as alcohol and other drug use while also acquiring greater autonomy over their food and lifestyle choices. Young adulthood in Australia is characterised by a peak in alcohol use[11]: within a 12 month period, 1 in 3 young adults consume alcohol at very high risk levels[12], and alcohol is among the leading contributors to total burden of death, disease and injury in this age group[13]. An accumulating body of evidence suggests that young people with symptoms of mental illness, such as anxiety or depression, are particularly susceptible to hazardous alcohol use and related harms[14].

In addition to school-based approaches to prevent substance use and mental disorders, it is vital to support young adults as they transition out of school. The transition to adulthood is associated with unique personal and social role changes, such as commencing new employment or study, new living arrangements, and increased autonomy and responsibility. This post-school period is an important opportunity to reinforce and strengthen the skills they learned while at school, or to assist those young people who require additional support to acquire these skills or to navigate the challenges of emerging adulthood.

INFORMATION REQUEST: RESPONSE

18.1 — GREATER USE OF ONLINE SERVICES

Despite the peak in development of mental and substance use disorders through adolescence to emerging adulthood, the vast majority of young people do not seek help. Barriers to help-seeking among emerging adults include concerns about privacy and stigma, cost, and difficulties accessing treatment[15]. In rural and regional areas, these difficulties are compounded by a lack of available services, and greater concerns about privacy in small close-knit communities.

Online services and programs have huge potential to increase the reach and impact of prevention and early intervention approaches, for three key reasons:

1) Young people report a preference for internet-delivered over face-to-face treatments, appreciating the greater anonymity, convenience ease of access and control that it provides[16],

2) Online early intervention programs have demonstrated effectiveness in helping young people manage commonly co-occurring mental and alcohol use disorders, e.g., the *Deal*[17] program for depression and hazardous alcohol use, and the *Inroads*[18] program for anxiety and hazardous alcohol use,

INFORMATION REQUEST: RESPONSE (CONTINUED)

18.1 — GREATER USE OF ONLINE SERVICES

3) Online programs have the potential to provide much needed resources to help young people in rural and regional areas, where there is a severe lack of services.

Given the accumulating evidence to support online the effectiveness of early intervention and programs to support wellbeing and productivity among young adults[17-19], it is recommended that tertiary institutions support intervention delivery by:

- Increasing mental health literacy and awareness of the services available to support wellbeing among young adults, including online programs,
- Promoting evidence-based online services via organisational websites and through student support and counselling services,
- Providing students with licences to facilitate free or subsidised access to evidence-based programs.

While the benefits of implementing online programs for university populations and within tertiary settings is established, it should be noted that strategies are also needed to reach emerging adults who are not engaged in tertiary education. eHealth has enormous potential to provide a scalable and sustainable prevention and intervention strategy that can be rolled out nationally to reduce the burden of mental and substance use disorders among young people. **Critically, it has the potential to provide much needed resources and coping skills development to young people in rural or regional areas where there is limited or no access to mental health services.**

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