THE UNIVERSITY OF NEWCASTLE AUSTRALIA

PRIORITY RESEARCH CENTRE
BRAIN AND MENTAL HEALTH RESEARCH

society for mental health research

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

Professor Frances Kay-Lambkin

Priority Research Centre for Brain and Mental Health, the University of Newcastle

&

President, Society for Mental Health Research

Submitted:

23 January 2020

Topics addressed from draft report:

Part II: Reorienting health services to consumers

- Supported online treatment
- Mental health workforce

Part IV: Early intervention and prevention

- Supporting people in tertiary education

Part V: Pulling reforms together

- A framework for monitoring, evaluation, and research

About the Priority Research Centre for Brain and Mental Health (PRCBMH), the University of Newcastle.

The PRCBMH (https://www.newcastle.edu.au/research-and-innovation/centre/cbmhr/about-us) is a funded strategic investment by the University of Newcastle that facilitates research into the brain, mental illnesses, and mental health. The PRCBMH brings together basic scientists, clinical researchers, cognitive scientists, and the mental health workforce to foster inter-disciplinary research excellence; support, train, and promote the next research leaders; and engage the public via open forums.

The PRCBMH is a funded partner institution in 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.

About the Society for Mental Health Research

Founded in 1970 as the Australasian Society for Psychiatric Research, the Society for Mental Health Research (www.smhr.org.au), is the peak body representing all mental health and psychiatric researchers across all disciplines in Australia and New Zealand. It acts as an international forum for researchers, clinicians, and consumers in mental health research to come together to share new research findings, seed new research ideas, advocate for mental health research funding and support of early-mid career research fellows, and raise money to support mental health research activities.

Introduction

The Priority Research Centre for Brain and Mental Health and the Society for Mental Health Research acknowledge the time and effort of the Australian Productivity Commission in completing a comprehensive review of mental health in Australia. We congratulate the Commission on an important and extensive report, which effectively highlights the challenges we face in tackling the increasingly prevalent and serious effects of mental ill-health.

At any one time, >10 million Australians experience a mental disorder (including alcohol/other drug use disorders), and this is increasing by about 3% each year [1]. Mental disorders are much like physical disorders; given appropriate and timely intervention, they can be successfully prevented, managed, and treated. Despite this, one-third of people who need mental health treatment in a 12-month period do not receive it [2]. For the two-thirds who do access care, very few receive an evidence-based treatment [3], and this is likely to be medication [4]. The University of Newcastle's Priority Research Centre for Brain and Mental Health and the Society for Mental Health Research support the findings of the Australian Government Productivity Commission draft report into mental health that indicate *'the Australian mental health system falls well short of the benchmark'* of a well-functioning healthcare system.

The Australian Productivity Commission draft report comprehensively outlines why this situation exists. To this, we would also add two key points from the 2018 Lancet Psychiatry Commission: (a) treatments have not been developed for many mental health disorders, and (b) there are not enough mental health workers to meet the demand for treatment [4].

When people do seek mental health treatment, it frequently does not meet their needs. A recent meta-analysis of 34 studies reported that 75% of people with mental disorders state a clear preference for psychological over medication-based treatment [5]. This was consistent across treatment-seeking and non-treatment-seeking samples. Yet in Australia, the most common mental health treatment provided is psychiatric medication (approx. 1 in 6 Australians), most often by a general practitioner (87% of all mental-health prescriptions), with the highest rates of mental health prescriptions occurring in rural/remote Australia [6]. Psychological and medication-based treatments for depression, anxiety, and alcohol/other drug use problems have similar efficacy [5]. However, psychological treatments are largely not available when people need them most, do not typically target the co-occurrence of many mental disorders simultaneously, and most receive a wide variety of treatments that are not evidence-based [4]. Despite significant investment by the Australian Government to improve access to psychologists for mental disorders (Better Access Scheme), there is no evidence of impact or effectiveness [7], accessibility is a significant issue especially in rural/remote Australia, and treatment is poorly targeted [8].

The need to improve mental health treatment is great; even the best treatments do not work for everyone, treatments have not been developed for many mental disorders, and the implementation of treatments needs to address issues of scalability and cultural diversity. We strongly support the reforms suggested by the Australian Productivity Commission, and the need within the next 10 years to *'close critical gaps in healthcare services'* (reform area 2) to *'allow timely access by people with mental ill-health to the right treatment for their condition'*. We strongly advocate for the critical role that digital health (eHealth) will play in achieving system reform, and the fundamental need for significant investment in and promotion of mental health research as the key to better knowledge, better prevention, improved early detection and effective treatment for all mental illness.

