



WITNESS STATEMENT OF PROFESSOR PATRICK MCGORRY

I, Patrick Dennistoun McGorry, Professor of Youth Mental Health at the University of Melbourne and Executive Director of Orygen, the National Centre of Excellence in Youth Mental Health at 35 Poplar Road Parkville, in the State of Victoria, say as follows:

- 1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current roles

- 2 I am the Executive Director of Orygen, the National Centre of Excellence in Youth Mental Health, Professor of Youth Mental Health at the University of Melbourne, and a Founding Director of the Board of the National Youth Mental Health Foundation (**headspace**).
- 3 I am a Fellow of the Australian Academy of Science, the Academy of the Social Sciences in Australia, and the Australian Academy of Health and Medical Science. I also serve as Editor-in-Chief of the journal Early Intervention in Psychiatry.
- 4 I am currently the President of the International Association for Youth Mental Health, and I am the past President of the Society for Mental Health Research (2013-2017) and the Schizophrenia International Research Society (2016-2018).

Background and qualifications

- 5 I have a Bachelor of Medicine and Bachelor of Surgery from the University of Sydney and a Doctor of Philosophy and a Doctor of Medicine from Monash University and the University of Melbourne, respectively.
- 6 I have over 30 years' experience working as a clinician, researcher, and reformer based in the Victorian public mental health system in the areas of early psychosis, early intervention and youth mental health.
- 7 I have published over 800 peer-reviewed papers and reviews in the area of mental health, edited 9 books, and authored 90 book chapters. Attached to this statement and marked '**PMc-1**' is a copy of my curriculum vitae.
- 8 While I have worked in all parts of the public and private mental health system, my predominant focus has been on early diagnosis and intervention in mental illness, and

the development of safe, effective treatments for, and research into, the needs of adolescents and young adults with emerging mental disorders.

The current state of the mental health system

- 9 The greatest unrealised opportunity in Victoria's public health system is to reduce the mortality and morbidity caused by mental illness. In contrast to improvements in cancer and cardiovascular disease, improvements in mental health, by these metrics, have been negligible in recent decades, indeed there is evidence that these measures are getting worse.^{1,2}
- 10 Rates of suicide have increased nationally (with last year more than 600 Victorians alone dying from suicide). Rates of homicide committed by untreated or undertreated patients with severe mental illness in the north western metropolitan region of Melbourne at least have seen a sharp rise over the past decade. This is likely to be a State-wide phenomenon, and I am convinced that, while homicides of this type are only perpetrated by a small minority of mentally ill patients, and typically prior to first access to care,³ public safety has been comprised by the collapse of the public mental health system which has prompted this Royal Commission. Early intervention and effective treatment prevent these tragedies and reduce suicide risk in the early years post diagnosis as well. Mental illness is also the largest and fastest growing source of disability.⁴
- 11 The severely mental ill are not getting the care they need, with about 3 in 4 young people with more complex mental disorders not able to access treatment and care in the northwest of Melbourne through our Orygen service. The same pattern is seen State-wide with only a minority (1.1%) of the 3% of Victorians with severe mental illness able to access any level of mental health care in the public mental health system. Such care is typically short-term, risk focused rather than treatment or recovery focused, and fails to offer the major forms of evidence-based care, hence outcomes are poor and deteriorating.^{5,6}
- 12 Whilst prevention, early diagnosis and sustained access to evidence-based treatment have underpinned health gains in other diseases, in my view these are poorly provided by a mental health system that is characterised by a narrow focus on acute, risk-

¹ ABS. 3303.0 Causes of Death, Australia, 2017.

² AIHW. Suicide and hospitalised self-harm in Australia: Trends and analysis. Canberra: Australian Institute of Health and Welfare; 2014.

³ Nielssen O, Large M. Rates of homicide during the first episode of psychosis and after treatment: A systematic review and meta-analysis. *Schizophr Bull* 2010;36:702-712.

⁴ Australian Government Department of Social Services. Characteristics of disability support pension recipients. Canberra: Australian Government; 2013.

⁵ Lawrence D et al. Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health; 2015.

⁶ Australian Institute of Health and Welfare 2007. Young Australians: Their health and wellbeing 2007. Cat. no. PHE 87. Canberra: AIHW.

oriented care, and which clings to the "soft bigotry of low expectations", in that cure or recovery are not regarded as achievable goals for patients, and mere stabilisation and management of risk are seen as the primary outcome target. The physical health of patients is largely ignored resulting in a major reduction of life expectancy of 15-20 years.^{7,8} Vocationally, people are consigned to the economic scrap heap and spend many decades on welfare payments.⁹ This is particularly tragic because there is unassailable scientific evidence showing that early intervention for psychosis in particular, evidence which was first produced here in Victoria from 1992, improves outcomes, reduces mortality by a factor of 4, including suicide, and saves large amounts of money.^{10,11,12,13,14}

- 13 A result of the severe underfunding of the public mental health system, at a level of around one third of what is required at a State level, is that little more than acute hospital-based care can be provided. The only way that the dramatically reduced number of inpatient beds that resulted from deinstitutionalisation and mainstreaming of mental health care into the major general hospital system could have functioned is if there had been strong, proactive and skilled multidisciplinary community mental health teams operating around the clock or at least extended hours till very late, and resourced to scale. This failed to occur and has eroded seriously in the past decade and a half. The result is a growing surge of emergency department (ED) presentations¹⁵ with no safety net between the GP, other primary care such as headspace, and the hospital.
- 14 The quality of care provided in acute inpatient units now is arguably worse than what occurred during the institutional era. It is limited largely to risk management and the acuity of the patients that can access the units is high. The experience for staff and patients alike is infused with risk and trauma of a variety of kinds. The old asylums were intimidating places too, but they were able to look after voluntary patients and enable people to stay in hospital long enough to experience treatment and for recovery to occur. The evidence-base for mental health care has improved a lot in recent years, however fewer and fewer patients get exposed to this. Examples include clozapine,

⁷ de Hert M et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry* 2011;10:52-77.

⁸ Chesney E et al. Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry* 2014;13:153-60.

⁹ National Mental Health Commission. Contributing lives, thriving communities—report of the National Review of Mental Health Programmes and Services. Sydney: NMHC; 2014.

¹⁰ Correll CU et al. Comparison of early intervention services vs treatment as usual for early-phase psychosis: A systematic review, meta-analysis, and meta-regression. *JAMA Psychiatry* 2018;75:555-65.

¹¹ van der Gaag M et al. Preventing a first episode of psychosis: Meta-analysis of randomized controlled prevention trials of 12 month and longer-term follow-ups. *Schizophr Res* 2013;149:56-62.

¹² Anderson KK et al. Effectiveness of early psychosis intervention: Comparison of service users and nonusers in population-based health administrative data. *Am J Psychiatry* 2018;175:443-52.

