Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF PATRICK MCGORRY AO

I, Patrick 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, say as follows:

Background

1 My relevant background is in the witness statement dated 2 July 2019 and tendered during the public hearings for the Royal Commission into Victoria's Mental Health System held in July 2019.

2 I am giving evidence in my personal capacity and not on behalf of any organisations with which I am associated.

Future trends

Future trends or changes that will alter the community's need for mental health services, particularly among young people

3 Young people are physically healthier than they have ever been before in history and most young people are resistant to COVID-19. The main cause of death for young people is deaths related to mental health and suicide. For that reason, young people are particularly sensitive to the types of macro future trends that exist.

4 VicHealth commissioned the CSIRO to produce the *Bright Futures* report in 2015 which identified five megatrends that will impact the mental wellbeing of young Victorians in the future:[1]

(a) *'the rising bar'* – a rise in skill and education levels in emerging economies and increased automation leading to a more competitive global job market;

(b) *'global reach'* – globalisation and digital technology creating a breakdown of traditional barriers changing the way workplaces, organisations, societies, governance structures and individuals operate;

(c) *'life's richer tapestry'* – a more diverse culture, society and consumer market where identification of mainstream is increasingly difficult;

[1] VicHealth, *Bright Futures: Megatrends impacting the mental wellbeing of Victorians over the coming 20 years*, see Figure 1 on pp4, available online at https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Mental-health/Youth-Megatrends-Report.pdf?la=en&hash=3D8EC92772E518FE869BB5D44A2ADBD5D4FF7AC6.

(d) *'overexposure online'* – young people will be increasingly exposed to wide ranging online content, privacy breaches and virtual relationships; and

(e) *'out of the shadows'* – scientific research will improve understanding and awareness of mental health, and service and delivery models will change.

5 These megatrends remain relevant in 2020. The competitiveness of the global job market and the 'rising bar' has been compounded by the winding back of employment rights of the general population over time, coupled with the casualisation of the workforce, i.e. the 'gig' economy. Ben Graeber, an anthropologist at the London School of Economics has published a book called 'Bullshit Jobs.' The book discusses the widespread existence of paid forms of employment that are *'so completely pointless, unnecessary or pernicious that even the employee cannot justify its existence.'* Many of these jobs have resulted from the privatisation of public sector functions, creating a more ruthless working environment for young people and the development of a new social class called the 'precariat' who are existing without predictability or security, affecting their material and psychological welfare.

6 The impact of the increasingly competitive job market is a sense of greater insecurity for young people. The first step in Maslow's Hierarchy of Needs includes having food, shelter, sleep, and a secure future, factors that are extremely important for mental health and are under threat for many people. The vulnerability of young people's stability and security of employment has been brought into sharp focus with COVID-19. We have observed people having a stable job one minute and subsequently being in a line outside Centrelink for welfare benefits the next. Those labour market effects can result in very serious mental health problems. At Orygen, we have done modelling prepared by the University of Sydney Brain and Mind Centre that shows a predicted increase in suicide of 25-50% as a result of the economic effects of COVID-19.

7 The trend of 'overexposure online' is having a mixed effect on young people's mental health. There is research from the US that demonstrates that increased levels of anxiety and depression for young people parallels the advent of the smart phone; Jean Twenge has made a strong case that the two changes are linked.[2] While there are some negative effects of social media and smart phones on young people's mental health, it can also be used to support mental health. For example, at Orygen we have developed mental health platforms that can be fully integrated with face to face care and are highly supportive of young people's mental health and have recently been funded to run across the state. In reality, social media and smart phones are another dimension to human life that we have to adapt to.

[2] Twenge J.M. Increases in Depression, Self-Harm, and Suicide Among U.S. Adolescents After 2012 and Links to Technology Use: Possible Mechanisms PRCP in Advance (doi: 10.1176/appi.prcp.20190015).

8 Australia's education system is struggling in terms of its effectiveness compared to world rankings. We have privatised our education system by stealth. Our universities are now businesses and we have sold a lot of the farm to overseas and fee-paying students because of the progressive defunding of universities over the past 3 decades. In that sense, the experience of university and tertiary education is very different these days. Orygen has reported to the government and has been funded to produce a framework for tertiary student mental health to help respond to these issues.

9 These changes to the tertiary education system have created financial pressures and increased inequity, both of which are having a negative effect on the mental health of young people. International students are a sub-group of tertiary students, many of which have serious mental health problems. This is not solely as a result of financial pressures, but in adapting to studying in another country without the support of their families and in an isolating environment. These issues are being compounded by COVID-19, with international students not being provided with welfare benefits from the Australian government and also having difficulty returning to their home country due to the lack of flights out of Australia.

10 COVID-19 has also thrown the whole tertiary sector into turmoil because the dependence on international students and their absence now in the post-COVID world has struck at the heart of the business model. It presents a major challenge for government and for the University and Tertiary sector but students will suffer the impacts of this.

11 Climate change greatly affects young people's sense of security and had led to a worldwide movement to enact change. Many of the other risk factors for mental health are the stable generic factors such as family stability, family mental illness and addiction.

12 A way of preparing and responding to these mega trends is to address the issues that are leading to greater social inequity. Richard Wilkinson and Kate Picket mapped the consequences of worsening inequality in their book *'The Spirit Level: Why More Equal Societies Almost Always Do Better.'* (2009). Their sequel 'The Inner Level' (2018) maps more specifically the impact of inequality on mental health and points the way to a more mentally health society.

13 The background to these mega trends is that the transition from puberty until mid-20s is a highly challenging period developmentally. Young people at this age are grappling with identity, independence from family of origin, establishing a peer group and possibly a life partner. These developmental tasks are being faced in a much more challenging and much less supportive environment than perhaps 40 or 50 years ago when the pathways to adulthood were very clear and mapped out and the supporting frameworks

or “scaffolding” were more solid and secure. There was less freedom and there were more restrictions, but more certainty. Perhaps now there is more freedom and flexibility but much less support and scaffolding around young people as they mature and become independent. The scaffolding is fragile and can be blown apart, collapse or fall away very quickly, especially in the face of mental illness.

Effects of prolonged quarantine or social distancing measures on wellbeing and mental illness

14 COVID-19 is different to other global disasters that have preceded it because it has forced us to behave in complete opposition to our need of societal and physical connections with each other. It is very damaging for our mental health.

15 There is a strong evidence base on the importance of attachment and loss. Separation, loss and trauma are very destructive forces for creating mental ill health and mental illness. Social distancing is causing separation of people from each other which causes anger, anxiety and depression. We are all suffering from a form of separation anxiety at the moment – separation from the things that make life worth living such as connection with the natural environment, physical connections and being physically fit. Many of the protective factors that we rely upon to keep ourselves mentally healthy have been stripped away and we are trying to survive.

16 We know from past research and under the circumstances I have outlined above, there will be an increase in new cases of mental illness and relapses of existing cases to a level of approximately 20-30%. The second wave of the pandemic will be mental illness – Orygen’s detailed recent modelling of this indicates that COVID-19 will lead to a 30% increase in mental illness which will extend for several years.

17 There are some upsides to the situation. For families that have previously suffered from not being able to spend enough time together, this period might be beneficial. For some people with serious mental illnesses or health conditions this way of living represents their normal lifestyle and in some ways validates it. However, for most people the social distancing and quarantine measures have been a substantial shock and are causing people to ask how long we can survive and live this way.

18 These effects can be mitigated to some extent with the aid of connecting technologies and other coping strategies however these may have a use-by-date.

Emerging changes to practice in mental health service delivery as a consequence of COVID-19

19 COVID-19 has affected everyone in a universal way. It has threatened everyone's sense of security and their mental health. It might be a starting point to prompt people to consider what kind of society we want to have in the future.

20 It has created opportunities such as making telehealth a viable option. Furthermore, we have been treating patients through a digital platform developed by my colleague Mario Alvarez, moderated online social therapy ('MOST'), which has been backed by the Victorian government. The content in the platform can be populated according to the diagnostic problem you are working on. We have used the MOST platform in normal diagnostic groups from schizophrenia and psychosis through to anxiety, depression and eating disorders. The system of care is flexible. The platform allows people to design their own therapeutic journey assisted by the program, artificial intelligence and by clinicians. The platform creates a community of people who support each other online and is moderated by clinicians and peer workers. It helps people connect with others in dealing with issues such as loneliness and isolation in between therapy sessions. Consequently, it provides people with a bigger safety net and another avenue for recovery.

21 Although some organisations and commercial entities are trying to replace face to face care with telehealth approaches, they are only going to work properly if they are complementary and augmenting face to face care. People still need human contact and people with severe and complex forms of illness need a multidisciplinary team approach to their therapy. I discuss these further below at paragraphs 59-60.

Emerging changes in demand for mental health services as a consequence of COVID-19

22 The initial impact was for people to withdraw and not seek help. Staff also withdrew into telehealth which was provided to a variable extent and especially favoured by federal changes to Medicare. Service delivery shrank and EDs were depopulated of mentally ill patients. The goal then was to build other options so they did not return to EDs at the only port of call. It is unclear whether this will be done. Careful scientific modelling by Orygen indicates a 30% increase in need for care building in the weeks and months to come and sustaining for several years. This is a combination of the acute impacts of COVID-19 but most powerfully driven by the socio-economic effects of the disaster, especially unemployment and educational failure.

Adapting suicide prevention strategies in Victoria in light of the COVID-19 pandemic

23 There is an urgent need to access real time surveillance data for suicide so that immediate post-vention strategies and responses can be deployed. This is currently only possible for schools to the extent that headspace school support is resourced to respond. School principals notify headspace national when a presumptive suicide occurs and the response team goes in to support the community and prevent contagion. This should happen on a statewide and national basis for all age groups. There are efforts nationally to progress this but I have doubts that it is being progressed as rapidly as it could be. The issue could be fast-tracked if suicide were made a notifiable event in all states and territories and a central agency either at state level or national entrusted with this data and a coordination role with local responses.

Community model of care

Staged and person centred care

24 I have spent the last 15 years at Orygen working on a model of how we can move mental health services to providing staged and person centred care. I have published a book with Ian Hickie on clinical staging.[3]

25 Based on our earlier research on early intervention in psychotic illnesses like schizophrenia, we observed that the same pattern that occurs in physical illnesses like cancer also occurs in mental health. That is, even if you do not cure the illness, you can improve the level of functional recovery and the prospects for a normal life through early treatment. You can also use simpler and safer treatments at an earlier stage of illness. We sought to extend the application of this approach from schizophrenia and psychosis to see how widely we could apply the principles of clinical staging and early intervention in mental illness. Through research we have established that early intervention and clinical staging are applicable to any mental illness that has the potential to become persistent and enduring, including anxiety, depression, bipolar, personality disorder and eating disorders. Currently, our grossly underfunded mental health system works in the opposite way by waiting for people to get sicker until the system responds. It is largely focused on stages 3-4, rather than placing a premium on stage 1 care and still solidly supporting the later stages including palliative care. In other words, turning people away until there is no option but to treat them because of risk or severe disability. This is in contrast to the approach taken for most other non-communicable diseases ('NCD') such as cancer, diabetes and cardiac disease.