Part II: Reorienting health services to consumers

Supported online treatment

Online services and programs have huge potential to increase the reach and impact of prevention, early intervention, and treatment for mental health and alcohol and other drug use problems, particularly for young people.

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 [9].

Our team has demonstrated the efficacy of online early intervention programs in helping young people manage commonly co-occurring mental and alcohol use disorders, e.g., the *Deal* program for depression and hazardous alcohol use [10], the *Inroads* program for anxiety and hazardous alcohol use [11], and the *Breathing Space*, moderated social networking program to reduce social isolation and promote health mood and behaviours [12].

Our team has demonstrated the efficacy of online early intervention and treatment programs for people experiencing depression and co-occurring alcohol, cannabis [13, 14], tobacco and physical health problems [15], and methamphetamine use disorders [16-19]. This has included people experiencing moderate-severe current and active symptoms.

A key outcome of our research at the PRCBMH investigating the role and value of online interventions for mental disorders is that engagement with online treatment programs is associated with increased engagement with traditional services for mental or alcohol/other drug use disorders for people who are still symptomatic at the conclusion of the trial [19]. Closer inspection of this result reveals a potential role of online programs in destigmatising mental health treatment and encouraging help-

seeking through relevant real time services when symptoms persist [20, 21]. This evidence also suggests that people using online technologies, particularly when reporting moderate-severe mental health and alcohol/other drug use symptoms, find online treatment programs as acceptable as face-to-face therapies, as effective as face-to-face therapies, and particularly important for people living in rural and remote areas [20]. Our research also provides evidence that online treatments are more effective for people high in perfectionism [22], for people with cannabis use and mental health comorbidity [14, 22], and for alcohol use and depression [13].

Digital treatments can rapidly and significantly improve treatment access, act in place of 'on the ground' services and be actively provided to people in earlier phases of their disorder. However, no clear models currently exist for digital treatment integration into health services, and Australian clinicians significantly underuse digital treatments in their clinical practice [23]. Integrating digital treatments into mental health care (draft recommendation 6.1) will require significant paradigm shifts in the mental health system and the way treatment for mental disorders is considered.

The PRCBMH and SMHR Recommend that:

- Barriers to digitally enabling mental health services are identified and addressed, by investing in a national audit of service structure, culture, training needs, and service principles to facilitate adoption of eHealth tools into mental health care and monitor the outcomes.
- Online interventions are made available to people across the spectrum of severity of high prevalence mental disorders, in line with evidence of efficacy across this spectrum. Note that across this spectrum of severity, online programs should be designed to monitor and identify signs of exacerbation and crisis and provide an active real-time pathway to care for people at immediate risk and those wanting to access further real-time care.

Mental health workforce

A thriving mental health and substance use research workforce is an essential element in creating a world-class mental health system.

In Australia, there not enough mental health providers available to meet the treatment needs for the one in five Australians who experience a mental disorder in any one year [e.g., 1 psychiatrist per 1,424 Australians with mental disorders in 2017, and 88% of these are located in major cities, 24].

There is a paucity of psychologists and allied mental health workers who can deliver evidence-based treatments for mental disorders [4]. eHealth (digital) programs are a key tool in responding to this problem.

Despite good evidence for program effectiveness, eHealth services in Australia exist largely independently of traditional healthcare service settings, with mental healthcare providers underutilising eHealth systems in their practice [25]. This is in contrast to almost every other sector in Australia, especially the commercial/corporate industries [26]. Thus, for all of the advantages that eHealth treatments offer, and the substantive evidence base for their efficacy, their potential impact is unrealised. Resistance to eHealth services arises from a number of sources. These include a lack of knowledge about, and training in, evidence-based programs, resistance to changes in practice, concerns around efficacy, confidentiality and safety (indemnity), lack of the financial incentives for implementation, and lack of established pathways to provision of eHealth services [27]. For these reasons, many clinicians are not able, or willing, to implement these interventions in practice. In Australia, we have completed a small scale research project examining the use of a digital treatment program in a NSW alcohol and other drug treatment setting [28]. The results of this small dissemination study revealed that, despite clients of the service reporting willingness to use the digital tool as part of their treatment program (over 80% agreement), fewer than one third of clients in the study were actually provided with access to SHADE by their treating clinician [29]. A significant cultural shift is required.