¹³ McGorry P et al. EPPIC: An evolving system of early detection and optimal management. *Schizophr Bull* 1996;22:305-26.

¹⁴ McCrone P et al. Cost-effectiveness of an early intervention service for people with psychosis. *Br J Psychiatry* 2010;196: 377-82.

¹⁵ Hiscock H et al. Paediatric mental and physical health presentations to emergency departments, Victoria, 2008-15. *Med J Aust* 2018;208:343-8.

cognitive behavioural therapy (CBT), individual placement and support (IPS), assertive community treatment (ACT), family interventions and home-based treatment. Non-evidence based models have emerged, such as ED based admission beds, to replace models that were evidence-based, such as home based treatment of acute episodes. Joint police and mental health programs like Police, Ambulance and Clinical Early Response (PACER) replaced the evidence based comprehensive response of Project Beacon in the 1990s in which crisis assessment and treatment teams (CATT) and police collaborated in an equal and balanced way.

- 15 Mental health services were “mainstreamed” within the large general hospital systems and have sat there like an iceberg which has slowly melted. They look integrated on the surface, but, unlike other major disease areas within that system, they have “failed to thrive” and progress. They have shrunk and involuted in real terms, and failed to introduce and offer the advances that have occurred through research. The funding and governance models have greatly contributed to this stagnation and shrinkage in real terms. This debasement of the system, the failure to grow in proportion to population growth and rising need for care, is directly responsible for the revolving door of patients who are let down, fail to benefit, and are often harmed in the process. This contrasts starkly with optimal care, which we also can see in certain oases within mental health, and with the high quality care that is accessed by patients with other Non-Communicable Diseases (NCDs), notably cancer and heart disease. Indeed, there are many stories of the same people experiencing cancer and mental illness, and they sharply contrast the two sets of experiences.
- 16 The World Economic Forum has revealed that among the NCDs, mental illness poses the greatest threat to the global economy.¹⁶ It is responsible for 35% of the loss of GDP due to health conditions. Cancer is responsible for only 18% of the loss of GDP due to NCDs or half as much as mental illness. Mental illness reduces global GDP by 4%, which is twice as much as NATO spends on defence. The reason that mental illness is so potent in this respect is due primarily to its timing in the life-cycle, which contrasts starkly with the other NCDs. 75% of mental disorders emerge before the age of 25 years,¹⁷ so if a substantial proportion of these are untreated, poorly treated, or are resistant to treatment, then they endure over several decades of unfulfilled potential, welfare payments and deepening disability, and can result in premature death. Vast amounts of downstream expenditure could be saved worldwide, and in Victoria, if the funding for direct care were allocated to scale. There is enormous opportunity to transform this scenario through three routes.

¹⁶ Bloom DE et al. The Global Economic Burden of Non-communicable Disease. Geneva: World Economic Forum; 2011.

¹⁷ Kessler RC et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005;62:593–602.

- (a) Firstly, **prevention**; some of this burden can be averted through effectively intervening with key risk factors such as childhood trauma, bullying and other social factors.
- (b) Secondly, the evidence for the cost-effectiveness of **early intervention**, especially for psychotic illnesses like schizophrenia and related disorders, is now very strong indeed. The return on investment is estimated in some research to be as high as 17:1.¹⁸ There is similar evidence for early intervention for depression and the principle is likely to apply more widely.¹⁹
- (c) Thirdly, increasing the treated prevalence and **reducing the “treatment gap”** between what is available, and what is needed, will reduce the total cost of mental illness. Intervening early and, once people are better, keeping them well and functioning has to be the additional priority. Early intervention without sustained intervention is a fruitless exercise, yet often in the binary thinking of the mental health field and, fuelled by resource constraints, these complementary priorities are strangely pitted against each other. The Productivity Commission Inquiry into Mental Health will reveal this picture clearly.

Staged care

- 17 One of the areas that needs consideration is to move mental health services towards providing staged and person-centred care. This means that supports must be targeted and weighted (right care, right intensity, right time) and more holistic.
- 18 In other major areas of health care there is full recognition of the need to fund prevention to reduce the incidence of illness, to place a premium on diagnosis at the earliest signs of potentially serious illness, and guarantee immediate access to care. This recognition and immediate access to care helps to sustain treatment efforts for as long as necessary using the best available evidence, and to keep people well or in remission, and, if the illness is progressive, to limit its impact eventually through palliative forms of care. This is delivered according to a **Staging framework** in many disease areas, notably, but not only, cancer.
- 19 My colleagues and I have developed a **clinical staging framework for mental disorders** which applies these principles to psychiatry.²⁰ The key goal is to reduce the risks of progression, from one stage to the next, through proactive yet proportional

¹⁸ Campion J, Knapp M. The economic case for improved coverage of public mental health interventions. *Lancet Psychiatry* 2018;5:103-5.

¹⁹ Chisholm D et al. Scaling-up treatment of depression and anxiety: A global return on investment analysis. *Lancet Psychiatry* 2016;3:415-24.

²⁰ McGorry PD, Hickie IB (Eds). *Clinical Staging in Psychiatry: Making Diagnosis Work for Research and Treatment*. Cambridge: Cambridge University Press; 2019.

treatment at each stage. A balance must be found between under-treatment (that is, waiting until the condition has worsened – which the concept of "stepped care" is based on) or overtreatment, in which treatments with significant risks are used prematurely. Academic and ideological debates about where this balance should be set have been common in mental health, but in the real world the system is dominated by under-treatment and late and reactive responses. Staging of treatment means proactive treatment that can be personalised according to stage as well as syndrome.

- 20 Further personalisation of treatment can be achieved in psychotherapeutic interventions which recognise special individual characteristics of people's lives and stories, and potentially in the future through the use of key biomarkers or other tests, as in cancer and other medical illnesses. In mental health, if we adopt a staging approach and embrace holistic care, which respects psychological, social and biological therapies equally and deploys them proactively, sequentially and in combination, patient outcomes can be substantially improved. Staging is not only a framework for safer, more effective and more personalised care, it is a vital framework for clinical and basic research in mental illness, which is already bearing fruit, and optimising care in novel and expanding youth mental health settings.²⁰

Early intervention

The imperative for intervening in the mental health of young people

- 21 The incidence of mental illness in young people is well documented,²¹ and is the highest of any age group. In the United States, the National Comorbidity Survey Replication revealed that 75% of people suffering from a psychiatric disorder have experienced its onset by 24 years of age, with the onset of most of the adult forms of mental illness falling within a relatively discrete time band from the early teens to the mid-twenties, peaking in the early twenties.²² Furthermore, this study has shown that the full lifetime risk for mental disorders approaches 50%. This is supported by other evidence, including a large prospective cohort studies such as the Great Smoky Mountain Study in the United States,²³ which showed that by 21 years of age, 61.1% of the participants had met criteria for a diagnosable psychiatric disorder at some time during the 12-year study period, while a further 21.4% had met impairment-based criteria for sub-threshold disorder, bringing the cumulative total to 82.5%. The National Comorbidity Study

²¹ Insel TR, Fenton WS. Psychiatric epidemiology: It's not just about counting anymore. *Arch Gen Psychiatry* 2005;62:590-2.