[3] McGorry PD, Hickie IB, Eds. Clinical Staging in Psychiatry: Making Diagnosis Work for Research and Treatment. Cambridge, UK: Cambridge University Press; 2019.

26 Staged care can be distinguished from the popular notion of stepped care, which is a model that has been popularised by the advent of the fatally flawed primary health network model ('PHN'), but is essentially a covert strategy for demand management and underservicing. Stepped care only offers the opportunity to progress to the next step in the ladder if a patient has failed, deteriorated or become more severe at the previous stage of their illness. The model is not proactive; it does not try to pre-empt progression of the disease or illness where staged care in cancer and other illnesses does. The other distinction from stepped care is that clinical staging is an evidence-based model. Stepped care is an ad hoc approach which appears to have face validity but little data to support its value. I am reluctant to say that judgements about healthcare models should be based on cost effectiveness, because that is clearly not used to ration expenditure in cancer, COVID-19 infections or indeed any other area of physical medicine where the heart rules the head every time. When it comes to mental illness both the heart and the head have been found wanting. Yet there is compelling economic analysis that demonstrates that staged care is also very cost effective. This is particularly the case because mental illness strikes early in a person's life; 75% of people suffering from a psychiatric disorder have experienced its onset by 24 years of age.[4] If people do not recover from those illnesses, do not fulfil their potential or die, it is a massive disaster and a loss for society. And a raft of empirical studies support this contention.[5]

A new model for youth mental health in Victoria

27 My colleagues and I have developed a clinical staging framework for mental disorders specifically for young Victorians aged 12-25 years.[6] The key goal is to reduce the risks of progression from one stage to the next, through proactive yet proportional treatment at each stage. The model is weighted in best practice "soft entry" community-based mental health assessment, treatment and care for adolescents and young people.

28 The reason we have designed the program for this particular age group is because this age range is the most vulnerable in terms of the rates of onset and prevalence of mental illness. However, the age boundaries are not hard boundaries – some 13 and 14 year olds might be quite immature and would benefit from being retained in the children's

---

[4] 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; 62:593-603.

[5] McDaid D, Park AL, Iemmi V, Adelaja B, Knapp M. Growth in the use of early intervention for psychosis services: An opportunity to promote recovery amid concerns on health care sustainability. 2016; Mihalopoulos C, McCrone P, Knapp M, Johannessen JO, Malla A, McGorry P. The costs of early intervention in psychosis: restoring the balance. Aust N Z J Psychiatry. 2012;46(9):808-811; Mihalopoulos C, Vos T, Pirkis J, Carter R. The economic analysis of prevention in mental health programs. Annu Rev Clin Psychol. 2011;7:169-201.
15. Phillips LJ, Cotton S, Mihalopoulos C, et al. Cost implications of specific and non-specific treatment for young persons at ultra high risk of developing a first episode of psychosis. Early Interv Psychiatry. 2009;3(1):28-34; Mihalopoulos C, Harris M, Henry L, Harrigan S, McGorry P. Is early intervention in psychosis cost-effective over the long term? Schizophr Bull. 2009;35(5):909-918; McCrone P, Singh SP, Knapp M, et al. The economic impact of early intervention in psychosis services for children and adolescents. Early Interv Psychiatry. 2013;7(4):368-373; McCrone P, Craig TK, Power P, Garety PA. Cost-effectiveness of an early intervention service for people with psychosis. Br J Psychiatry. 2010;196(5):377-382.

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

system, while some 11 year olds might already be experiencing adolescent types of issues and conditions. The model we have designed is bespoke to an extent for young people but many features are also largely translatable to an adult community mental health system.

29 Our proposed model for youth mental health in Victoria ('Model') provides a comprehensive, seamless and integrated clinical service system across:

(a) a range of mental health conditions;

(b) severity of presentation from mild to moderate to severe;

(c) degree of complexity, including comorbidities with physical health conditions and substance use; and

(d) primary, secondary and tertiary levels of care.

30 The Model consists of eight principles, eight core service components and six critical enablers shown below.

Principles	Core service components	Critical enablers
• 'Yes we can help' • Young person centred • Best available scientific evidence • Shared decision making • Relational and engagement focused • Socially inclusive and culturally accessible • Trauma informed • Family inclusive	• Youth and family lived experience engagement • Front end – entry and engagement • Integrated and networked service centres • Extended response service and assertive outreach • Access to youth friendly acute services (inpatient and bed alternatives) • Access to youth specific sub-acute beds • Community engagement and case detection • Digitally enhanced care	• Statewide oversight Governance • Leadership • Culture • Translational research • Vertical and horizontal integration • Resources (workforce and funding)

Supporting people with milder presentations to appropriately self-manage their mental illness and seek professional help when needed

31 The front end of the Model involves creating an environment in the community where there is increased knowledge and awareness about how mental ill health develops and when the appropriate time is to seek help. Educating the public generally, and young

people in particular, in mental health literacy is a key aspect of this. The Model is designed to strike the right balance between ensuring that people do not delay in seeking help for a risky or potentially persistent problem, while avoiding people seeking help for trivial reasons, or where peer or family support and self-help might be sufficient for a brief time-limited problem.

Improved entry points for young people into mental health services

32 When young people do seek help, there should be several ways to do it. Component two of our Model is front end entry and engagement, 'the Front Door.' Front end entry would be physically based at integrated service centres using one multimodal (face-to-face, phone, internet) clinical system to facilitate accessible, coordinated and seamless services. For young people accessing the service in person, the physical design of the entry foyer is crucial and includes a youth café, open spaces and no visual barriers such as reception desks. It is important that the space is informal, flexible and youth friendly while having real clinical expertise sitting behind that within the same venue. Such venues should also be able to provide drop-in and social and health promoting programs in group mode and leisure activities to promote engagement and a holistic approach.

33 In addition to the physical integrated service centres, it is important to have other soft entry points available for young people. These would include seeking help through health professionals on school campuses (e.g. school counsellors, GPs and psychologists), walk in services and drops in, family and brief interventions and through local service partnerships and community programs. Contrary to some views, this will not result in an overwhelming increase in demand because people are generally reluctant to seek help. Service models have to take affirmative action and be very "magnetic" and welcoming to overcome this reluctance to seek help. For this reason, it is also vitally necessary to provide outreach services, which I discuss below at paragraphs 69-76.

34 The Model includes integrated service centres that have GPs, allied health professionals, drug and alcohol expertise and Individual Placement and Support ('IPS') or vocational workers to help young people with their studies or employment. Headspace was developed because traditional GP clinics were simply not youth friendly and many young people are physically healthy and less likely to have a relationship with a GP. However GPs who do detect mental ill health in young people also need back up from these focal points in a community and can still play a role in shared care as part of a team based approach.

35 In contrast to young people, most adults have an existing relationship with a GP. Instead of a new or improved entry point, adults need rapid access to specialist multi-

disciplinary teams, like a community health centre setting. There may be exceptions to this, for example in rural and regional communities where it may be more difficult to access federally funded programs for mental health. The expansion of telehealth may help to solve this problem.

The role of youth peer workers and volunteers in a future child and youth mental health system

36 Youth peer workers and volunteers have an essential role in the child and youth mental health system. For this reason, a core service component of the Model involves a commitment to the inclusion of young people at all service levels and engagement in aspects of service governments. This means there will be partnership, co-designing of services and co-implementation through all stages of care and models of service delivery, including:

(a) youth and family engagement strategies across all aspects of the Model, including program and service design, decision making in services, development of new interventions and programs and their implementation;

(b) the employment of youth peer workers and family peer workers; and

(c) engagement of a broader volunteer workforce and network of advisors and advocates.

37 Headspace in its current form would be improved by having more youth volunteers and peer workers involved in the initial contact or primary care setting. We have observed this in other countries. For example, the headspace equivalent in Maastricht employs 70 young volunteers to make the initial contact and the clinician drops in at the end of the interview and organises the follow-up if necessary. This also helps to normalise mental health care and connect the local community to the endeavour of reducing the impact of mental ill-health and suicide.

Essential design features, elements and service offerings in inpatient units for children and youth

38 Ideally, the future mental health system will have much stronger upstream services and preventative community care so that people do not get to the point of a severe acute relapse. Current acute inpatient facilities have been jerry-built cheaply and crammed into car parks and narrow spaces of major hospitals. This contrasted with the wide open spaces and natural beauty of the old asylums which was one of their few positive features which has been lost. The acute units in general hospitals have been allowed to run down and fall apart over the last 20 years so that they are now dilapidated and demoralising places to reside or work in and are actually shockingly worse than the old

mental hospital wards that I trained in during the 1980s. As the culture of the mental health system and particularly inpatient units has been under increasing pressure, it has become much less therapeutic and far more risk focussed. Risk will always be present, but the best way to manage risk is to help all patients get better. Most of these units are traumatic for patients and staff alike and seclusion and restraint which under optimal conditions can be greatly reduced or abolished is at an all time high.

39 The existing inpatient units need to be mostly decommissioned and rebuilt with genuine co-design with consumers, staff and families. They need to be properly staffed and backed up by a broad spectrum of residential services and much stronger pre-emptive and pro-active community services as a safety net. Services such as PARC and community care units need to be strengthened and the therapeutic model reconceived, as they are slower stream and can be very therapeutic. By contrast, the acute units are essentially just risk management units and are quite a toxic and traumatic experience for most patients. Consumers have very negative experiences in acute units and staff are traumatised by working in them. Consumers would appreciate a system with more heart and compassion as well younger, more optimistic and skilled staff which is itself a product of good morale and great leadership; one that is warm, compassionate and caring and where clinical leaders walk the talk. This is a cultural shift for practitioners that we need to emphasise and help them to achieve.

Hope cafes and crisis lounges

40 The concepts of hope cafes and crisis lounges need to be given much more consideration as currently they are peer run without much clinical expertise. They are a desperate but reactive step aimed at diverting patients from EDs which are not fit for purpose for the acutely mentally ill and suicidal patients. They need a rethink however and clinicians need to be side by side with the peer workers and volunteers. The Federal Government has funded the first 8 versions of a new model of adult community hubs aimed at covering the 'missing middle'. The adult mental health hub concept was formulated as a way that moderately complex but not severely ill people could get ongoing care. Service design and development are underway and this model could attract both state and federal funding and play a pivotal role in a new system of care.

Frameworks for determining how much of what type of care each consumer receives

41 The National Mental Health Service Planning Framework considers the question of how to determine how much of what type of care each consumer will receive. The framework considers what percentage of need in different groups of consumers is reasonable to address, concluding that it is approximately half of the people with very mild conditions, 70-80% of the people with moderate conditions and 100% of the people with severe

conditions that need care. These figures are still reactive and ideally the system would offer care to more people with mild to moderate conditions to prevent the conditions becoming severe. However, it is a great step forward to have benchmarks.