We strongly support Recommendation 6.2 in the draft report that proactive steps be taken to increase public and professional support and recognition of the role, credibility, safety, and efficacy of eHealth interventions as a legitimate, and often, first-line tool for mental health problems and disorders. In partnership with this activity, a significant audit of the challenges and structural barriers to implementing eHealth tools in mental health services also must occur, with funding provided to overcome these barriers and enable services to become ‘digitally enabled’ (see Part V, below).

The PRCBMH and SMHR additionally recommend that:

- The healthcare workforce receives specific, ongoing support to become 'digitally capable' and 'digital capability' should be a core requirement within national minimum qualifications frameworks for mental health workers.
- The healthcare workforce receives specific, ongoing support to increase research capability and interest, and 'research' should be a core requirement within national minimum qualifications frameworks for mental health workers and factored into workload models.
- Barriers to digitally enabling mental health services are identified and addressed, by investing in a national audit of service structure, culture, training needs, and service principles to facilitate adoption of eHealth tools into mental health care and monitor the outcomes.

Part IV: Early intervention and prevention

Supporting people in tertiary education

Information Request 18.1 – Greater use of online services

Given the accumulating evidence to support online the effectiveness of early intervention and programs to support wellbeing and productivity among young adults [30-32], 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.

Our team has partnered with the University of Newcastle counselling service to provide an online platform (eCliPSE – https://uoneclipse.com.au) that wraps around the face-to-face service to reach out into the University student population, provide real-time virtual access to screening tools for mental health and substance use problems, link those 'at-risk' or with signs of disorder to online, evidence-based programs, and links student assessment officers and counsellors to students needing real-time appointments, briefer check-in sessions to supplement online treatment, and for counsellors to monitor progress. This has been implemented with success but requires further funding to scale up and support. A service restructure within the counselling services has occurred in partnership with this

innovation and might serve as a model to scale up across other tertiary institutions and settings.

Information Request 18.3 – International students' access to mental health services

We support a focus on international student mental health, which is a major factor in claims made to private health insurance companies supporting international students at the University of Newcastle. Our internal analysis indicates that our international students are accessing emergency and acute care services for their mental health problems more frequently than they are prevention, early intervention and psychological treatment options. There is a considerable opportunity to improve the mental health literacy of international students around mental health, mental illness, help-seeking, and alcohol/other drug use (including tobacco) to encourage earlier recognition of distress and the need to seek support for this distress. Universities can play a key role in this, by offering this training as part of the induction/orientation process for international students. Online screening and intervention tools can facilitate access to evidence-based monitoring and support programs for those students who screen as 'at-risk' or in distress, noting the additional evidence for online programs facilitating engagement with real time therapies (see Part II: Supported online treatment).

The PRCBMH and SMHR additionally recommend that:

Tertiary institutions support greater use of online services for mental health by:

- Increasing mental health literacy and awareness of the services available to support wellbeing among students, 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.
- Integrate online programs with real-time student support service to promote seamless access to face-to-face therapies as required. The UON eCliPSE portal is an example of how this could occur.
- Reorient student support services to integrate online therapies into the model of care. The UON eCliPSE portal is an example of how to do this.

International students must be supported by Universities with specific initiatives to:

- Increasing mental health literacy and help-seeking, including online programs.
- Promoting evidence-based online services via organisational websites and through student support and counselling services.
- Support the development of culturally-appropriate online and face-to-face services to support mental health and wellbeing.

Part V: Pulling reforms together

A framework for monitoring, evaluation, and research

In 2013, the NHMRC Translation Research Faculty Mental Health Steering Committee released a call-for-action for depression, inviting submissions from Australian experts to identify a significant gap where strong research evidence exists, but is not being used in healthcare practice. Completed and published in 2015 [27], this case-for-action proposal represents consensus opinion and research evidence from Australian experts in eHealth and depression, and highlights the critical need to bridge the gap between what we 'know' and what we 'do' in utilising effective eHealth programs to treat depression in Australia. While the case-for-action has provided the field with a roadmap, there have been no objective studies conducted to date that guide the operationalisation of the translation of eHealth into clinical practice. Objective data are therefore needed to guide practice and to assess outcomes.