²² Kessler RC et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62:593-602.

²³ Copeland W et al. Cumulative prevalence of psychiatric disorders by young adulthood: A prospective cohort analysis from the Great Smoky Mountains Study. *J Am Acad Child Adolesc Psychiatry* 2011;50:252-61.

Adolescent Supplement, showed that 40.3% of United States adolescents aged between 13 and 17 experienced a mental disorder in any one year.²⁴

- 22 Even though there is 'desistance', or resolution of a proportion of mental ill-health in young people by their late twenties, much suffering, unrealised potential, disability or premature death will have occurred by then. In a large and rigorous cohort study, Gibb et al.²⁵ have shown that 50% of young New Zealanders had experienced a diagnosable mental disorder between the ages of 18–25 years, and that these disorders had a significant impact on young people's economic and social outcomes at age 30, confirming and extending the findings of the Great Smoky Mountains Study.²³ This impact is often underestimated in young men, since the research measures used typically focus on emotional aspects of mental ill-health, and young men tend to present with externalising symptoms with emotional distress being less overt.²⁶ Thus, mental ill-health is a reality that most people will confront either in themselves and/or within their families as they make the transition to adulthood.
- 23 There are complex biological, psychological and sociological reasons for why young people are so uniquely vulnerable to, and often heavily impacted by, the onset of a mental illness. The physiological changes that occur during puberty have a significant influence on behaviour and emotional functioning, and create a disjunction between physical, intellectual and psychosocial maturity.²⁷ Adolescence and early adulthood is also a time of major structural and functional change in the brain, driven by a series of maturational processes that result in the refinement of the neuronal circuitry, and a recalibration of the inhibitory/excitatory balance, particularly in the frontal cortex.^{28,29} The developmental challenges that must be met during the transition from childhood to independent adulthood, take place against the background of these highly dynamic changes in brain architecture, which creates a unique biological 'window of vulnerability' to the onset of mental illness.
- 24 As physical health improves worldwide, children are reaching puberty at an earlier age. The rapidly increasing changes in our social, economic and technological environments has meant that young people must stay in education or training longer, delaying their entry into mature social roles.³⁰ This has stretched the developmental phase of

²⁴ Kessler RC et al. Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Arch Gen Psychiatry* 2012;69:381–89.

²⁵ Gibb SJ et al. Burden of psychiatric disorder in young adulthood and life outcomes at age 30. *Br J Psychiatry* 2010;197:122–27.

²⁶ Rice SM et al. Development and preliminary validation of the male depression risk scale: Furthering the assessment of depression in men. *J Affect Disord* 2013;151:950–8.

²⁷ Patton GC et al. Pubertal transitions in health. *Lancet* 2007;369:1130–9.

²⁸ Paus T et al. Why do many psychiatric disorders emerge during adolescence? *Nat Rev Neurosci* 2008;9:947–57.

²⁹ Keshavan et al. Changes in the adolescent brain and the pathophysiology of psychotic disorders. *Lancet Psychiatry* 2014;1:549–58.

³⁰ Arnett JJ et al. The new life stage of emerging adulthood at ages 18–29 years: Implications for mental health. *Lancet Psychiatry* 2014;1:569–76.

'emerging adulthood' and made it less secure in many ways.³¹ Hence, today's young people must make the transition to independent adulthood in increasingly complex, and often conflicting, social environments.³² It is hardly surprising that mental illness, even when brief and relatively mild and especially when more severe and persistent, can seriously disrupt this developmental trajectory and limit a young person's potential. All too often, mental ill-health in young people is associated with impaired social functioning, poor educational achievement, unemployment (and under-employment), substance abuse, violence and victimisation, leading to a cycle of dysfunction and disadvantage that can be difficult to break.^{33,34}

- 25 Despite the statistics that emphasise their obvious need, young people are reluctant to seek help from, or cannot access or engage with, mainstream health services.³⁵ In Australia, young people have had the worst access to mental health care at any time across the lifespan, with only 13% of young men with a mental health issue accessing professional help, with this figure increasing to approximately 30% for young women. This has meant that the vast majority of young people who could benefit from mental health care did not receive it.³⁶
- 26 Other large-scale studies, such as the National Comorbidity Survey Adolescent Supplement from the United States,³⁷ have shown similar results. Our current primary health care services are geared to catering for physical ill-health, and are largely designed for young children or older adults, this developmental blind spot and the narrow clinical focus can be alienating to young people, who consequently fail to engage with services. Since young people in developed countries are usually in good to excellent physical health, they may not visit health practitioners often, and when they do, they find it extremely difficult to mention emotional concerns.³⁸ Furthermore, many practitioners lack the skills, patience and time to engage young people and work constructively with them.
- 27 Many factors contribute to young people's disengagement with the health care system. At the individual level, barriers to help-seeking include poor mental health literacy, failure to recognise a need for care, unhelpful beliefs involving personal strength and autonomy, and the level of psychological symptoms experienced, with those with higher

³¹ Arnett JJ. Emerging adulthood. The winding road from the late teens through the twenties. New York: Oxford University Press; 2004.

³² Sawyer SM et al. Adolescence: A foundation for future health. *Lancet* 2012;379:1630–40.

³³ McGorry PD. The specialist youth mental health model: Strengthening the weakest link in the public mental health system. *Med J Aust* 2007;187:S53–5.

³⁴ Scott J et al. Adolescents and young adults who are not in employment, education, or training. *BMJ* 2013;347:f5270.

³⁵ Patton GC et al. Service responses for youth onset mental disorders. *Curr Opin Psychiatry* 2007;20:319–24.

³⁶ Slade T et al. The mental health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra: Department of Health and Ageing; 2009.

³⁷ Merikangas KR et al. Service utilization for lifetime mental disorders in US adolescents: Results of the National Comorbidity Survey-Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry* 2011;50:32–45.