42 In northwest Melbourne, Orygen's modelling indicates that there are 90,000 young people in our catchment area of 1.5m plus who would meet the criteria for a mental disorder in any given year out of approximately 300,000 young people living in the area. We are currently able to treat approximately 6,000 young people in the existing headspace and state system and some others may be receiving treatment through their GP, allied health or school counsellors. This means that we are only providing care to a small minority of the people who need it. However, we have to weigh up how many people will actually seek help and whether that help is clinically based as opposed to self-help or spontaneous resolution of the problem. Even assuming that many conditions would resolve with self-help or be self-limiting, the level of unmet need is high. The system needs substantial expansion. There are over 300 high schools in this region and these have an annual budget of $10-20m per annum. The State Government's investment in specialist mental health for young people for this same region is around $25-30m in total. Federal investment is substantially less than this. So growth of several orders of magnitude is clearly warranted.

Strengths and weaknesses of the current approach of having health services responsible for the delivery of both bed-based and community based mental health services

43 The mental health system has suffered from being broken up and moved to the hospital networks as a result of deinstitutionalisation. The promise was that embedding the mental health system in mainstream services would reduce stigma, improve the medical care of patients and allow mental health an equitable share of the resources. None of these things have happened and it has been a massive failure. The health networks have failed to demonstrate a commitment to improving mental health care and essentially use the mental health block funding structure as a cash cow to prop up the rest of the hospital operations when budgets are overrun in other areas of the hospital network. This has been going on for years in Victoria and in other jurisdictions, and evidence has been given at the Royal Commission to confirm this has been happening. While there may be a symbolic benefit to having mental health perceived to be on an equal footing to physical health through 'mainstreaming', the reality is the exact opposite. Mental health care has become an even poorer cousin than when mainstreaming commenced and the safety and quality of care has declined especially in the past 15 years. The only viable solution is a separate and watertight financial and governance structure to protect the funding and nurture and improve the safety and quality of mental health care. .

44 The relative shrinkage and retreat in the face of escalating demand in the current system means that services are rewarded for waiting until people get really sick before they treat them. People are only treated when it is no longer possible for treatment to be withheld. Due to low resourcing and inevitably poor work culture, every conceivable barrier is placed in their way before this happens. Instead, the system should provide incentives that support intervening earlier through both carrot and stick approaches. This may involve financial incentives such as higher rebates for psychiatrists offering home-based treatment or working within a multidisciplinary team, and increasing the baseline salary in public health so that psychiatrists do not leave to work in private practice. And more money for services who meet targets in terms of activity and timeliness of action. While the carrot approach is usually preferred, the stick can also be useful. For example, in the UK hospitals are penalised through an NHS trust if patients wait longer than four hours in ED. Similarly, the NHS trust is penalised if patients with a recognised psychotic illness are required to wait more than two weeks to be seen. In fact, in safety terms, this should be hours not days or weeks as with chest pain or breast lumps.

45 Aside from financial incentives and penalties, health services also need to build a more optimistic and positive work culture. It would be empowering if psychiatrists were more involved in leadership, administration and decision-making in a more genuine way rather than marginalised into purely medical domains. I discuss this further below at paragraphs 146-147.

46 Mental health benefits from being seen as a branch of the health system and if it were seen as purely a social or welfare service there would be even less funding available. However, it is not treated as a respected or equal division within health compared to the other major NCD areas like cardiovascular disease and cancer even though it rivals these as a cause of burden of disease. Even though mental health is the largest cause of disability in Australia it is much less well funded than physical disability via the NDIS. It seems physical health problems are valued much more highly, and deaths from suicide are clearly seen as of lesser importance than deaths from COVID-19 and cancer for example. This supports the need for a new financial model for funding mental health care, and governance and financial protection of mental health care in the health system. And a model that integrates health (blending mental health and substance use disorders) and social care under one envelope and system.

Defining characteristics of 'good service integration' between service providers and the benefits of vertical and horizontal integration of child and youth mental health services

47 Vertical and horizontal integration enabled through centralised governance and clear leadership is critical to good service integration, and is a critical enabler in our Model. This involves integration across:

(a) Streams of funding (State, Commonwealth (MBS and other), private, PHI, NDIS, philanthropic and other research funders nationally and internationally). Given the interconnected and interdependent nature of bringing together service-related funding pools it is critical that budgets should be tightly ring fenced to protect resources and budget allocations should be made recurrent.

(b) Operational tools required for success such as IT, human resources and finance. For example, facilitating timely access to services between the front end system and across say 5-6 integrated service centres will require an integrated and coordinated information system across a geographical region. Smaller clusters and devolved models will be required for regional Victoria. This includes use of one medical record, secure messaging systems and interoperability across Electronic Medical Records platforms and data collection systems.

48 In order to deliver proactive or pre-emptive specialised care, the centre of gravity for specialist mental health services needs to be close to the primary care services instead of being mired in the middle of a large hospital campus. That is the worst possible centre of gravity for acute services. Beds should be seen as a small distinct resource that is drawn upon when needed. Having vertical integration would mean that instead of simply having co-locations, services are clinically led structures within a single clear governance.

Mechanisms and structures to better integrate community based and acute mental health services to create pathways for people living with mental illness

49 Currently there is tremendous fragmentation across the State in relation to PHNs, NGOs and drug and alcohol services. The idea behind PHNs was to apply market philosophy to the provision of mental health care so that people compete for tenders and resources. While the rhetoric has been to plan and integrate mental health services the result of the competitive tendering ideology and model has inevitably fragmented a very poorly funded system even further into smaller inefficient pieces, and this is very bad for patient care. The Drug and Alcohol system has declined from a clinically based and better funded base into a smorgasbord of dozens of deprofessionalised non-

evidence based programs with very poor outcomes and a reactive model of care which makes these outcomes inevitable. I discuss this further below at paragraphs 96-102.

50 Services should be commissioned with integration as the principle, meaning integrated practice units with single clinical governance, as described by Michael Porter from the Harvard Business School.[7] Instead of co-locations and service agreements, there would be multi-disciplinary leaders who are accountable for a system of care.

51 Our proposed Model involves multiple integrated and networked centres that better integrate community based and acute mental health services. Each integrated and networked centre would provide a 'one stop shop' model of treatment and care, offering a full range of services across the spectrum of mental ill-health (mild-moderate-severe) and complexities. The service centres would be multi-disciplinary not just in a health sense, but in a social sense as well with the proper inclusion of vocational workers, educational workers and drug and alcohol workers as core team members, instead of these workers dropping in once a week as contractors.

Providing flexibility in commissioning arrangements to respond to local needs while still ensuring fidelity to system wide expectations and equity of access between different populations

52 My experience on the topic of commissioning has been forged by what has been done at the federal level and what I have learned and witnessed over the years in the UK and Canada. When headspace was set up, we commissioned it across the whole country from the central office in Melbourne. A template model was designed and, when an area was identified by the government as being awarded a headspace centre, a competitive process was set up by the national headspace office. A lead agency would put together a consortium from that region to bid for the headspace, and they would provide information on local demographics and other special features required. Other bids would be formulated with competing lead agencies. A key aspect of the process was that the bidders could not change the core model, e.g. they could not remove vocational workers from the program by saying it was not appropriate for a particular community. They could however propose additional elements if there was a special local issue. This ensured that commissions were prohibited from throwing out evidence-based components of the model and reducing fidelity. The process was extremely successful and resulted in headspace scaling up rapidly and successfully with a common brand across the whole of Australia. It was recognisable and the positive culture was palpable and reproducible as well as having an appropriate degree of flexibility.

[7] Porter ME, Lee TH. The strategy that will fix health care. Harvard Business Review (Boston), October, 2013; 50–70.

53 PHNs were set up in 2016 under the mantra that it was necessary to plan and commission services according to local needs as if each community in Australia had little similarity to any other. This sounds good in theory, however the PHNs have been singularly inefficient and unsuccessful. It has resulted in local bureaucracies that comprise the many of the familiar faces from the last 20 years of divisions of general practice and Medicare locals and with the same issues and dysfunction but rebranded. The big difference is that PHNs are commissioners not service providers or coordinators and have the responsibility for allocating large volumes of taxpayers' funds. PHNs chew up a lot of government money and essentially represent the privatisation of commissioning. They have government contracts but these are loose and high level and there is a serious lack of transparency and accountability regarding decision-making, and no way of appealing their decisions as they are not subject to the Administrative Appeals Tribunal or other regulatory processes. This lack of transparency opens up the system to the potential risk of conflicts of interest being concealed for personal advantage, and there are examples of this in the public domain and it is possible that there are many others which have not yet seen the light of day. Similarly negative conflicts of interest are likely to operate behind the scenes as well with little scrutiny applied. When taxpayers funds are at stake there is no role for private companies to be conducting the commissioning process.

54 PHNs are also slow and inefficient and frequently lack expertise in many areas of their mandate. One may point to positive programs that they have created however these have emerged despite rather than because of the model of commissioning through the work of individuals with talent and ability.

55 Despite the rhetoric which accompanied their birth, the PHNs have not tailored services to local needs; they typically lack the capacity or the skills to do that. What has been sacrificed in the process is a commitment to standardisation, reliability and evidence-based care which are the cornerstones of modern health policy. There should be a centralised commissioning model which certainly needs the ability to consult and listen to local needs to shape the service but safeguards the evidence based integrity of the model of care. That has worked well at headspace until 2016 and has to a reasonable extent survived the transition to the PHN model because of the ring fencing of the headspace funds in a non-flexible funding pool within PHNs. For example, 45% of the clientele at the Collingwood headspace identify as LGBTIQ, whereas that is very different to the needs of the clientele in Glenroy where I work so that headspace has a number of different practical and cultural features. There needs to be an ability to adapt to local needs without sacrificing core features.

Ensuring the physical health needs of people with a mental illness are understood and treated, alongside their mental health needs

56 Apart from the reduction in life expectancy from suicide, the major cause of loss of life expectancy for people with mental illness results from increased risk of other major medical problems like heart disease and cancer. This group is at a higher risk of major medical problems and yet they receive poorer quality medical treatment. This is another failure of the 'mainstreaming' of mental health services. Life expectancy should have improved by operating mental health services through general hospitals but this has actually worsened if anything, resulting in a major reduction of life expectancy of 15-20 years[8] as I mentioned in my witness statement last year.

57 The first way of addressing this issue is by reducing risk factors for physical health such as poverty, smoking, substance use and obesity. The issue of poverty could be addressed by enabling more people with mental illness to work via vocational support programs such as IPS (Individual Placement and Support) and not be on welfare payments. This is definitely possible in a substantially higher proportion of patients. Exercise physiology and related programs, anti-smoking and integrated drug and alcohol programs would target other key risk factors but are rarely funded or implemented. Mentally ill people smoke a substantial proportion of all the cigarettes smoked in Australia and this also adds to their poverty. Very little effort goes into this issue. Physicians in other domains of medicine have largely neglected mental illness as a risk factor for other NCDs like cancer, cardiovascular and respiratory disease and diabetes. This is a manifestation of discrimination within medicine and a failure of the mainstreaming of mental illness with acute hospital systems.