A range of financial, structural and technological health system barriers exist [25] adding to the significant issues facing clinicians who want to improve access to effective treatments for their clients. Mental health researchers and clinicians must respond to these issues by developing and evaluating eHealth treatment programs that minimise cost and maximise efficient use of clinician time and client outcomes, and to translate the potential to deliver eHealth–capable services into practice. By enhancing their program structure, culture, and treatment planning activities, mental health and D&A services should be able to deliver fully eHealth–capable services.

At the PRCBMH, our team is currently progressing work on the eHCAT (eHealth Capability Assessment Tool), as one example of how to address these challenges. Development of the eHCAT is currently underway, with collaboration from mental health and drug services, policymakers, and international experts in implementation science. This tool will use a fidelity assessment methodology to embed e-health programs into the care pathway within and between mental health and drug services, and to monitor the outcomes. eHCAT will enable a systematic audit of the infrastructure, policies, culture, training, assessment, and treatment capabilities of the target service to implement e-health programs within routine service provision. Service managers, service providers, consumers, families, and other relevant stakeholders are included in the data collection and audit across these domains. Its development and validation will be based on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) tool [33], developed by key collaborator Prof McGovern (Dartmouth). As with the DDCAT, the eHCAT tool will assist services to identify the key barriers to integrating eHealth tools into routine care, and (with funding) will provide access to training and supports to remove these barriers. The eHCAT tool can be completed over time to monitor progress towards eHealth capability for the service.

The PRCBMH and SMHR additionally recommend that:

- Barriers to digitally enabling mental health services are identified and addressed, by investing in a national audit of service structure, culture, training needs, and service principles to facilitate adoption of eHealth tools into mental health care and monitor the outcomes.
- Routine auditing (monitoring) of eHealth service capability be introduced and supported across mental health services.

25.4 Research

Both the University of Newcastle and the Society for Mental Health Research support the inclusion of research within the scope of the draft report. Research is the key to better knowledge, prevention, early detection and effective treatment for mental illness, just as in all forms of illness. We also advocate strongly that any framework for workforce development, system reform, and improved early intervention, and treatment includes research at its core, and includes mental health researchers in the development and implementation of these frameworks, policy developments, and activities. We strongly support the creation and funding of clinical trials networks in mental health, closing a critical gap in improving the links between research and practice.

Significant progress has been made in putting mental health on the social and political agenda. Recent years have seen increased government investment in and philanthropic support for mental health service providers and advocacy organisations. Deep investment in medical research over the last 30 years into non-communicable diseases (NCDs) has had huge impact in "bending the curve" of mortality and morbidity. Survival rates in cancer have increased from 48% to 68% in the last 33 years[1] and mortality from heart disease has decreased by 70% since the 1970s.[2] Cancer and cardio-vascular disease are not only extremely well-funded by government, but enjoy equally potent support from corporate, public and philanthropic sources. This is not the case for mental health research.

Mental health research receives 11 times less funding support from corporate and private funding and half as much from Government, when compared with Cancer Research [34]. In 2015, $763m in funding was awarded by the NMHRC to over 1,037 projects and fellowships across all health categories. Of these, 85 projects were in mental health and the sum of these project funds corresponded to 8.6% of funding [34]. The Million Minds Mission was established under the auspices of the Medical Research Futures Fund to provide targeted research funding for mental health

[1] Cancer Australia 92017), All cancers in Australia, canceraustralia.gov.au/affected-cancer/what-cancer/cancer-australia-statistics
[2] Heart Foundation (2015), Australian heart disease statistics 2015

research across Australia. However, this investment was five times less than that provided for the Genomics Health Futures mission, half that of the Cardiovascular Mission and Traumatic Brain Injury Mission, and significantly less that provided for in the Dementia, Aging and Aged Care Mission.

Under-investment in mental health research is reflected in today's undersupply of researchers, divisive competition, and lack of collaboration within the mental health sector (service provision and research). There is a need for funding and reform across all of mental health and for mental health research - to not just do more and better research, but to translate research into what is a complex system, as system that demands a better outcome.