³⁸ Ambresin AE et al. Assessment of youth-friendly health care: A systematic review of indicators drawn from young people's perspectives. *J Adolesc Health* 2013;52:670–81.

symptom levels being less likely to seek help.³⁹ Young people from culturally and linguistically diverse or indigenous backgrounds face additional help-seeking barriers, including reliance on informal supports, the challenges associated with maintaining close connections with family and culture, complex needs involving grief and loss, and stigma and shame around seeking help for mental health and wellbeing, which often lead to seeking help at later stages of illness. At the service level, issues of accessibility, confidentiality and cost, as well as the organisation, location, milieu and even decor of the services available, are critical barriers to engagement.^{38,40}

- 28 When young people or their families do seek help, they have great difficulty in accessing the existing specialist mental health system, as their complex and evolving symptom profiles often do not meet the stringent criteria required for acceptance, particularly into an adult service, despite the significant distress and impairment associated with them. This is driven by poor resourcing and design, factors which also severely limit access to child and adolescent services. These have evolved from a paediatric focus on the needs of younger children within their family, educational and social contexts, with an artificially imposed age cut-off of 18 years, or in some cases, 16 years.⁴¹ It has been a worldwide struggle to develop child psychiatry. Older adolescents, especially those with more severe disorders, frequently find that the only access to care is via older adult services. So mental health services for children have reached upwards to try to include adolescents, and adult services, which have their origins and mandate in the asylum era and still mainly focus on the middle-aged, have reached down with very limited success. The split at age 18 presents problems for some physical health conditions; however, for mental health it is a fatal design flaw. The result is that young people and their families are an afterthought, rather than the priority they should be, in terms of need for care and return on investment.
- 29 This structural divide between the specialist child and adolescent, and adult mental health services is a major problem, not only due to their differences in focus and therapeutic approach, but also because the discontinuity between service streams falls right within the age range where the incidence of new onsets peak,⁴² and the system is weakest where it should be strongest.⁴³ Thus, the surge in new incident cases is not accommodated with the existing system. This situation is compounded for those young people with existing mental health issues who reach the end of their tenure of care with a child and adolescent service, and who need ongoing care within an adult service. The

³⁹ Rickwood DJ et al. When and how do young people seek professional help for mental health problems? *Med J Aust* 2007;187:S35-9.

⁴⁰ Roberts J et al. Global adolescent health: Is there a role for general practice? *Br J Gen Pract* 2012;62:608-10.

⁴¹ Patel V et al. Mental health of young people: A global public health challenge. *Lancet* 2007;369:1302-13.

⁴² McGorry PD et al. Age of onset and timing of treatment for mental and substance use disorders: Implications for preventive intervention strategies and models of care. *Curr Opin Psychiatry* 2011;24:301-6.

⁴³ McGorry PD. The specialist youth mental health model: Strengthening the weakest link in the public mental health system. *Med J Aust* 2007;187:S53-5.

TRACK study from the UK has shown that although the majority of these young people are referred on to adult services, around one-third are not, and of those that are accepted by adult services, a quarter are discharged without being seen.^{44,45} This service gap arises in part because the adult services, with their narrow focus on established severe mental illness, a legacy of the asylum era from the ashes of which these services arose, do not cater for special needs groups who have received help in childhood for developmental disorders; for example, those with intellectual disabilities, autism spectrum disorders, attention deficit/hyperactivity disorder (ADHD), nor those with emerging mood, anxiety, personality or substance use disorders. Further, although some transfer between services does painfully occur, the adult services often have difficulty engaging and working with young people at this transitional stage, due to the morale and culture of such services.

- 30 To improve access, quality, and continuity of care, a new approach to youth mental health is urgently required. A specific mental health service stream is appropriate for young people for two major reasons.
 - (a) Firstly, because this population is heterogeneous, with varying and clinically uncertain illness trajectories; young people in the early stages of a mental illness tend to present with blends of co-morbidities of variable intensity, particularly substance abuse and challenging personality traits, which require an integrated model of care. Thus, services that acknowledge the complex and evolving pattern of morbidity and symptom fluctuation seen in this age group are needed.
 - (b) Secondly, developmentally and culturally appropriate approaches are essential for the management of emerging disorders; young people's individual and group identity and their help-seeking needs and behaviours need to be central to any service model.^{46,47} The available evidence shows that youth-specific services should be provided in an accessible, community-based, non-judgmental and non-stigmatising setting, where young people feel comfortable, have a say in how their care is provided, and can feel a sense of trust.^{46,47} Ideally, this means creating a novel youth mental health model overlapping and linking with, but discrete in culture and expertise from, systems for younger children and older

⁴⁴ Paul M et al. Transfers and transitions between child and adult mental health services. *Br J Psychiatry* 2013;54:S36–40.

⁴⁵ Singh SP et al. Process, outcome and experience of transition from child to adult mental healthcare: Multiperspective study. *Br J Psychiatry* 2010;197:305–12.

⁴⁶ McGorry PD. The specialist youth mental health model: Strengthening the weakest link in the public mental health system. *Med J Aust* 2007 187:S53–56.

⁴⁷ McGorry PD et al. Designing youth mental health services for the 21st century: Examples from Australia, Ireland and the UK. *Br J Psychiatry* 2013;202:S30–40.

adults.⁴⁸ Such a model will largely overcome the issue of poor access to care and transition between the current service streams.⁴⁷

The definition of early intervention

- 31 As the Editor of the international journal "Early Intervention in Psychiatry", I have given a great deal of thought to definitional issues. In the professional and academic arena, Early Intervention is defined as intervening early in the course of mental ill-health and mental disorders in order to improve the chances of cure, recovery and better outcomes. The term has been used in Victoria and Australia in a more diffuse and confusing way by Departments of Health to refer also to intervention for risk and for disorders appearing "early in life" (usually early childhood), and in relation to relapses of established and long-term illness, for intervening "early in episode". While these are valid goals, the term early intervention should be restricted to the focus on intervening early in the course of the disorder.

Prevention, early intervention and continuing care

- 32 In thinking about the relative balance between prevention, early intervention and ongoing treatment and care, we can see that the incidence and prevalence of mental disorders rises sharply around puberty, perhaps from age 10-12 years, and surges through adolescence and early adulthood where it reaches its peak in the lifespan. Risk factors for later onset of disorder are a key focus for early to middle childhood when much useful preventive work could be done to reduce childhood trauma, abuse and damage to attachment.
- 33 Parenting programs, more effective treatment of parental mental illness and addiction, and anti-bullying programs are examples of preventive interventions with an evidence base. There are a number of disorders which have their onset prepubertally, and these include autism, conduct disorder, ADHD and anxiety disorders. They require early intervention and treatment in their own right, and also as risk factors for later onset of adult-type disorders. However, the culture of care and the make-up of the professional multidisciplinary team to respond to these disorders are quite different from what is appropriate for adolescents and emerging adults. In an ideal system, prevention, early intervention and continuing care would be occurring both in the 0-11 age group and the 12-25 age group, however the relative balance of investment would shift with increasing age and developmental stage.

⁴⁸ McGorry P. Should youth mental health become a specialty in its own right? Yes. BMJ 2009;339:b3373.