58 The second aspect is ensuring that people living with mental illness are provided with access to medical care when their physical health problems start to develop. Currently, both GPs and psychiatrists alike are more focussed on treating the person's mental health issues, thereby overlooking and sacrificing their physical health. In our Model, the proposed integrated and networked centres that I describe above at paragraph 51 will have in house GPs as well as connecting to the wider local network of GP practices. That means that every patient who comes in for an appointment with a multidisciplinary team not only sees a psychiatrist, case manager and vocational worker, but also a GP. That is what we aim for at headspace. We need to bring the medical services into the mental health platform and not rely on it happening in a random way outside of that.

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

Digital technology

59 Sometimes digital mental health services are marketed as the 'solution' to mental health and are seen as something that will remove or reduce the need for face to face treatment. This has been further popularised during the pandemic as telehealth and digital were expanded. However, digital technology will never remove the need for face to face services – both online and face to face services need to be expanded; they are complementary and synergistic.

60 It is vital that digital mental health services are supported by evidence. Consumer choice is a powerful force and products need to be developed that connect with the consumer movement, however they also need to work. Currently, the attrition rate for standalone population-based apps is appalling. People will engage for a short while and then drop out. Digital technology would benefit from more investment in R&D. It is a space that needs a different modus operandi to spark innovation, as opposed to the clinical services environment which is structured, formal and risk focused.

61 Orygen has worked for 10 years to build a scientifically based research and development program led by Professor Mario Alvarez and funded by NHMRC and a range of other grants. A range of products have been developed which integrate with face to face care and which are now scaling up across headspaces and CYMHS services in Victoria with Victorian Govt support.

Missing middle

Roles and responsibilities of the Victorian and Commonwealth governments in responding to the 'missing middle' in the future

62 The current stepped care approach in responding to the 'missing middle' essentially involves two or three 'steps' at most, and they are weak steps. The weak or non-existent middle steps mean that people move from primary care to ED – it is an ambulance at the bottom of a cliff. The Victorian and Commonwealth governments need to build the steps in the ladder and allow people to move up and down them as they need.

63 Recently, Orygen and headspace proposed to the Federal Government with KPMG's modelling and support to strengthen headspace model to become 'headspace plus'. We would like the Federal Government to add more specialised resources at the backend of each headspace as they have already done in relation to psychosis in 6 regions of Australia. Headspace and Orygen were provided with funding under the Gillard government in 2013 to develop the headspace early psychosis model which meant that people with emerging psychotic illnesses were able to receive specialised care over five years within the headspace environment and with headspace as the entry portal. We

are now advocating for this to be extended to all diagnostic groups and for the funding to be linked to headspace centres.

64 The primary care system needs to be able to work with community platforms, whether they are integrated or not, to provide medium to long term care for people with complex and persistent illnesses. The State Government has some capacity to do that where there is a community mental health system, however the mental health system is now so degraded that currently it just offers risk management and medication provision. Building a strong integrated service hub in close proximity to primary care is the solution to the missing middle. There needs to be a runway of longer term multidisciplinary care, or something additional to the basic Better Access program provided from the federal primary care level upwards.

65 Part of the difficulty in solving this issue is that it falls between the two governments. The Federal Government is reluctant to step into the more specialised community mental health space and the State Government is reluctant to step too far away from EDs, hospital beds and the acute end at the bottom of the cliff. The wide gap between federal and state responsibilities is a deep-seated problem in Australian health and is much wider and more problematic in mental health compared to other NCDs because of the dependence on community treatment as part of the model of care. There needs to be a common purpose between federal and state. COAG meetings on mental health and the National Mental Health Plan that is revamped every five years in a rather futile manner are processes that have failed to achieve any progress. The 5th Plan like most of its predecessors except the first one, is merely a wish list without timelines, funding or accountability.

Service providers working together to respond to the 'missing middle'

66 Orygen is essentially a translational research institute and also a service provider that transcends the federal and state divide by being funded by both levels of government. We are seeking to extract the governance of the state funded service from the LHN (Melbourne Health) and integrate it fully with the governance of our Commonwealth funded service under one health service framework. This can be achieved via a direct health services agreement with the State Government independently of Melbourne Health. This is only way that the efficiency and quality of care within a single welcoming culture of care can be assured.

67 The Productivity Commission has recommended having regional commissioning bodies that pool Commonwealth and state funds and commission services that people need using both sources of funding. Those bodies would replace the PHNs which are purely federal commissioners. Alternatively, the PHNs could be redesigned into a commissioning structure that also uses state funds, however I would not be

recommending that approach. As mentioned above at paragraph 53, the PHNs are private companies that are too devolved with no control. The regional commissioning model has positive features but would not safeguard nationally relevant evidence based approaches such as early psychosis and headspace. National oversight and state oversight are essential.

68 The ideal approach is to have a co-commissioning structure that is centralised but has a way of blending federal and state money, with a national overlay. We have learnt at headspace that the needs across Australia are more common than they are different, according to different communities. The national overlay involves creating a template model based on principles of scientific evidence. There could still be state and regional based co-commissioning structures. Beyond Blue is a great example of pooling state and federal funds to create a structure that performs a national role. It was successful because the federal and state governments both retained an element of control. So a "2 green light" model would be required with a veto on each side of the equation.

Role of crisis outreach teams

The role of crisis outreach in the mental health system of the future

69 Crisis outreach is essential in the mental health system of the future. A lot of young people who are developing mental health problems will not necessarily be able to get over the moat and seek help; they may be house bound with anxiety, paranoia, psychosis or other mental health problems. The Royal Commission will be judged in part upon how successfully it reinvents, revitalises and redesigns the mobile assertive care world. When done properly, crisis outreach has high levels of consumer satisfaction.

70 There are two aspects to crisis outreach. The first is assertive community treatment ('ACT') which is case management done in a mobile and intensive way for people who are more complex and difficult to engage. It involves ongoing management and care. It is evidence based and highly effective, but it is not really done anymore. The second aspect is CAT or crisis resolution teams. CAT teams are highly evidence based, largely from studies done in the UK and New South Wales. Victoria enthusiastically embraced this model in the very early years of the deinstitutionalisation period in the 1990s. However, they have become a shadow of their former selves partly due to being overwhelmed with demand and underfunded, and partly due to poor work practice and culture. These team based evidence based strategies were replaced by non-evidence based strategies which located the centre of gravity in emergency departments, which there is no evidence for and which has increased harm and risk.

71 An innovation that will strengthen and protect the fidelity and integrity of the home model is the Hospital in the Home ('HITH') concept. HITH provides care in the young person's home or usual place of residence that would otherwise need to be delivered within a hospital to an admitted patient. The program involves a mandated amount of visits each day with clinical expertise including psychiatrists, and is properly resourced by government funding. The funding is proportional to the number of beds the HITH service commits to providing. This is in contrast to a CAT team where the output is very ill defined. Under the HITH model, practitioners are required to make a certain number of visits a day to patients in need which can be quite intensive and involves teaching the family what to do when the practitioner is not there. The care is much more regulated and specified, similar to an inpatient unit. It is a diverse multidisciplinary team which includes peer workers, nurses and allied health staff, and a pharmacist.

72 The HITH model will not work for everyone. Some families are not able to play that role, or patients may not have families. There are also certain circumstances where a presentation is too acute or risky to be managed in the home, such as an acute manic episode when a person has a lot of energy and they are disruptive in the home. Regardless, the model is a good conceptual advance. It could involve a tail of flexible home visiting, with treatment tapering off as the episode resolves and the person needs less intense support.

73 Acute capacity like HITH needs to be based somewhere in the community setting, closely linked to the primary care platforms. HITH is included in our Model as an alternative to inpatient care in hospitals. Telehealth could also be woven into these models, as could digital health. None of these concepts should be considered in isolation.

How this compares with CAT team frameworks described in the 1990s

74 The mistake of the 1990s CAT team frameworks was moving them from community based settings into hospitals. When CAT teams were first set up they were in the community. Ideally, all the routine care of patients should be provided in the community, rather than in a large central hospital. They were also not protected from open ended demand and they became provider focused over time as did the case management system and work practices deteriorated to a minimalistic model which was insensitive and unresponsive. To be fair much of this was driven by unrelenting demand and burnout.

75 We are in the early stages of implementing HITH. As a result, it is not yet fully clear how it will differ from the CAT team frameworks, aside from the aspect of accountability and ringfencing from open demand. As mentioned above at paragraph 71, practitioners will

be more accountable, will have clearer expectations about output and will be protected from being overwhelmed by demand.

76 At Orygen, we have been allocated 15 beds for HITH to develop in the northwest. We also have a Youth Access Team, similar to a CAT Team, which covers 1.5 million people. That is one $3m team to cover 1.5 million people and several hundred thousand young people. By comparison, there are 300 high schools in our region which cost about $10-20m each. The YAT team is overwhelmed with demand. However, in relation to the 15 HITH beds, regardless of demand there will only be 15 beds. The care of those patients will have to be provided to a certain standard and will not be diluted. If that is not enough beds, which it probably will not be, we will report to the government on the number of beds required. We will not be forced to stretch the resources beyond what they are supposed to do.

Streaming and specialisation

Different streams of care that the system should account for

77 The typical mental health system manages different streams of care on the basis of acuity. Given the fluidity and descriptive nature of psychiatric diagnoses, there is a need for that because many of the treatments are trans-diagnostic. Our staging model has tried to take account of that. However, there are different subgroups of patients who have different or specialised needs according to their diagnostic complexion.

78 A lot of evidence has been developed through research within the current diagnostic boundaries. For example, clinical practice guidelines for schizophrenia or bipolar. At Orygen, we started with an early psychosis program that focussed on psychotic illnesses and developed many approaches and strategies specific to that diagnostic group. We then expanded our approach into youth mental health more broadly and developed the program for other streams such as mood disorders, personality disorders and substance abuse. There is a lot of comorbidity and overlap between those disorders. The other key point is that the human and development needs of young people are common across the diagnostic groups.

79 It is important to have diagnostic streaming up to a point, however it is best not to have specialist clinics such as schizophrenia and bipolar clinics that are too rigid. There needs to be a balance between having a needs and complexity based approach while also weaving in scientific evidence that is specific for particular patient groups. That is what we try to do at Orygen. We have specific services for early psychosis through EPPIC, a bipolar service and a personality disorder service for borderline patients. The clinical reviews are conducted within those streams even though the service structures are slightly more needs based.

80 As I mentioned above at paragraph 58, it is important that physical health expertise is brought within mental health services. For example, if you have a teenager with anorexia and depression, you want to be able to treat both of those problems using experts in both those areas. If a 55 year old person entered the public health system with diabetes, kidney failure and eye disease, all the different sub-specialty teams will be able to be involved in the treatment of those issues. We need the same diversity of expertise.

Key considerations that should determine who needs a separate 'stream' of care

81 The way the mental health system has historically dealt with people who need a separate 'stream' of care is by ignoring the problem that it is not set up to treat. In other words, if a person enters the public mental health system with schizophrenia, diabetes and alcohol and drug problems, they will probably only be treated for schizophrenia and the remaining co-morbidities will either be undertreated or ignored.

