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Dear Commissioners King, Abramson & Whiteford,

Re: Comment and feedback on the Draft Report on Mental Health

We acknowledge your significant efforts in distilling a large volume of submissions for your draft report and recommendations.

Having made an initial submission, and subsequently explored your draft report, we wanted to avail ourselves of the opportunity to provide further comment and feedback.

Notwithstanding the many helpful recommendations you make, the most discomforting omission in the draft report is the lack of emphasis on the prevention of mental ill-health. Primary prevention - pertaining to reduced onset of mental ill-health – must be distinguished from secondary prevention, referred to in the report as “early intervention” and “screening”.

Early screening of 0 – 3 year olds, for example, may yield benefit, but still reflects a strategy of waiting for signs of pathology, and then responding. From a ‘big picture’ public health perspective, this is insufficient.

Ensuring schools assign a mental health and wellbeing leader is a good idea, but absolutely requires that they be provided with direction on current evidence-based approaches. In our experience, schools are very well intentioned in their support of mental health and wellbeing initiatives, but are often not in a position to identify, consume, and understand the latest scientific evidence for these initiatives.

Universal, primary prevention is absolutely vital to the improvement of Australia’s collective mental health. In making its recommendations, the Commission must consider the following:

- Universal, school-based prevention programs have demonstrated the ability to reduce the onset of symptoms of anxiety and depression in young people[1].

- Universal, primary prevention is inherently de-stigmatising because it requires the broad dissemination of skills and knowledge around mental health and does not require the identification and segregation of any particular “at risk” population.

[1] Nehmy, T. J., & Wade, T. D. (2015). Reducing the onset of negative affect in adolescents: Evaluation of a perfectionism program in a universal prevention setting. *Behaviour Research and Therapy, 67*, 55-63.

- Identifying “at risk” or symptomatic children for early intervention will exclude many young people who are not flagged for intervention but may develop symptoms in the future and would benefit from preventive interventions.

- Many individuals who become symptomatic do not seek, or do not get referred to, treatment. Thus, remedial efforts miss many young people who could benefit from school-based interventions.

- Of those who experience recurring episodes of mental ill-health in adulthood, 75% of those cases had their onset in youth. Providing treatment for young people is unlikely to be as efficacious in impacting long-term outcomes as primary prevention.[2]

- A universal prevention program may relieve the distress and impairment of sub-threshold depression that might otherwise go unnoticed and/or untreated. Children and adolescents with sub-threshold depression still burden the health care system and their families[3]

- Indicated programmes have often been recommended in research for the greater likelihood of detecting statistically significant changes in symptoms, however control groups in such studies are likely to regress towards the mean over time and thus inhibit the detection of prevention effects[3].

- High rates of comorbidity amongst psychological disorders and common/shared risk factors indicate a *transdiagnostic* focus is required. Transdiagnostic approaches are those that target mechanisms and processes that operate across and between multiple disorders. A transdiagnostic approach to universal, primary prevention allows a core set of skills to be taught to young people that are broadly beneficial in terms of emotion regulation, reducing risk factors and enhancing protective factors. Transdiagnostic approaches have the potential to increase the cost-effectiveness, generalisability and efficacy of prevention efforts[4].

- Psychological disorders increase later risk for other, different disorders. This is known as heterotypic prediction, and is a core argument for transdiagnostic universal prevention. If we wait until pathology has emerged before intervening, and then provide a disorder-specific treatment, we forgo the opportunity to teach the broad skill-set that affects and reduces symptoms of multiple disorders[4].

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[2] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of general psychiatry, 62(6), 593-602.
[3] Nehmy, T. J. (2010). School-based prevention of depression and anxiety in Australia: Current state and future directions. Clinical Psychologist, 14(3), 74-83.
[4] Nehmy, T. J., & Wade, T. D. (2014). Reduction in the prospective incidence of adolescent psychopathology: A review of school-based prevention approaches. Mental Health & Prevention, 2(3-4), 66-79.

World recognised experts, including Australia's own Professor Anthony Jorm from the University of Melbourne, are making strong recommendations for universal prevention in their current (in press) article in *Mental Health & Prevention.* They suggest embedding universal prevention approaches in major institutions including schools at a large scale, and simultaneously targeting multiple determinants of mental health (for example, enhance parenting as well as teaching emotion-regulation skills to young people)[5].

Thank you for your consideration of our feedback. We trust it will be useful in shaping subsequent versions of the Commission's report.

Yours sincerely,

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On behalf of

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[5] Ormel, J., Cuijpers, P., Jorm, A., & Schoevers, R. A. (in press). Fixation what is needed to eradicate the depression epidemic, and why. *Mental Health & Prevention*, 200177.