An analogy with cancer

- 34 While there have been breakthroughs in cancer treatment recently, the major gains in terms of cure and prolonged survival have flowed from prevention (where possible), early diagnosis and much better delivery of quality evidence-based care grounded on pre-existing knowledge. More people are being cured, and many more surviving much longer, because of this well-resourced effort in which no expense is spared. Applying this approach in mental illness would yield an enormous crop of low hanging fruit and offer widespread benefits. These benefits would result partly from the timing, and partly from the implementation, of interventions that actually work. Embedding and supporting mental health research much more strongly within routine Victorian service systems would also catalyse better quality care and workforces, as well as yielding novel treatments, just as we have seen in cancer and cardiovascular disease. Some of these benefits are already evident at Orygen's translational mental health research institute and service platforms, and through the Impact Centre at Deakin University through clinical trial platforms.

The process of early intervention and detection, including the signs and symptoms of mental illness early in the illness, how detected and by whom, how treated

- 35 Our journal (Early Intervention in Psychiatry) has published thousands of articles on early intervention, and the literature spans many other publications and journals. The evidence base is very strong for schizophrenia and psychotic disorders, which are the most potentially serious and disabling illnesses. We can now say that Cochrane level 1 evidence (that is, the top quality of evidence) has been assembled over the past two decades to support the fact that we can delay the onset of psychosis in people with early warning signs of psychosis,^{49,50} and improve the outcomes over the first two years at least for people with a first episode of psychosis.⁵¹ These gains can be maintained in quality care beyond the initial "critical period" of the first two years.^{52,53,54} There is accumulating evidence in support of this principle being applied to a range of other

⁴⁹ van der Gaag M et al. Preventing a first episode of psychosis: Meta-analysis of randomized controlled prevention trials of 12 month and longer-term follow-ups. *Schizophr Res* 2013;149:56–62.

⁵⁰ Stafford MR et al. Early interventions to prevent psychosis: Systematic review and meta-analysis. *BMJ* 2013;346:f185.

⁵¹ Correll CU et al. Comparison of early intervention services vs treatment as usual for early-phase psychosis: A systematic review, meta-analysis, and meta-regression. *JAMA Psychiatry* 2018;75:555–65.

⁵² Ising HK et al. Four-year follow-up of cognitive behavioral therapy in persons at ultra-high risk for developing psychosis: The Dutch Early Detection Intervention Evaluation (EDIE-NL) Trial. *Schizophr Bull* 2016;42:1243-52.

⁵³ Norman R et al. Symptom and functional outcomes for a 5-year early intervention program for psychoses. *Schizophr Res* 2011;129:111-5.

⁵⁴ Malla A. Comparing three-year extension of early intervention service to regular care following two years of early intervention service in first-episode psychosis: A randomized single blind clinical trial. *World Psychiatry* 2017;16:278-286.

diagnoses, including borderline personality disorder, depression and bipolar disorder.^{55,56,57}

- 36 Early intervention is made up of two elements. Firstly, early detection which involves reducing diagnostic delay, and identifying the earliest signs of need for care. Early detection can be achieved through intensive community education aimed at promoting recognition of the early signs of mental disorders, especially less familiar ones such as emerging psychosis. For this to be effective, it must be linked closely to a mobile early detection service which is in turn embedded with a highly porous or "soft entry" platform of care. For mental illness as a whole, this would correspond to our headspace platform for young people, where such mobile teams could be based and able to link with schools, tertiary education settings and families. For other age groups linkage with primary care and community settings would be needed. The second element of early intervention is stage-linked multidisciplinary clinical care to cover the early years of illness post diagnosis. With these elements in place, the use of involuntary hospitalisation can be minimised, and a much better patient and family experience also assured. While this evidence has been available for nearly two decades, it has recently become overwhelming especially for early psychosis, however the vast majority of Victorians and Australians still have no access to such models of care.

Addressing the concern that too much focus on early intervention may risk over-medicalisation and unnecessary stigma

- 37 Psychiatry and mental health are plagued by binary thinking and there is a strong anti-medical and anti-medication bias in some quarters, driven in part by justifiable concern about the narrow way that treatment is provided in routine services. It is true that there has been an over-reliance on medication alone, with a neglect of the other evidence-based approaches needed to achieve recovery. The clinical staging model is designed to deal with this concern about over-treatment and premature use of medications, by stressing that medication is typically not a first line treatment option (see above). Medication also needs to be used more carefully, and in much lower doses, than currently seen in routine care. There is often very poor practice here, driven by the hyper-acute and brief nature of current hospital stays.
- 38 The major issue here though is the contention that the boundary for access to mental health care has been too ill-defined, and with too low a threshold such that people risk being inappropriately regarded as suffering from mental ill-health and will suffer stigma and labelling. These contentions are largely ideologically and theoretically driven, since

⁵⁵ Davey CG, McGorry PD. Early intervention for depression in young people: A blind spot in mental health care. *Lancet Psychiatry* 2019;6:267-272.

⁵⁶ Chanen A. Prevention and early intervention for borderline personality disorder: Current status and recent evidence. *Br J Psychiatry* 2013;202:S24-29.

⁵⁷ Vieta E. Early intervention in bipolar disorders. *Am J Psychiatry* 2018;175:411-26.

the reality is that it is extremely hard to gain access even in severe and complex cases to the public mental health system, which serves only 1.1% of the Victorian population. In primary care and headspace, the entry threshold is low, but stigma is also very low in these settings, and labels are not necessary to access help. This means that these are the best settings for all patients to enter treatment in order to minimise stigma.

- 39 The hard facts, as opposed to ideological opinions, are that the overwhelming problem is not premature and overtreatment, but late intervention and undertreatment. Ironically, this undertreatment scenario leads to crude and harmful responses, and over-medication when treatment is eventually accessed, which in turn reinforce fears of over-medicalisation and of medications in general. A low threshold for access or “soft entry” and early intervention before illnesses become acute and severe is the solution to this issue.
- 40 My colleagues and I have taken the risk/benefit issue as the key guiding principle to addressing this question, and have done extensive research in operationally defining these boundaries and stages of illness, as well as tailoring proportional interventions sensitive to risk benefit considerations. We have conducted a whole series of research studies and clinical trials to support the correct approach.^{58,59,60}

Headspace and Orygen

- 41 Headspace is a national Federally funded program of enhanced primary care, which enables young people to gain access to youth-friendly multidisciplinary primary care close to where they live. Access is possible by direct presentation or walk-in, online, by referral from schools or general practices, and via family or friends. Young people aged 12-25 years are eligible, and do not need to identify as experiencing mental ill-health. Headspace offers a holistic approach, including youth engagement and co-design, youth peer support, vocational support, physical health care through GPs, and drug and alcohol expertise. However, most of the needs are related to emerging mental ill-health. There is extensive literature^{61,62,63} and two external evaluations^{64,65} supporting the value

⁵⁸ McGorry PD et al. Effect of ω -3 polyunsaturated fatty acids in young people at ultrahigh risk for psychotic disorders: The NEURAPRO randomized clinical trial. *JAMA Psychiatry* 2017;74:19–27.