82 At Orygen, we have cross fertilisation of the different sets of expertise. For example, if you have borderline personality disorder and a psychotic illness, you will be in the psychosis program because we consider psychosis to be the dominant syndrome. However, you will also be allowed to see people who are experts in personality disorder. In order for co-treatment to occur, there must be expertise of different comorbidities within the same service system. Having this capability is vital as it is very common for people to develop multiple disorders in their life. For example, anxiety bleeds into depression which bleeds into substance abuse or personality disorder. It does not mean they are all completely separate disorders, rather they might be different expressions of the same underlying issue.

83 Developing expert streams of care means that clinical research should ideally be part of the landscape and expert subspecialising clinicians are leading them. The missing streams in public mental health care are Drug and Alcohol which is crucial, Borderline Personality Disorder, Mood and Anxiety Disorders And Eating Disorders.

Alternatives to streaming

84 We need a matrix model of stage/complexity with a pre-emptive stance. The streams are woven within that to allow for syndromal specialisation while allowing for common transdiagnostic needs to span all streams. Many interventions are not syndrome specific e.g. family support and vocational interventions.

Demarcation of age groups

85 The boundary age of 18 years old is the worst possible demarcation between youth and adult mental health services. It needs to be shifted upwards to 25 years old. The reason

for this is threefold. Firstly, the epidemiology shows that the peak period of incidence for new cases of mental illness tends to level off after 25. There is some compelling and ground-breaking new data from a Dunedin study in New Zealand by Avshalom Caspi and Terrie Moffitt confirming that 75% of mental disorders appear by the age of 25.[9] Secondly, developmentally most young people are still reliant on their parents well into their 20s, compared to previous generations where it was expected you would be independent by at least the age of 21, if not 18. So the definition of mature and independent adulthood has changed in recent decades as revealed by the work of Jeffrey Arnett on "Emerging Adulthood".[10] The third reason is the evidence that brain maturation is not fully developed until about the age of 25. One more issue is that with COVID-19 there is likely to be even more financial and other dependency of young people on their parents until well into the 20s and beyond.

86 By the age of 45, 85% of the population has crossed the threshold in meeting the diagnostic criteria for one or more mental disorders.[11] Only 15% of people can expect to reach the age of 45 without having developed a potential need for professional mental health care at least for a period and often for the long term. Some people would argue that this viewpoint is medicalising the human condition such that everyone becomes a mental health patient. However, that attitude is not held towards people's physical health and it should not prevent people with mental health conditions being treated. People are able to access physical health care on an as needed basis for short episodes or for more long term conditions without such ideological judgements inhibiting this. This attitude derives from an exaggeration of the effects of "labelling" which is understandable but can easily be overcome if the approach to and culture of care is changed.

87 As I mentioned above at paragraph 28 in relation to our Model, the demarcation of the 12-25 year old boundary for youth mental health services needs to have flexibility. Some children grow up faster than others and this is sometimes related to class.

88 It is now crucial that with the federal system having adopted the 12-25 model, state specialist services catch up and integrate with this. This reform is now being adopted in

---

[9] Longitudinal Assessment of Mental Health Disorders and Comorbidities Across 4 Decades Among Participants in the Dunedin Birth Cohort Study Avshalom Caspi, PhD; Renate M. Houts, PhD; Antony Ambler, MS; Andrea Danese, MD, PhD; Maxwell L. Elliott, MS; Ahmad Hariri, PhD; HonaLee Harrington, BS; Sean Hogan, MSW; Richie Poulton, PhD; Sandhya Ramrakha, PhD; Line J. Hartmann Rasmussen, PhD; Aaron Reuben, MEM; Leah Richmond-Rakerd, PhD; Karen Sugden, PhD; Jasmin Wertz, PhD; Benjamin S. Williams, BS; Terrie E. Moffitt, PhD JAMA Network Open. 2020;3(4):e203221. doi:10.1001/jamanetworkopen.2020.3221.

[10] Arnett JJ. Emerging adulthood: the winding road from the late teens through the twenties, 2nd edn. New York: Oxford University Press, 2014.

[11] Longitudinal Assessment of Mental Health Disorders and Comorbidities Across 4 Decades Among Participants in the Dunedin Birth Cohort Study Avshalom Caspi, PhD; Renate M. Houts, PhD; Antony Ambler, MS; Andrea Danese, MD, PhD; Maxwell L. Elliott, MS; Ahmad Hariri, PhD; HonaLee Harrington, BS; Sean Hogan, MSW; Richie Poulton, PhD; Sandhya Ramrakha, PhD; Line J. Hartmann Rasmussen, PhD; Aaron Reuben, MEM; Leah Richmond-Rakerd, PhD; Karen Sugden, PhD; Jasmin Wertz, PhD; Benjamin S. Williams, BS; Terrie E. Moffitt, PhD JAMA Network Open. 2020;3(4):e203221. doi:10.1001/jamanetworkopen.2020.3221.

over 15 countries worldwide and endorsed by the World Economic Forum (WEF/Orygen Project May 2020).[12]

Families and carers

Initiating and embedding models that develop consumer, family and carer engagement over time

89 The status quo at the moment is that clinicians feel there is a tension between the needs of the emerging adult and their family members. On one level, this is true because one of the tasks of adolescents is to create a separate identity from their family of origin and establish themselves as an independent adult. Of course, this is a western individualistic approach which is far less valued in traditional cultures which are more collective. Despite young people establishing their independence, most developmental processes still involve the young person remaining on good terms with their family and requiring the support of their family in making the transition to adulthood. They are usually vital scaffolding for the successful completion of the transition to mature adulthood and independent living.

90 At Orygen, I would estimate that 80% or more of the young people we see are on good terms with their families. Many of them are still living at home well into their mid-20s and family is a vital part of the scaffolding which does not suddenly disappear at 18. In that sense, the current system approach of regarding an 18 year old as an adult and not allowing family involvement is outdated and dangerous. Factors such as privacy concerns and confidentiality are cited as reasons for providing such individualistic treatment. However, sensible clinicians will involve the person's family. The family is usually the young person's main supporters, even more so if the person becomes mentally ill. In 95% of cases that I have been involved in, the young person is comfortable with the involvement of their family. If you speak to the young person and ask them what they are comfortable sharing with their family, quite often they are happy for their family to join the interview.

91 This is especially dangerous for graduates of statutory care where young people have been "emancipated" or actually "kicked out' of the system at 18. The casualty list of this neglect is shocking with high rates of suicide, incarceration, mental illness, homelessness and accidental death. The age for this transition is being raised to 21 but even this is insufficient for this highly vulnerable group who are massively overrepresented in mental health services.

[12] Killackey E., Hodges, C., Browne, V. Gow, E., Varnum, P., McGorry, P. & Purcell, R. (2020) A Global Framework for Youth Mental Health: Investing in future mental capital for individuals, communities and economies. World Economic Forum, Geneva.

92 The system needs to be reformed so that the status quo is involving families in the care and treatment of a young person. Clinical services need to be well funded to work with families. Some clinicians are underconfident and not properly trained in working with families and tend to exclude them through anxiety. They need to be upskilled to involve families effectively. In a small number of cases family involvement is not appropriate because the young person is not on good terms with their family or has been mistreated by their family in various ways – in that scenario it should also be acceptable for the family not to be involved if the young person is under 18 years of age.

Supporting the workforce to better engage with parents and carers of young people as partners in care provision and mental wellbeing

93 Supporting the workforce to better engage with families and carers of young people is an educational task and one that involves, philosophical, cultural and resourcing issues. There is very little funding for family peer work within the mental health system. To support a new model of care, these roles must be funded. The second shift that needs to happen is a cultural change on the part of clinicians to regard the family as an asset and a part of the necessary scaffolding of the building that is the young person. This involves educating and training existing clinicians to appreciate the importance of involving families and carers and changing the philosophy that care should be purely individualised.

94 A key principle of our proposed Model is that it is family inclusive. The Model promotes family inclusive practice, the requirement of which will vary for each young person and their families. The level of illness, prior experience with a service and the service context will all shape how family inclusive practice is delivered. The expectations of a family and their own need for support is also an important consideration in the delivery of family inclusive practice. Family inclusive practice needs to recognise that family does not simply mean parents but can include siblings, partners and other support people.

Balancing the interests of the person living with mental illness and the interests of families and carers

95 One of the main tasks of becoming an adult is to form a strong sense of one's identity as a separate individual from one's parents and family of origin. So there needs to be space for that to occur while not severing those relationships. This developmental task needs to be understood and respected while retaining the link with young person's support system in the care approach. This requires skill and a clear model of care but is eminently feasible.

Alcohol and other drug use

Best practice service response and consumer experience for young people with co-occurring mental illness and problematic alcohol and other drug use

96 The integration of the mental health system and alcohol and other drug ('AOD') services should have occurred 20 years ago. Both services were integrated in the old system on the same institutional campuses. However, during the Kennett era AOD services were separated from the system, de-professionalised and defunded so that the AOD system is now a fragmented mess of 73 NGOs with weak training and clinical skills and approximately five addiction specialists in the whole of Victoria. This is a disaster for people with AOD conditions who must fall to "rock bottom" before help is available. It is typically "too little too late" and purely on the terms of the provider not the consumer.

97 I recently wrote a perspective piece on this issue with Dan Lubman, the Executive Clinical Director at Turning Point and Professor of Addiction Studies and Services at Monash University. Our view and the view supported by all scientific evidence is that the interventions for alcohol and other drug use issues should be fully integrated within mental health services.[13] There is a very high comorbidity rate of co-occurring mental health and AOD issues. Approximately 60% of people with mental illness have an AOD comorbidity and in many AOD services close to 100% of people would have a diagnosable mental health condition. The point here is not that there is an overlap between the two issues – they are different expressions of the same problem.

98 The concept that the treatment of mental health is philosophically different to the treatment of AOD issues is driven by lay people working in the AOD area. There also appears to be a bizarre view held by the AOD sector that they do not want to be stigmatised by being associated with the mental illness sector. In reality, AOD issues are much more heavily stigmatised and seen judgementally by the public. This philosophical divide between the mental health system and AOD services has been fostered through ineffective government policy in my opinion, particularly in Victoria, and also by non-evidence based leadership within the AOD sector.

99 Currently, the model of care in AOD requires people to get to a point where they hit rock bottom and are at the end stage of their issues before they end being forced to seek help for the problem. Denial is a very common problem which the sector has no strategy to tackle. By this late stage of the condition, it is often too late, with severe physical complications and the person's social and financial life in ruins. A more holistic service that involves AOD, mental health and physical health wrapped up in the same

[13] Thomas M Kelly and Dennis C Daley, Integrated Treatment of Substance Use and Psychiatric Disorders, Soc Work Public Health. 2013; 28(0): 388–406. doi: 10.1080/19371918.2013.774673; Savic M, Best D, Manning V, Lubman DI. Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review. Subst Abuse Treat Prev Policy. 2017;12(1):19. Published 2017 Apr 7. doi:10.1186/s13011-017-0104-7.

preventive and pre-emptive envelope would provide the opportunity to intervene much earlier with AOD. The same model of care should be provided to mental health and AOD within the same system. Headspace already aspires to do this but lacks the right funding streams and expertise currently. The content of the interventions may differ depending on the presentation of the patient, but the overall model of care should be the same.