The mental health sector is seeking collaboration, and there is a strong public appetite to support health and medical research. Federal and State Governments have made significant investment into health and medical research, but specific, targeted mental health research funding is now required to:

- Build mental health research sector capacity through investment in the future of mental health research workforce, building the capacity to scale the volume of researchers driving better understanding and new approaches to prevention, early intervention and treatment.
- Generate visionary research that transforms mental health through investment in research programs that inspire and take on the biggest challenges in mental health.
- Strengthen, align, and expand the mental health research sector by fostering links between researchers, services delivery agencies and mental health professionals for more and better translation of research, and the generation of meaningful, consumer and service-driven research questions.

The PRCBMH and SMHR Recommend that:

- Increasing research capability among the mental health workforce is recognised as essential to closing the evidence-practice gap in mental health, and incorporated into service workload models and national minimum training standards for the mental health workforce.
- New, targeted funding is provided via boosting the Medical Research Futures Fund Million Minds Mission to increase the evidence base for effective prevention and early intervention in substance use and mental disorders; increase the scientific evidence for knowledge of causes and risks of substance use and mental disorders; and disseminate and implement the science of prevention and early intervention of substance use and mental disorders into practice.
- Strong and active partnerships (e.g., joint training, joint positions, joint projects) are fostered and funded between Universities and health services in mental health.
- As the peak body for mental health research in Australia and New Zealand, the Society for Mental Health Research is part of the consultation process to establish Australia's first clinical trials network in mental health.

References

1. ABS, *National Health Survey: First Results, 2017-18* 2018, Australian Bureau of Statistics: Canberra.
2. Burgess, P.M., et al., *Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing.* Australian and New Zealand Psychiatry, 2009. **43**: p. 615-623.
3. Wang, P.S., et al., *Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication.* Archives of General Psychiatry, 2005. **62**: p. 629-640.
4. Holmes, E.A., et al., *The Lancet Psychiatry Commission on psychological treatments research in tomorrow's science.* Lancet Psychiatry, 2018. **5**: p. 237-286.
5. McHugh, R.K., et al., *Patient preference for psychological vs pharmacologic treatment of psychiatric disorders: a meta-analytic review.* Journal of Clinical Psychiatry, 2013. **74**: p. 595-6-2.
6. DHS, *Pharmaceutical Benefits Schedule: Mental Health-Related Prescriptions*, D.o.H. Services, Editor. 2017, Commonwealth of Australia: Canberra.
7. Jorm, A.F., *Australia's 'Better Access' scheme: Has it had an impact on population mental health?* Australian and New Zealand Journal of Psychiatry, 2018. **52**(11).
8. AGPC, *Productivity Commission 2019, Mental Health, Draft Report*. 2019, Australian Government Productivity Commission: Canberra.
9. Boydell, K.M., et al., *Using technology to deliver mental health services to children and youth: a scoping review.* Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Academie canadienne de psychiatrie de l'enfant et de l'adolescent, 2014. **23**(2): p. 87-99.
10. Deady, M., et al., *An online intervention for co-occurring depression and problematic alcohol use in young people: Primary outcomes from a randomized controlled trial.* Journal of Medical Internet Research, 2016. **18**(http://dx.doi.org/10.2196/jmir.5178).
11. Stapinski, L.A., K. Prior , and N.C. Newton, *Protocol for the Inroads Study: A Randomized Controlled Trial of an Internet-Delivered, Cognitive Behavioral Therapy–Based Early Intervention to Reduce Anxiety and Hazardous Alcohol Use Among Young People.* JMIR Research Protocols, 2019. **8**(4): p. e12370.
12. Kay-Lambkin, F.J., et al., *The iTreAD project: a study protocol for a randomised controlled clinical trial of online treatment and social networking for binge drinking and depression in young people.* BMC Public Health, 2015. **15**: p. 1025.
13. Kay-Lambkin, F., et al., *Clinician-assisted computerised versus therapist-delivered treatment for depressive and addictive disorders: A randomised controlled trial.* Medical Journal of Australia, 2011. **195**: p. S44-S50.
14. Kay-Lambkin, F.J., et al., *Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: a randomized controlled trial of clinical efficacy.* Addiction, 2009. **104**(3): p. 378-388.
15. Kay-Lambkin, F.J., et al. *iHeLP: A pilot trial of an online program for smokers with depression*. in *World Congress of Behavior and Cognitive Therapies*. 2016. Melbourne, Australia.
16. Kay-Lambkin, F.J., et al., *Stepping through treatment: reflections on an adaptive treatment strategy among methamphetamine users with depression| NOVA. The University of Newcastle's Digital Repository.* 2010.
17. Kay-Lambkin, F.J. and F.J. Kay-Lambkin, *Technology and innovation in the psychosocial treatment of methamphetamine use, risk and dependence.* Drug and Alcohol review, 2008. **27**(3): p. 318-325.
18. Tait, R.J., et al., *Breakingtheice: A protocol for a randomised controlled trial of an internet-based intervention addressing amphetamine-type stimulant use.* BMC psychiatry, 2012. **12**(1): p. 67.
19. Tait, R.J., et al., *A randomised controlled trial of a web-based intervention for users of amphetamine-type stimulants: Six month outcomes; Part 2.* Journal of Medical Internet Research, 2015. **17**(4): p. e105.
20. Kay-Lambkin, F.J., et al., *It's worth a try: The treatment experiences of rural and urban participants in a randomized controlled trial of computerized psychological treatment for comorbid depression and alcohol/other drug use.* Journal of Dual Diagnosis, 2012. **8**(4): p. 262-276.
21. Kay-Lambkin, F., et al., *Acceptability of a clinician-assisted computerized psychological intervention for comorbid mental health and substance use problems: Treatment adherence data from a randomized controlled trial.* Journal of medical Internet research, 2011. **13**(1).
22. Kay-Lambkin, F.J., et al., *The moderating effect of perfectionism, need for approval, and therapeutic alliance on eHealth and traditionally-delivered treatments for comorbid depression and alcohol/cannabis use problems.* International Journal of Behavioral Medicine, 2017. **24**(5): p. 728-739.
23. Batterham, P.J., et al., *Developing a roadmap for the translation of e-mental health services for depression: Review.* Australian and New Zealand Journal of Psychiatry, 2015. **49**(9): p. 776-784.
24. DoH, *Australia's Future Health Workforce 2016 – Psychiatry*. 2017, Australian Government Department of Health: Canberra.