⁵⁹ McGorry PD et al. Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: Twelve-month outcome. *J Clin Psychiatry* 2013;74:349–56.

⁶⁰ McGorry PD et al. Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. *Arch Gen Psychiatry* 2002;59:921–8.

⁶¹ Rickwood DJ et al. Changes in psychological distress and psychosocial functioning in young people visiting headspace centres for mental health problems. *Med J Aus* 2015;202:537–42.

⁶² Rickwood D et al. Satisfaction with youth mental health services: Further scale development and findings from headspace - Australia's National Youth Mental Health Foundation. *Early Interv Psychiatry* 2017;11:296–305.

⁶³ Rickwood DJ et al. Headspace - Australia's innovation in youth mental health: Who are the clients and why are they presenting? *Med J Aus* 2014;200:108–11.

⁶⁴ Muir K et al. Independent evaluation of headspace: The National Youth Mental Health Foundation. Sydney: UNSW; 2009.

⁶⁵ Hilierty F et al. Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program. Sydney, NSW: UNSW; 2015.

of headspace. Outcomes are modestly improved for mild to moderately ill young people, and access is greatly enhanced, as is satisfaction with the care received. Headspace is very popular with local communities, with young people and with families. Although there are still challenges to the full implementation of the model, it has spread to 110 communities Australia-wide, with a further 30 centres still to be opened.

- 42 Orygen, preceded headspace, and is a blend of a State government funded specialist public mental health service integrated with the headspace centres in the northwest region which are operated by Orygen also. It also involves Australia's largest mental health research institute (MRI) which focuses solely on early intervention and youth mental health. It has a policy and translation arm which drives reform, education and training, and global and national progress in youth mental health. In recent years, the population growth, underinvestment and enormous demand for specialist care in the northwest region have placed the specialist elements of Orygen, which focus on psychosis, personality disorders and mood disorders, under extreme pressure. 3 out of 4 young people (part of the so-called "missing middle") with severe and complex disorders now being turned away to minimal or no care.
- 43 Orygen is a translational medical research institute, which is unique globally and Australia's largest mental health research institute. It is in fact a clinical laboratory, which provides treatment through State and Federally funded clinical platforms including headspace centres. Orygen designed and led the development of headspace nationally from 2005. A key stream of Orygen's work is service innovation and multicentre clinical trials, which have shaped mental health reform nationally and globally in a profound manner. Orygen has partnerships with the top research centres worldwide, and has received highly competitive research funding from the US National Institute of Mental Health, the Wellcome Trust in the UK, and the Broad Institute at Harvard/MIT in Boston. A youth model of care based on the system architecture built in the northwest region, can be assembled across Victoria as soon as appropriate funding models can be constructed and supported.

The importance of psycho-social treatments and programs

- 44 Psychosocial interventions are crucial, as the initial steps of mental health care are always needed as a complementary aspect, even when medication is indicated. The relationship with the health professional is crucial and must involve continuity of care. Trust is essential, and on this basis evidence based interventions like CBT, dialectical behaviour therapy (DBT), and IPS can be effectively offered. Psychosocial interventions have been shown to delay the onset of psychosis⁶⁶ and are effective in a wide range of

⁶⁶ Hutton P, Taylor PJ. Cognitive behavioural therapy for psychosis prevention: A systematic review and meta-analysis. *Psychol Med* 2014;44:449-68.

conditions.^{67,68} Sadly, they are in short supply in Victoria's public health system. Some of these interventions are available through NGOs, but they are typically through less qualified staff. Nevertheless, the staff are very helpful to people by providing the stability of a personal relationship, and the fact that basic needs such as housing and purposeful activities are supported. Some of the crucial evidence based multidisciplinary interventions such as assertive community treatment are largely psychosocial. DBT and cognitive analytic therapy (CAT) therapy for borderline personality disorder are effective but hard to access too. Innovation in psychosocial interventions, through online versions and technology assisted therapy, notably via virtual reality, are being researched and translated at Orygen.

- 45 Australia, and Melbourne in particular, is seen as the epicentre of progress in early intervention and youth mental health. The early intervention models and therapies developed at Orygen, and its precursor the Early Psychosis Prevention and Intervention Centre (EPPIC), have spread all over the world.^{69,70,71} Early intervention programs in psychosis are in most centres in Canada, England and Denmark as well as in many other places, including six Australian centres. There is a major scaling up exercise in the USA for early psychosis care based on Victorian innovation and research. Similarly for subthreshold psychosis, where our Personal Assessment and Crisis Evaluation (PACE) clinic has made it possible for people to access care before becoming frankly psychotic.⁷²
- 46 This seminal work in the 1990s has transformed the field.⁷³ In youth mental health, 12 countries have embraced similar models to headspace, which was designed and implemented by Orygen from 2005 across Australia.⁷⁴ Orygen founded and hosts the secretariats for two international networks coordinating these reforms, namely the Early Intervention in Mental Health (IEPA), and the International Association for Youth Mental Health (IAYMH). These organisations have developed and supported global networks of clinicians and investigators, as well as young people and families with lived experience, and 20 years of international conferences and activities. Orygen hosts the Wiley journal Early Intervention in Psychiatry, which I edit.

⁶⁷ Hetrick SE et al. Cognitive behavioural therapy (CBT), third-wave CBT and interpersonal therapy (IPT) based interventions for preventing depression in children and adolescents. Cochrane Database of Syst Rev 2016;9:CD003380.

⁶⁸ Hetrick SE et al. Effective psychological and psychosocial approaches to reduce repetition of self-harm: a systematic review, meta-analysis and meta-regression. BMJ Open 2016;6:e011024.

⁶⁹ McGorry P et al. Designing youth mental health services for the 21st century: Examples from Australia, Ireland and the UK. Br J Psychiatry 2013;202:S30-5

⁷⁰ McGorry PD. Early intervention in psychosis: Obvious, effective, overdue. J Nerv Mental Dis 2015;203:310-318.

⁷¹ Malla A et al. From early intervention in psychosis to youth mental health reform: A review of the evolution and transformation of mental health services for young people. Soc Psychiatry Psychiatr Epidemiol 2016;51:319-26.

⁷² Yung et al. PACE: A specialised service for young people at risk of psychotic disorders. Med J Aust 2007;187:S43-6.

⁷³ McGorry P. Beyond the "at risk mental state" concept: Transitioning to transdiagnostic psychiatry. World Psychiatry 2018;17:133-142.

⁷⁴ Hetrick S et al. Integrated (one-stop shop) youth health care: Best available evidence and future directions. Med J Aust 2017;207:S5-18.

- 47 Orygen also has a formal contract with the World Economic Forum. This involves supporting the global spread of the youth mental health paradigm, and extensive research and clinical collaboration with the leading world centres in mental health research and care. Orygen has provided formal advice to many governments around the world, and is contracted by the Australian government for a number of key national policy and reform tasks and roles. Headspace, which was founded in 2005, and designed and led by Orygen, is based in Victoria and Orygen remains a key player and partner in the headspace project.