100 The following references are useful in the context of considering a best practice model for co-occurring mental illness and AOD treatment:

(a) Mark Deady, Emma L Barrett, Katherine L Mills, Frances Kay-Lambkin, Paul Haber, Fiona Shand, Amanda Baker, Andrew Baillie, Helen Christensen, Leonie Manns, Maree Teesson. *Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check review brokered by the Sax Institute* (www.saxinstitute.org.au) for the NSW Mental Health and Drug and Alcohol Office;

(b) NSW Health Mental Health Branch, Comorbidity Framework for Action - NSW Health Mental Health/Drug and Alcohol (1 April 2008), available at: https://www.health.nsw.gov.au/aod/resources/Pages/comorbidity-frame.aspx;

(c) Darvishi N, Farhadi M, Haghtalab T, Poorolajal J (2015) Alcohol-Related Risk of Suicidal Ideation, Suicide Attempt, and Completed Suicide: A Meta-Analysis. PLoS ONE 10(5): e0126870. doi:10.1371/journal.pone.0126870;

(d) Deady M, Teesson M, Kay-Lambkin FJ. Treatments for co-occurring depression and substance use in young people: a systematic review. Curr Drug Abuse Rev. 2014;7(1):3-17. doi:10.2174/1874473707666141015220608;

(e) Drake R E, Mercer-McFadden C, Mueser K T, McHugo G J, Bond G R. Review of integrated mental health and substance abuse treatment for patients with dual disorders. Schizophrenia Bulletin 1998; 24(4): 589-608.

Defining what it means to provide a fully 'integrated response' to individuals who have co-presenting substance use issues

101 The Centre for Addition and Mental Health in Toronto is one example of an organisation that provides both sets of expertise in AOD and mental health.[14] That allows them to provide an integrated response and means that patients genuinely have access to whatever they need. If the AOD problem is dominant with some mental health issues, the person will mainly be treated by the addiction team and vice versa. There is cross-fertilisation of practices within the one organisation. This fits into the streaming or matrix model outlined above.

[14] http://www.camh.ca/.

102 The mental health system and AOD services are more integrated and better funded in New South Wales. There are more addiction specialists in NSW because the State did not de-medicalise the specialty to the extent that they did in Victoria. The AOD system in Victoria is missing real clinical evidence based expertise.

Compulsory treatment

103 The mental health system has retreated to treating a core of patients that it cannot avoid treating. As a result, more people are ending up in such a state that they can only be treated on an involuntary basis. This is a pure reflection of under resourcing and late intervention. It also results in excessive levels of restraint and seclusion and the advent of wall to wall security staff in EDs and inpatient settings is a sad marker of this collapse. These measures now appear necessary for staff safety and are difficult to wind back however if upstream care were effective much smaller numbers would end up in involuntary care and seclusion and restraint would be virtually abolished. This has been achieved in some jurisdictions overseas.

104 The solution to reducing the rates of compulsory treatment would be a well-resourced system that is proactive and pre-emptive to avoid patients getting to a point where they require involuntary treatment. It would be difficult but perhaps not impossible to abolish involuntary treatment altogether as there are some forms of mental illness where people completely lack insight even from the beginning. However, most people who get to that point have been through a phase where they could have been engaged and persuaded to seek help earlier.

105 The system needs to be properly resourced to enable early intervention and pre-emptive care to be a possibility, if not the preferred approach. The other aspect is incentivising care by rewarding short durations of symptoms before intervention and penalising delays between the time when a person is identified as requiring care and when they are offered care. For example, the duration of untreated psychosis is a measurable variable in the UK that is used to reward or punish services depending on the length of the variable, as I mentioned above at paragraph 44.

Forensic mental health

Responses to people living with mental illness, particularly in the justice system

106 Since deinstitutionalisation, there has been a criminalisation of the mentally ill in many western countries including Australia. The reduction in beds in acute inpatient units and the failure of mental health services has resulted in many more mentally ill people having custodial sentences and being incarcerated.

107 In relation to young people, the crime curve that shows the rise in prevalence in offending behaviour parallels exactly the rise in the emergence of mental ill health and mental illness in young people. There is a surge in crime from puberty which peaks in the mid-20s and is followed by a phenomenon called "desistance" around the age of 25. This is exactly the same as the onset and desistance curve for mental illness.

Good practice models of forensic mental health services for young people in contact with the justice system

108 There have been adolescent forensic psychiatry services in the UK for many years that are much better developed than the services that exist in Victoria, though they do not extend to 25 years. They recognised the overlap between offending and the onset of mental illness in adolescents and young adults. Adolescent forensic psychiatrists exist as a distinct subspecialty species in the UK and also to a minor extent in NSW. Andrew Chanen, my colleague at Orygen and Dr Clair Gaskin in Sydney can provide further evidence on this.

Key changes that would effectively support young people to better manage or resolve co-occurring mental illness and engagement with the justice system

109 There needs to be a preventative forensic mental health system in Victoria that is strongly resourced around the teenage and young adult period. In Victoria, there has not been a forensic youth mental health service at all until the last few years, merely a general health team. The Forensic Youth Mental Health Service at Orygen is embryonic and there are some resources via the Alfred Hospital CYMHS service too, but they are also embryonic. Prior to those services being created, there was simply an adolescent forensic health service which had a few GPs and psychologists providing a service into juvenile justice. There was no significant specialist mental health input apart from a psychologist and an on-call psychiatrist.

110 The system needs to be a fully-fledged independently designed system that is analogous to the adult forensic mental health system. It requires inpatient beds, widespread community services across the State and an effective interface with the mental health system. If this was done properly it would contribute to a much lower level of incarceration and recidivism. That is what some of the data from the UK is suggesting.[15]

[15] Bailey S Dolan M Adolescent Forensic Psychiatry Taylor and Francis 2004 New York.

Governance

Empowering health service providers to deliver improved outcomes for mental health consumers, families and carers through governance arrangements

111 The old mental hospital system which came to an end in the 1990s was a standalone system where each hospital had its own superintendent who was a psychiatrist. The mental hospitals were a powerful confederation of structures within the health system. Each hospital had their own financial and governance system and they worked together in a collaborative way to protect the resources and the system, despite the fact that it was clearly a 19th century system that needed to be replaced. There was great hope that merging with the general health system would result in a more modern system that could provide good medical and psychiatric care to patients, but as we know that did not happen. Over time psychiatrists have been marginalised within acute hospitals, their leadership and governance roles replaced by generic managers, something that has not happened to other medical units in these hospitals and have had no real chance of defending their turf and budgets against powerful executives and physical health interests within the hospital system. The fact that mental health is funded according to a block funding model means it is uniquely vulnerable to diversion of its core funds to other areas via suspect taxing arrangements. Psychiatrist clinical directors are powerless to stop this and cannot speak out publicly to reveal the extent and impact of this behaviour. The evidence for this is the rise in recent years in the costs of providing mental health care within this system due to MH subsidising the overall enterprise. This at the same time as fewer services and lower coverage of the population is being delivered.

112 The mental health system once again needs to have completely separate governance and financial structures. There can still be co-location of certain aspects of the system to achieve the appearance of a single health system with equal value attached to mental and physical health. For example, acute inpatient beds may or may not be on the same campus as the general hospital. However, the budget of the mental health system either needs to be ring-fenced or there needs to be stronger safeguards to protect it, for example through sub-boards or a separate board for mental health. In my opinion, current hospital boards, CEOs and local health networks are unlikely to be able to effectively govern, protect and enhance mental health care because they have demonstrated a lack of commitment to this field. The only excuse they might have is that their total hospital budgets have been inadequate and they therefore have been forced to divert funds from mental health to reduce the overspend in other areas.

113 Mental health budgets have not been ring-fenced or protected. In the 2018 budget, realising the state of the mental health system was serious, DHHS provided hospitals with substantial additional funding for mental health. In our network at Melbourne

Health, at least initially not a single cent of that money was allocated in fact to mental health. It is unclear what proportion did end up being allocated because there is extremely low transparency within this system. This is what will always happen unless we introduce watertight ring-fencing of governance and finance.

114 An alternative option is to leave acute beds with the local health networks and run every other part of the system separately (i.e. sub-acute beds, mobile teams and community mental health) in close association with primary health structures. In other words, community and primary care would be integrated and governed and financed in a different way to the acute aspect of care. Currently, the acute part of the system is the tail wagging the dog. The link between the two is a piece of orthodoxy which lingers from the 1990s, one which led to the depletion of community care, the one strategy which was essential to enable the reduced number of acute beds to be safe and feasible. The solution is not more beds alone but many more community services. At Orygen, if there are 1,000 young people on the books, only 16 of them are in hospital at any one time and the remaining 984 young people are in the community. Instead of merely adding more beds (some are definitely needed due to huge population growth), funding should be rapidly invested in upstream dynamic community services such as HITH and ACT/IMYOS, which will take the pressure off ED within months.

Integrated governance

115 We seek to achieve integrated governance at Orygen, which is essentially a youth version of the Collaborative Centre model, proposed for adult mental health by the Royal Commission interim report. Orygen is a translational MRI or Medical Research Institute which runs extensive innovative clinical services and translates research into practice and reform. We are seeking to integrate our specialist state-funded services for the northwest with the 5 headspace centres that we run under contract to the local primary health network in the north west. Without such integration the patient experience is less than optimal and major barriers exist. Orygen seeks to create a separate health services agreement with DHHS to become an independent heath service so the specialist and primary care services can be fully integrated. We have come to this position having failed to secure the cooperation of Melbourne Health as a network to allow us to manage the specialist workers under Orygen's leadership as an MRI such that they can be fully integrated with the headspace system to optimise patient care and research. As the world's leading translational youth mental health research centre, it is essential to integrate and operate both the specialist services and the primary care services. This separate health service model in which research is a central pillar would be the optimal approach for the Adult Collaborative Centre as well. Finally, if adopted, Orygen should be mandated to provide an oversight, co-commissioning, training and support role for the new Statewide system we have

formulated for the Royal Commission and the Government to consider. And the same role allocated to the new adult collaborative centre for the adult system.

116 There is also a case for this model to be considered for the new mental health system as a whole i.e. separate Mental Health LHNs with separate health services agreements.

Funding and Commissioning

Objectives and features of an effective commissioning strategy

117 In considering how our proposed Model would be commissioned, we have looked at examples in the UK and New Zealand. My personal experience with commissioning was in relation to the first wave of headspace services, which was very successful. As I explained above at paragraph 52, the process was successful because model fidelity and integrity was prioritised and central control was preserved with local modification as negotiated and agreed after consultative mechanisms.

118 Regional commissioning sounds good in theory, however the PHNs have not been successful in conducting the commissioning process. This has essentially resulted in 31 new health departments and 31 bureaucracies without a competent structure to do the job. A major issue with the current PHN commissioning processes is that there is very little respect for scientific evidence. We have "31 varieties" of mental health care with serious fragmentation and variability with a weak or no basis for this.

119 An effective commissioning strategy would involve a very strong central model with capacity for local consultation and local adaptation of the model, but on the terms of the model of care itself. That is the only way one will secure a scientifically based model in mental health. A body such as Mental Health Reform Victoria that has been set up under Pam Anders and Dr. Simon Stafrace could evolve into a such a commissioning body.