25. Christensen, H., J. Reynolds, and K.M. Griffiths, *The use of e-health applications for anxiety and depression in young people: challenges and solutions.* Early Intervention in Psychiatry, 2011. **5**(Suppl 1): p. 58-62.
26. Burns, J., I. Hickie, and H. Christensen, *Strategies for adopting and strengthening e-mental health: A review of the evidence*, in *Rapid Reviews*, S. Institute, Editor. 2014, Commissioned on behalf of the Mental Health Commission of NSW: Sydney, Australia.
27. Batterham, P.J., et al., *Developing a roadmap for the translation of e-mental health services for depression: Review.* Australian and New Zealand Journal of Psychiatry, in press, accepted 26 March 2015.
28. Kay-Lambkin, F.J., et al., *Study protocol: a dissemination trial of computerized psychological treatment for depression and alcohol/other drug use comorbidity in an Australian clinical service.* BMC psychiatry, 2012. **12**(1): p. 77.
29. Kay-Lambkin, F.J., et al., *Dissemination trial of computer-based psychological treatment in a Drug and Alcohol Clinical Service: Predictors of technology integration.* Addiction Science and Clinical Practice, 2014. **9**: p. 15.
30. Deady, M., et al., *An Online Intervention for Co-Occurring Depression and Problematic Alcohol Use in Young People: Primary Outcomes From a Randomized Controlled Trial.* J Med Internet Res, 2016. **18**(3): p. e71.
31. Dear, B.F., et al., *Treating anxiety and depression in young adults: A randomised controlled trial comparing clinician-guided versus self-guided Internet-delivered cognitive behavioural therapy.* Australian & New Zealand Journal of Psychiatry, 2017. **52**(7): p. 668-679.
32. Stapinski, L.A., et al., *Protocol for the Inroads Study: A Randomized Controlled Trial of an Internet-Delivered, Cognitive Behavioral Therapy–Based Early Intervention to Reduce Anxiety and Hazardous Alcohol Use Among Young People.* JMIR Res Protoc, 2019. **8**(4): p. e12370.
33. McGovern, M.P., A.L. Matzkin, and J. Giard, *Assessing the dual diagnosis capability of addiction treatment services: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index.* Journal of Dual Diagnosis, 2007. **3**(2): p. 111-123.
34. Betterham, P., et al., *NHMRC funding of mental health research.* Medical Journal of Australia, 2016. **205**(8): p. 350-351.