Missing middle

- 48 Although the capacity of the primary care system to provide access to people with milder mental health conditions, such as anxiety and depression, has strengthened somewhat, and stigma has been reduced for these conditions, this is not the case for those people with moderate to severe mental health conditions.
- 49 This group of people, which I call the "missing middle", is characterised by the nearly two million Australians and several hundred thousand Victorians, both young people and older adults, whose illnesses are too complex, too severe and/or too enduring for primary care alone to be sufficient.

Examples of the missing middle

- 50 Mental illness can be divided in a static way into three tiers of severity, though of course people will move up and down this continuum. It is estimated that of the 20% of the general population (26% of young people) who have a mental illness or period of mental ill health in any given year, 11% at any one time will be classified as mild and therefore treatable in primary care settings, such as general practices or headspace centres. 6% (or around 10% of young people) will be classifiable as moderate in severity/complexity, and 3% as severely ill. State governments have traditionally been expected to provide acute and community care for at least the 3% of severely ill, however this has shrunk in Victoria to only 1.1%. The Federal government, through its funding of GPs and the Better Access to Mental Health Care initiative (**Better Access**), supports the care of the 11% of mild cases and some of the 6% of moderately ill patients via Medicare Benefits Schedule (**MBS**) payments to private psychiatrists (though this coverage is very inequitable and has major geographic and cost barriers). The rest of the 6% (or 10% for young people) of moderately ill patients, and the 2%, are severely ill but locked out of State government public mental health services have been termed "the missing middle". This amounts to around 300,000 Victorians in any given year.
- 51 This "missing middle" is comprised of several kinds of people and conditions. It includes people who have presented with mild or early stage disorders, who have not responded

in primary care to psychological interventions such as CBT or to single medication trials, or whose condition has worsened during an initial treatment phase. It also includes people who present in primary care with illnesses that are already moderate or severe, or more complex in terms of comorbidity or chronicity. Examples include borderline personality, bipolar disorder, eating disorder, PTSD, OCD and complex or enduring mood and anxiety disorders. These disorders often overlap, and are often complicated with substance use comorbidity, housing instability and homelessness, relationship breakdown, and financial and other stressors. These disorders are typically non-responsive to brief episodes of care and first line interventions, and require multimodal and longer-term team-based care which includes psychiatrists, addiction specialists, case management, and mobile assertive community treatment across extended hours.

Current treatment, support and care available for the missing middle, and reforms or opportunities exist for the mental health system to better treat them

- 52 Currently these patients are stranded in primary care, which may even exclude them, and generally, unless they have the means and skills to access private psychiatry. Their only access to the mental health care system is when a crisis occurs, and they present with suicidal or disorganised behaviour to emergency departments, or through offending or aggressive behaviour to the criminal justice system. What is urgently required is a series of reforms to build new community-based models of care which link closely to primary care, and provide access for these more complex cases upstream from emergency departments.
- 53 Community mental health hubs in local communities are one model which could provide holistic expert mental and physical team-based health care as well as social care, such as housing and vocational support over extended hours and accessible to general practitioners. In the case of young people, this second tier of extended and expert care could be built on the foundations of the headspace platform. These structures, if funded to operate around the clock, could dramatically reduce the flow of acutely mentally ill people into emergency departments, and reduce attempted and completed suicide substantially. I have already worked with Mental Health Victoria, Australians for Mental Health and KPMG to design a prototype model of such hubs. I have also worked with my Orygen and headspace colleagues, and KPMG to design a youth version which could be embedded in the headspace platform in Victoria. It is logical that both State and Federal governments should jointly fund such new structures, perhaps via Primary Health Networks (PHNs), but with tight service specifications for commissioning purposes, which would make "stepped care" or better still "staged care" a reality.
- 54 Attached to this statement and marked 'PMc-2' and 'PMc-3' are Youth and Adult Community Mental Health documents.

The mental health care system and reform

- 55 It must be acknowledged that there are cases of good practice in the Victorian mental health system, but they are hard to find. The youth mental health model, though incomplete and under major pressure, is best developed in this State through Orygen, and more recently through the addition of Federal early psychosis funding to the Alfred Child and Youth Mental Health Service (**CYMHS**) and local headspaces in the southeast of Melbourne. Victorian headspace centres include some of the best performing centres nationally. The advent of Prevention and Recovery Care (**PARC**) services is regarded positively, as an alternative to acute inpatient care and as a subacute model of residential care, however the evidence base for this model is weak.
- 56 Almost every other aspect of public mental health care has deteriorated over the past two decades. There are rising rates of aggression in more acutely ill patients, which has been driven to an extent by increased use of illicit drugs, especially stimulants. This has meant that emergency departments, and inpatient units, are more disturbed and violent. The use of security staff has resulted in a traumatising atmosphere and culture, and the anxiety of health professionals has meant that the threshold for triggering the use of security staff has reduced. In one recent example, security staff were called because a 14 year old girl in an adolescent unit would not go to bed on time. In emergency departments, a psychiatric patient raising their voice, or questioning a decision, can elicit a coercive security response with restraint and forced sedation. There is still some isolated home treatment being conducted by some CATT teams, and many gifted and committed staff, however the exception highlights the rule. Morale is low and a sense of futility and inertia, weighed down by excessive red tape and risk management activities seeking to defend the indefensible, and assemble medico-legal immunity, is widespread.
- 57 Victoria is the global centre for youth mental health reform and is also home to headspace, beyondblue, and to other internationally respected research centres such as the Impact Centre and the Centre for Mental Health Economics at Deakin University, and the Alfred Psychiatry Research Centre, where the Women's Mental Health and Brain Stimulation Therapies have been a key focus.

How the system compares to what was envisaged in the 1990s

- 58 In the 1990's when the new system of community oriented mental health care was designed and launched, the initial phase from 1994-2000 was filled with hope, optimism and a sense that innovation and reform were going to drive a system which would be greatly superior to the asylum system that had been dismantled.