Examples of commissioning that demonstrate the merits of a regionalised approach

120 There are no good examples that demonstrate the merits of a regionalised approach, at least not in mental health. The devolution of the commissioning model in the UK to trusts resulted in incredible variability. There might be some examples in physical health because in physical health there is deep respect for scientific evidence. For example, in physical health there could never be credible arguments made that breast cancer should be treated differently in Cairns compared to Rockhampton because the people there have very different needs.

121 Western Australia has a separate Mental Health Commission. It sounds like a good idea in principle, however I am not at all sure whether the results in Western Australia are any better than anywhere else. If so it could be due to underfunding. However, it seems to be the only model that is capable of delivering what we aspire to deliver.

State and Commonwealth government working together to better commission mental health services, reduce fragmentation and improve consumer outcomes

122 The State and Federal Governments could co-commission services, allowing both governments to have a veto and requiring agreement to be reached at both levels. There could be a separate agency or commissioning body at the state level to work with the relevant Commonwealth commissioning structure. For example, 'headspace national' could work with a Victorian state commissioning authority to build an enhanced headspace system with specialist capacity integrated across Victoria. If the PHNs survive and continue, then the state commissioning authority could work with the PHNs to create jointly funded federal and state services.

Multiple funding sources in the proposed Model

123 The integrated services centres in our Model rely on multiple funding sources, which does carry risk. For example, if the PHN decided to reallocate a headspace tender within a regional cluster to another other agency that would fragment the regional Model. However, if a service were able to provide fee for service practitioners irrespective of a Commonwealth commissioned model of care, any state funded mental health service could host or integrate private practitioners within the model and draw on federal funding streams. That would result in a hybrid model and an informal alternative to winning Commonwealth contracts. However that is a less desirable approach to joint commissioning. Primary care and other specialist inputs such as NDIS could also be rolled into the model in a more organic way rather than a block funded way.

Workforce and change readiness

Capabilities and practices underpinning the workforce of the future

124 Fostering a workforce for the future is a huge challenge and something that has been neglected over the last 25 years. Our proposed Model involves a diverse workforce. The integrated service centre teams comprise GPs, psychiatrists, neuropsychologists, practice nurses, mental health nurses, social workers, occupational therapists, speech therapists, dieticians, exercise physiologists, addiction medicine specialists, drug and alcohol workers, pharmacists, peer works, vocational workers, volunteers and trained 'lay workers', family support workers, social inclusion and cultural workers, operational and clinical leadership and management and reception/administration. The specific mix

of professionals within integrated service hub teams will vary by location in response to local demographic and service system variables.

125 This diverse workforce needs initial training and ongoing development. There needs to be designated positions of clinical team leaders, senior staff and on-the-ground staff in a variety of different roles, including particular consideration to the peer, lay and volunteer workforces. Further, the staff must be supported by a robust and well-resourced operational / business model that covers other areas such as administrative staff, quality assurance staff, professional development, financial management staff or avenues from which these are sought in existing services.

126 Orygen has the capacity to set up various courses and training systems because we have a training and translational arm. We could play a role if we were funded to do so and run many courses through the University of Melbourne or other mechanisms.

127 In relation to the clinical workforce, Orygen is creating a training program for youth psychiatry in partnership with the University of Melbourne. We have a youth mental health section in The Royal Australian and New Zealand College of Psychiatrists which is expected to become a faculty to complement the child and adolescent faculty, but will focus on the overlapping adolescent period and the young adult period.

128 I believe there is a need to separate mental health nursing from or elevate it within general nursing training. Mental health nursing was integrated into general nursing about 20 years ago and this has considerably weakened the expertise of psychiatric nurses. They receive minimal training in mental health and the training they do receive is in settings that are very aversive for learning such as the current inpatient units. The training program for nurses should be a more expansive, inspiring and positive experience, with more involvement in the community setting.

129 The specialisation of some disciplines such as psychology, occupational therapy and social work is being lost to the standard case management role. The case manager role is an important one because clients value the continuity of that relationship. However, there needs to be a way of safeguarding this generic therapeutic relationship while freeing up specific skillsets so that people can work in the discipline they were trained in.

Timing and sequencing considerations for growth and reform of the mental health workforce

130 When people move from physical healthcare into mental health care, they sadly report clinicians working at half the pace that their colleagues work at in the physical system. I want to be clear that this is not a criticism of the clinicians. Part of the explanation is that

mental health care requires taking time with people, being patient and creating space for the patient relationship. It is also because of how incentive setting works under block funding. Currently in our case management system, case managers are funded on a salary. There is an enormous amount of red tape and paperwork they have to deal with, but their output is low. This is largely driven by risk management and defensive medicolegal dynamics. They are required to spend hours writing up notes, filling in risk forms and going to meetings. This means they are only able to actually see two to three patients a day. If the same people worked in a fee for service system they would see about eight patients a day. A hybrid model is optimal and depends on the right incentives. The red tape needs to be stripped out and work practices need to change so that existing resources can be more efficient and productive. The pace in the public mental health system has also resulted from the poor work practices and the failure of middle management to walk the talk. There needs to be much more inspiring leadership and well trained staff to carry out the vision. The poor morale that has resulted from the collapse of the system makes this hard and it is not appropriate to criticise staff for this.

131 One of the important things for the wider public and indeed consumers and health professionals from other disciplines to appreciate is that the degree of difficulty faced by mental health professionals in doing their professional roles is very high much of the time especially in acute settings. This is especially so these days when only the most acutely ill people are accepted and then in a stage of illness when distress, anger, hopelessness and suicidal behaviour is at a peak level. Many patients in such mental states are rejecting help and some are hostile and aggressive, usually through no fault of their own but through the effects of their illnesses, often compounded by drug effects. Help is all too often either refused or rejected or alternatively not appreciated. This contrasts with the gratitude and appreciation which health professionals in areas like cancer medicine or cardiac units receive. Flowers and chocolates are rarely seen in acute psychiatric settings. To engage such acutely ill psychiatric patients in a compassionate, skilled and effective way requires a level of personal commitment and rare skill that rivals that seen anywhere in health care. The culture in which this is attempted is often demoralised, the facilities dilapidated and the clinical leadership weak and inconsistent. This makes it hard to live up the ideals and training that are necessary for such care to be optimal."

132 Funding should be activity based with KPIs and incentives at the clinician level. If you are going to fund the system as if it is akin to the New Delhi Railway Station where you just sell as many tickets as you can because the line never gets any shorter, then you will not get a good result. We need to consider what a reasonable workload is for a mental health clinician. Currently, case managers are monitored based on the size of their case load rather than what they accomplish each day, which is the wrong variable. I have a case load of probably 40 patients myself, however I only work clinically a day or

so a week and some patients are interstate and I see them less. My case load looks high but the frequency with which I see some patients is low and that is what needs to be monitored. A full time clinician's caseload is not the only variable to monitor but the case mix and frequency of contacts should be essential elements too. I am aware other parts of the health system are monitored in a much more efficient and effective way. We are very primitive in mental health in this respect. There is obviously also an industrial relations element to the analysis in ensuring that practitioners are not overworked, since burnout is a genuine issue in mental health care.

Research and evaluation

Enabling and incentivising the development and implementation of new and innovative service models that are evidence-based and responsive to consumer needs

133 Research is something that appears to be missing from adult mental health in the last 20 years. Other areas of physical health have research embedded at the heart of the clinical system, such as cancer with the Victorian Comprehensive Cancer Centre. In the US, there are university health care systems running the clinical services for a region in relation to mental health. The concept of integrated academic health science centres is important. We have achieved something close to this model at Orygen, though it is hampered by current governance arrangements.

134 Research must be built into how services are funded and structured. Currently, there is not enough respect for evidence in the mental health system. At Orygen, we want our youth mental health service to be overseen by a governance structure with a research focus. Currently, we have 12 professors working full time, which is larger than any psychiatry university department in Australia – we have built a culture of clinical research and translation. We still face some barriers, however having clinical academics leading key parts of the system ensures that research is respected.

135 Translational research and continuous improvement is a critical enabler of our Model. The Model will have at its core an ongoing focus on interfacing research with clinical care to:

(a) build evidence and deliver real-world practical solutions;

(b) discover and test novel treatments and supports to appropriately respond to emerging mental illnesses in young people at different stages of illness (including research into service models which integrate face to face, mobile and online services); and

(c) design research projects so that they fit into clinical settings and complement their activities, enhancing the experience and outcomes for young people, families, staff and researchers participating.

136 Research should be the focal point for the adult mental health system as it is a way of embedding innovation and evidence based care into the system. We need to create a new generation of academically orientated leaders to run services with a link to a central focal point such as an adult mental health research centre. In relation to youth mental health research, Orygen should be given a state-wide role to oversee, guide and influence the other youth mental health services in the State to have academic leadership.

Balancing the consumer voice and evidence

137 The Commission has been very influenced by the consumer voice and rightly so. However, the visible part of the consumer movement has been led by a group of courageous activists most of whom who have been treated very poorly by the mental health system. Some of these people reject any role for health care in a new system which is an understandable overreaction. This view is overrepresented within the consumer voice and does not represent the views of the silent majority. We need constructive as well as critical consumer voices and in fact it is possible to offer both. I have been intensely critical of the same failures and abuses of the system as activist consumers and have called the apologists for the system over the years including former Directors of Mental Health in this State. But we must offer solutions not just seek to "destroy the joint" and attack clinicians who have been operating in a "learned helplessness" paradigm for many years. Furthermore it is important that the consumer voice is complemented by scientific evidence – both are of crucial importance. It is also important to listen to a wide spectrum of consumer voices and family members too.

Mechanisms to facilitate continuous improvement of service delivery

138 Ensuring that services are data driven in real time to test the efficacy and progress to the achievement of KPIs to support them providing evidence-based care and fidelity to the model is crucial. Any research centre or service needs to ensure that it keeps moving forward. There needs to be an embedded learning culture within the organisation. If you simply set and forget, institutionalisation creeps in. I have seen this at Orygen and across the mental health system as a whole. We have had to reinvent and shake things up every five years or so. Hence our local slogan "never settle" and our tagline "revolution in mind".

139 Health and quality improvement is another key pillar in facilitating continuous improvement of service delivery. Currently, services have quality committees that in

recent years have too often just been disconnected bureaucratic processes without much meaning – fiddling while Rome burns.

Engaging and attracting the workforce to the public sector through approaches to research and evaluation, and subsequent opportunities

140 Orygen attracted 12 full time professors by establishing a Medical Research Institute. Gradually we were able to attract funding and recruit a new wave of emerging academics in 2001. Some of those recruits evolved into full time professors internally and others went on to other places, such as Dan Lubman who was with us for eight years. Most of those professors have NHMRC Senior Fellowships and that is how most of their positions are funded. The challenge now is to identify, recruit and nurture the next generation of clinical research talent for mental health at Orygen and in the adult and other domains. This will take massive effort.

141 We had a vision of what we wanted to achieve, which was a field of research in youth health and early intervention. We had a first wave of success with early psychosis in the 1990s and it broadened from there and grew over time – people perceived it as an attractive area to work in. One of the difficulties in attracting young psychiatrists to pursue a research career is the fact that it is difficult and competitive to secure NHMRC fellowships. The State would do well to take some affirmative action by funding joint academic and clinical positions as they used to in the 1980s and 1990s. It is important that the system identifies talent and persuades talented practitioners to follow a career in psychiatry. We need to plant the seeds and then grow and nurture them and mentor people to help them find their voice. We have a culture at Orygen that does that as well as anywhere in mental health, however it is limited by funding and job security. We have no reserves of funding such as the Walter and Eliza Hall Institute of Medical Research (WEHI), the Murdoch Children's Research Institute (MCRI) and the Baker Heart and Diabetes Institute possess.

142 Overseas settings with high clinical services and cutting edge research have status associated with academic research, such as the CAMH in Toronto or the Institute of Psychiatry in London. In other words, if you are a world leader it counts within the service – it has deep credibility attached to it. This type of status exists in Victoria in relation to neurology, paediatrics and cancer, for example. We have world leaders in stroke research who are also directors of those clinical services – it is a valued and respected part of the system and the leadership of the system. We have that culture in youth mental health and we need to create it again in the adult mental health system in Victoria.

Leadership and reform

Capabilities and skills required of leaders to drive and oversee reform

143 To use the football analogy, the mental health system needs a captain coach and a champion team. In other words, there needs to be a small respected leadership team driving and overseeing reform. This team will be leaders in research and will also have emotional intelligence and be respected as clinical experts. They need to walk the talk, meaning they must have excellent clinical skills and be seen to contribute. We do not want leaders who move into pure administration in a bid to retreat from their patients. The leadership team needs to share the same inspirational vision and commitment to transformational change.

144 The system needs to find leaders that will find self-fulfilment in their role by tapping into that top level in Maslow's Hierarchy of Needs. Fulfilment and meaning is an important driver of people's behaviour. For example, in Oregon in the US, several inspiring early psychosis services were set up in the 2000s which spread across the whole state. The idea came from an inspirational woman, Tamara Sale, whose brother had schizophrenia and who organised a leadership team to develop this service and spread it. They applied the EPPIC model that we created in Melbourne from 1992. That is similar to what we have done with early psychosis and youth mental health at Orygen. I have a team of true believers working with me at Orygen, but they are also scientists and clinical experts. People say anecdotally that success cannot just be based on the passion of individuals or small groups, but in my opinion that is the only thing that makes it work. There are obviously other essential ingredients but without passion and belief the mission fails. It might seem clichéd but the quote from Margaret Mead does sum it up, *'Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has.'*

145 We need to attract inspiring leaders to the profession of psychiatry – it is not well understood that this is an area that can be immensely rewarding. It gives one a breadth of knowledge in the concept of mind and the human condition which is not available elsewhere in medicine. It is not really a highly technical health area, it is a human area. It provides the opportunity for the right type of people to make huge contributions and have a wonderful professional life. This message needs to be sold more by the Royal Australian and New Zealand College of Psychiatrists, other professional groups, and by medical schools.

Structures and mechanisms for supporting the ongoing development of leaders that are equipped to drive and oversee transformational change

146 The system does not need to create inspiring leaders because they already exist, though many are undiscovered. However, in most aspects of the public mental health system the people who are in leadership positions can sometimes be slow to embrace innovative and inspiring ideas because they find it threatening. Psychiatrists are appointed to clinical director roles and do not have a voice in decision-making. Real leaders in the system need to be prepared for conflict and to fight for their patients and their mission. The system needs to at least tolerate and ideally support leaders who have a vision that is pragmatic, supported by scientific evidence and above all is compassionate and humanistic in its nature.

147 Leadership, an optimistic culture and respect for clinical work needs to be embedded in the infrastructure of the mental health system. This can be difficult if the system is being controlled by senior executives focused on process and the budget and leaders that also come from a physical medicine background as there is still a lot of prejudice against psychiatry and mental health within physical medicine. The mental health system has to run its own race by finding and nurturing the right leaders and the right system values. This needs to happen internally rather than by hiring consultants to come in and tell one's organisation what its values should be through fake processes. We need to support the inspirers, the innovators, the true believers who want to make a difference and who walk the talk. They should be rewarded for doing so. The rest will follow.

148 Embedding academic research expertise within clinical services will assist in creating a learning culture that expects to do effective things, not just what political and cultural interests suggest should be done.

Prevention

Extent to which mental illness or its reoccurrence can be prevented

149 There is an enormous literature on this topic. Mental Health Promotion is concerned with wellbeing and positive mental health. It is often assumed (and we see this in the heart of the current pandemic) that improving wellbeing will reduce the risks of mental ill health and mental illness but there is very little evidence for this. Wellbeing and "flourishing" is desirable in itself and is possible to co-exist too with even serious mental illness. Prevention itself can be divided into universal prevention which is focused on the whole population, selective prevention which is focused on high risk groups, and indicated prevention which is really the first stage for early intervention when early symptoms have emerged.

150 Early intervention is defined as early detection of the first signs of mental ill-health or illness. This links to the staging model which I have adapted from general medicine. Stage 0 is people who as yet have no illness but may have variable levels of risk. Stage 1 is when early clinical feature have appeared and intervention is indicated to reduce the risks of progression to the next and more serious stage and so on. There is good evidence for the value of selective prevention and indicated prevention in mental health. Examples here include interventions for children of parents with mental illness and addiction and people with early symptoms of depression or psychosis who have not yet reached diagnostic threshold. Universal prevention is theoretically possible for example through the reduction of key risk factors such as child abuse and neglect, poverty and inequality, however these are major social trends which are notoriously difficult in terms of feasibility to tackle. It is also difficult to conduct research which demonstrates that universal prevention is effective.[16]

Forms of mental illness that can be prevented

151 There is evidence that most mental and substance use disorders are able to be prevented or ameliorated. I have established a successful international journal *"Early Intervention in Psychiatry"* which has expanded the field of prevention and early intervention since 2007. A huge literature now exists which has especially assembled strong evidence that intervening early can change the course of major mental disorders with the best evidence supporting this for psychotic illnesses including schizophrenia. Our own research at Orygen with early psychosis has played a central role. We now know that we can delay the onset of psychosis and if psychosis does occur, then reducing delay in delivering comprehensive stage linked care and extending this for several years post diagnosis results in better short to medium term outcome, reduced suicide and functional recovery. There is a series of seminal references supporting this.[17] Here are some but there are many more:

[16] Cuijpers P Examining the Effects of Prevention Programs on the Incidence of New Cases of Mental Disorders: The Lack of Statistical Power (Am J Psychiatry 2003; 160:1385–1391).

[17] van der Gaag M, Smit F, Bechdolf A, French P,. Linszen DH, Yung AR, McGorry Cuijpers P. Preventing a first episode of psychosis: Meta-analysis of randomized controlled prevention trials of 12 month and longer-term follow-ups Schizophrenia Research 149 (2013) 56–62; McGorry PD. Early intervention in psychosis: obvious, effective, overdue. J Nerv Ment Dis. 2015; 203(5):310-318; Lally J, Ajnakina O, Stubbs B, et al. Remission and recovery from first-episode psychosis in adults: systematic review and meta-analysis of long-term outcome studies. Br J Psychiatry. 2017;211(6):350- 358; Correll CU, Galling B, Pawar A, et al. Comparison of early intervention services vs treatment as usual for early-phase psychosis: a systematic review, meta-analysis, and meta-regression [published online May 2, 2018]. JAMA Psychiatry. doi:10.1001 /jamapsychiatry.2018.0623; Malla A, Joober R, Iyer S, et al. 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(3):278-286; Kane JM, Robinson DG, Schooler NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. Am J Psychiatry. 2016;173(4):362-372.

(a) For those with early clinical signs of psychosis, treatment can halve the risk of transition in the short term, with risk reduction benefits in some research still present at 4 years.[18]

(b) Early detection and reduction of the duration of untreated psychosis ('DUP') modestly improves the 10-year outcome for first episode psychosis.[19]

(c) The clinical and functional impacts following psychosis onset can be altered, with specialised early intervention services producing significantly superior outcomes than treatment as usual, including a 24%–30% improvement in remission, relapse prevention, hospitalisation, treatment engagement and recovery.[20]

(d) Such improvements in outcome are dependent upon early detection. If DUP is prolonged, the benefits from specialised stage specific care for first episode psychosis cannot be realised.[21]

(e) Outcomes are further improved when tenure of care is extended to 5 years.[22]

(f) In the UK, every £1 spent on early detection and intervention for psychosis produces a return on investment of £10.27 and £17.97, respectively.[23]

(g) Integrated youth mental health services have shown positive outcomes for help-seeking, better access to care, symptomatic and functional recovery and client satisfaction.[24] In Australia, headspace clients have especially shown reductions in self-harm, suicidal ideation and days out of role;[25] however, for more substantial improvements, the 'missing middle' of more complex cases must be offered sustained specialised care.

Effective approaches in preventing mental illness or its reoccurrence

152 Again there is a huge literature on relapse prevention and it is beyond the scope of this statement to report this. Relapse prevention in depression and psychosis and other conditions is highly achievable with the right system and there is great evidence for this.

---

[18] van der Gaag M, Smit F, Bechdolf A, 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.
[19] Hegelstad WT, Larsen TK, Auestad B, et al. Long-term follow-up of the TIPS early detection in psychosis study: effects on 10-year outcome. Am J Psychiatry 2012; 169: 374–380.
[20] Correll CU, Galling B, Pawar A, 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: 555–565.
[21] Kane JM, Robinson DG, Schooler NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. Am J Psychiatry 2016; 173: 362–372.
[22] Malla A, Joober R, Iyer S, et al. Comparing three-year extension of early interven- tion 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.
[23] Knapp M, McDaid D and Parsonage P. Mental Health Promotion and Mental Illness Pre- vention: The Economic Case. London: Department of Health, 2011.
[24] Hetrick SE, Bailey AP, Smith KE, et al. Integrated (one-stop shop) youth health care: best available evidence and future directions. Med J Aust 2017; 207: S5–S18.
[25] Hilferty F, Cassells R, Muir K, et al. Is Headspace Making a Difference to Young People's Lives? Final Report of the Independent Evaluation of the Headspace Program. Sydney: Social Policy Research Centre, 2015.

Delaying the onset or reducing the severity of mental illness through preventative approaches

153 The best evidence for this is in the area of psychosis:

(a) On delaying the onset of psychosis, see: van der Gaag M, Smit F, Bechdolf A,French P,. Linszen DH, Yung AR, McGorry Cuijpers P. Preventing a first episode of psychosis: Meta-analysis of randomized controlled prevention trials of 12 month and longer-term follow-ups Schizophrenia Research 149 (2013) 56–62; and

(b) On improved outcomes for psychosis patients with early detection, see: Hegelstad WT, Larsen TK, Auestad B, et al. Long-term follow-up of the TIPS early detection in psychosis study: effects on 10-year outcome. Am J Psychiatry 2012; 169: 374–380.

sign here ►

print name Patrick McGorry

date 22 June 2020