- 59 However, the system was not funded to address the scale of the problem. It had serious design flaws, particularly in terms of inpatient facilities. The system design also failed to understand that although mental illness needed funding equity with physical illness, mental illness is not in fact the same as physical illness, and the design and structure of services needed to reflect this. The governance and financial model underpinning the new system exposed it to major vulnerability at the hands of general hospital administrators. Funds from block funded mental health budgets were diverted to other health domains through various devices. For instance, psychiatric bed day costs were deliberately underfunded by the health department, which meant that funds were then stripped from crucial community mental health programs to cover the shortfall. This accelerated the collapse of these services, and the rising tide of emergency department presentations.
- 60 Initially dynamic mobile assertive community outreach, and home treatment teams, began to falter and retreat into the hospital. Many were dismantled and merged with case management, which enabled further cuts to be made. Good money was thrown after bad, resourcing non-evidence based care in emergency departments with poor results. Clinical care became increasingly generic and non-evidence based. The experience of patients who were treated in this system became increasingly negative. The system focused increasingly on risk management rather than the delivery of evidence-based treatment. The threshold in mental health triage teams for entry to the system became impossibly high, and many clinicians and police refused to invoke the Mental Health Act even in clear-cut cases, when care should have been assured through this route.
- 61 Conversely, it became very difficult to enter the system unless the Mental Health Act was invoked. For instance, if a patient could consent to treatment, then they were usually deemed not eligible for acute care. This represents a classic catch-22 situation. Psychiatric leadership within the general hospital networks over the past 20 years has been weakened by placing generic managers in control of budgets, and restricting the mandate of clinical directors to oversight of medical staff and Mental Health Act issues. The majority of graduating locally trained consultant psychiatrists rapidly deserted the failing system, leaving it to a dedicated few local survivors and cohorts of overseas trained psychiatrists. This produced a weakened and fragmented medical leadership in psychiatry, in contrast to other medical specialties within powerful hospital structures.
- 62 On the other hand, the mental health service tended to sit like an archaeological artefact within these hospital networks, however, it did not integrate or evolve and grow with the times, as did the other specialties. The only partial exceptions are those services in which mental health research was flourishing such as Orygen, the Alfred Hospital,

Deakin and one or two others which did allow innovation to an extent to continue. The rest have generally involuted or stagnated.

The most significant challenges facing the mental health system in meeting the needs of people affected by mental health

- 63 The major challenges are a major change in the **governance** of mental health care, **new financial models** which enable need and demand to be fully addressed and reduce the flow into the acute end of the system, the creation of humane, hopeful and optimistic **cultures of care**, and the rebuilding and **empowerment of specialised clinical workforces**, including psychiatry, allied health and nursing as well as new workforces, such as vocational recovery experts, peer workers, exercise physiologists, dieticians, family educators and mentors.
- 64 The training of the traditional workforces especially psychiatrists, nurses and allied health needs a major review and modernisation. Security staff should be scaled back and reserved for extreme situations. The role of the police and ambulance staff, who have by default been thrust into the front line of mental health care, must be fundamentally redefined and placed in a support and backup mode. Finally, the **community must be mobilised and engaged** to embrace and offer much more support for the mentally ill, who are in everyone's family and yet are often lonely and isolated.

The critical elements of a well-functioning mental health system

- 65 In my view they are as follows:
- (a) Much more effective and mandated professional leadership is needed from senior psychiatrists, who should be empowered to oversee the clinical governance of the whole system they lead. Senior psychiatrists should be able to grow, protect and control budgets for their programs with the support of a financial director or manager.
 - (b) Equity of funding with the other major NCD's. Funding in proportion to the level of need.
 - (c) Optimised operational and, where possible, clinical governance integration with primary care structures or networks. Clinical governance of community mental health services needs to be at least separated, and fully protected, from the governance of acute systems of care. The latter may or may not remain with general hospital networks. Activity based funding for community care will be essential if demand is to be met, and is probably also needed for inpatient care, though sufficient bed stock is crucial here.

- (d) Humane holistic values and an optimistic culture with people with lived experience and families involved at all levels in the system in significant numbers and diverse roles.
- (e) Visible platforms of care that draw on both Federal and State funding sources.

The importance of non-binary thinking and the detriments of a siloed approach to mental health

- 66 Partly because of the funding neglect and scarcity in mental health, but also because of philosophical and ideological differences and reductionistic thinking, there are many false dichotomies in mental health and psychiatry. This stems in part from the fundamental split between mind and body.
- 67 We see many examples of binary or "either-or" thinking and destructive debates. Examples include, a biomedical approach versus a psychosocial perspective on mental illness and treatment, drug therapies versus psychological therapies, brain disease versus the consequences of adverse life experiences, prevention versus treatment, early intervention versus the needs of people with enduring mental illness and so on. We do not see this fruitless debates or conflicts in the same level in other health areas such as cardiovascular disease and cancer.
- 68 Mental health care is also subject to ideological attack from campaign groups like Scientology and fellow travellers who are antiscientific. Another consequence of a divided field is the fragmentation of services such that drug and alcohol services have a completely different treatment philosophy, set of standards and culture from mental health services, and from physical health care. Similarly non-government organisations operate another segment of mental health care, and once again have different philosophies, cultures and workforce standards.
- 69 Competitive tendering is another negative feature which fragments services even further, and which is a particular risk with Federally funded programs with the current PHN framework, which has worsened the situation.

What non-binary thinking in mental health would look like

- 70 Non-binary thinking in mental health would mean that all the false dichotomies were eliminated, and it would be possible to offer integrated biopsychosocial mental health care across all stages of illness, including preventive approaches for high risk groups and the general population. To transcend the binary scenario, adequate funding is essential so that forced choices between areas of equal priority are eliminated. Different perspectives however, such as brain and mind, drug therapy and psychosocial interventions, are valuable and should be mutually respected.

The specific challenges that investment in, and reform of the mental health system encounters in relation to siloing and binary thinking

- 71 Where whole of system integration is missing, competition for scarce resources leads to mis-perceptions in public debate that one model necessarily excludes others. This is exactly the problem as identified above, however, there is an ideological and non-scientific element to this fuelled by external forces including Scientology and antipsychiatry. External forces such as these are campaigning to foster such divisions, and undermine integrative approaches, which are what patients really need to have the best chance of recovery.
- 72 As in other major NCD areas, a population health approach is crucial to seriously impact on morbidity and mortality. This means addressing the social and economic, as well as biological determinants of illness, to reduce incidence and prevalence. Early intervention, and full coverage with evidence-based treatment, can reduce prevalence and is complementary to a population health and preventive approach.
- 73 Without access to evidence-based clinical care, those people for whom prevention has not been successful can have the best chance of reducing the duration, impact and therefore prevalence of illness and the level of disability that results.

Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

- 74 While a non-binary mindset is critical, the Royal Commission must make radical recommendations for a redesign, refinancing and governance of the State *clinical* mental health system as the centrepiece of the reform process, with a key focus on culture, financial models and governance. The flawed original design and subsequent neglect of the mainstreamed mental health system of the 1990s, combined with substantial population growth and rising expectations from the public, has led to a serious collapse in the access to and quality of mental health care. Culture, workforce, funding, leadership and public engagement are crucial issues if the reform is to be achieved and sustained. Other aspects in the community, and social welfare sector, as well prevention, are important secondary reform areas. A **standing commission on mental health** with independent powers to monitor the implementation of reforms, to safeguard and continue further reform and growth into the future, will be essential if these goals are to be met.

sign here ▶ 

print name Patrick McGorry

date 2/7/19