ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room,
90-130 Swanston Street,
Melbourne, Victoria

On Friday, 5 July 2019 at 10.00am

(Day 4)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols SC
Ms Fiona Batten
Ms Georgina Coghlan

MS COGHLAN: Good morning, Chair and Commissioners. Today we are continuing on with the topic of prevention and early intervention.

As Lisa Nichols identified yesterday, a key challenge for the Commission is to identify evidence-based prevention and early intervention approaches to consider how they could be implemented in ways that are sustainable and effective, reaching those in greatest need.

There will be a number of witnesses called today. The first is Amelia Morris who's a 21-year-old young woman and consumer. After that, you'll hear from Dr Gaynor Blankley who is a specialist in perinatal care.

But, before hearing from Dr Gaynor Blankley, you will hear from Shaun McClare who is a principal at Kalinda Primary School, and he will give evidence about Positive Education and the impact it has had at the school where he is the principal.

You will also hear from Dr Ric Haslam who is the Director of mental health at the Royal Children's Hospital. He will give evidence about the current infrastructure for youth mental health services within the hospital context and he will also address the difficulties in access for children and young people.

Finally, this afternoon, you will hear from Professor Pat McGorry. He is the professor of youth mental health at the University of Melbourne and Executive Director at Orygen, the National Centre of Excellence in Youth Mental Health.

He will give evidence about the many issues facing the mental health system and will opine about the elements he sees as critical to a well functioning mental health system.

I propose to call the first witness now. I call Amelia Morris.

<AMELIA JANE MORRIS, affirmed and examined: [10.03am]

MS COGHLAN: Q. Just make yourself comfortable, Amelia, make sure we can hear you in the microphone. Now, you've provided a statement to the Commission in relation to your

experience?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0005.0001] You are currently 21 years of age?
A. Yes.

Q. You live in Melbourne, but you grew up and went to school in country Victoria?
A. Yes.

Q. Can you tell the Commissioners about, really, your first experiences in relation to any mental health issues you might have had?
A. Yep. So, I've been diagnosed with major depressive disorder, generalised anxiety disorder, and comorbid attention deficit hyperactivity disorder. When I was 11 or 12, I started to become withdrawn, I kind of withdrew from things I'd previously enjoyed, like hanging out with friends. I spent a lot of time in my room when I was home, I didn't spend time with my family which was a real change to how I'd been before.

A lot of those changes were kind of dismissed by people around me as puberty and hormones, and so, it wasn't until I was 16 in 2015 that I kind of realised something was wrong and I shouldn't be feeling like this, so I spoke to my mum to try and get some support for my mental health; that was in January 2015.

Q. Where did you go then for that initial support?
A. So, I first saw my local GP and, very soon after that, I also started having appointments at Headspace; so, I was seeing them both kind of simultaneously.

Q. How did you select the GP that you saw?
A. The GP was kind of locally acknowledged as the expert in mental health in the town; so, he was who my mum thought would probably be good for me to see.

Q. What assistance did you get from the GP at that time?
A. I was initially diagnosed with anxiety, which I didn't feel was right and later was given a different diagnosis, which is my current diagnosis. He was reluctant to put me on any sort of medication even though I'd expressed a desire to try because I didn't feel the talking therapy I was having at Headspace was helping me very much.

He told me to try an online anti-anxiety course and, when I tried to sign up for it, it wouldn't let me because you had to be over 18 years to use it and, when I told the doctor this, he told me to lie about my age.

Q. And, you were 16 at that time?
A. Yes.

Q. Was it at that stage that you had a feeling like, is this it, is this all there is?
A. Yeah, I felt quite hopeless and it really felt like there wasn't really any sort of help there, because there wasn't really any other kind of solution offered by the GP.

Q. Can I ask you a bit more about Headspace. You mentioned that you effectively were seeing someone at Headspace at the same time as seeing the GP?
A. Yep. So, I was seeing a psychologist at Headspace, and we were doing a lot of talking therapy, which I didn't feel was helpful.

I also saw a psychiatrist at Headspace who did end up putting me on some medication. Unfortunately, I really wasn't getting any better. I kind of reached the halfway point of the ten Medicare subsidised sessions and I was really beginning to worry about what I would do afterwards because I wasn't improving at all, and I was already halfway through, so I really, really was stressing about what was going to happen at the end, how we were going to kind of afford it; the burden on my family.

My psychiatrist also ended up going on emergency leave, which really sucked for me because I really liked him and I felt very validated by him, but he had a family emergency and had to go, so I couldn't see him any more. And, I was having some suicidal thoughts that weren't going away. I had disclosed those to the psychologist and the psychiatrist and they were helping - trying to help me manage those, but I really wasn't getting any better.

Q. I'll come back to that just in a moment. You talked about the perceived burden this had on your family. Just in terms of getting to and from the Headspace, how easy was that for you or how difficult?
A. It was very difficult. So, the Headspace was a 40, 45 minute drive away. There was no kind of public transport

link for me to use, and obviously, because I was 16 I didn't have my own licence, so my mum had to drive to school, pick me up, take me to the appointment 40 minutes away, wait for me to finish, drive me back to school and then drive herself back to work.

So, it ended up being probably a two hour round trip for her, which was really, really difficult. She was a single parent; I have two other sisters, so having to do that once a fortnight was a really big burden on her.

Q. And it meant you missed out on about a half a day of school once a fortnight as well?
A. Yeah, I was very stressed because of school, and so, I'd go to Headspace to help me manage that stress, but unfortunately it meant I missed more school, became more stressed, and it was a bit of a vicious cycle.

Q. You mentioned your siblings, they were 13 and 15 at the time?
A. Yes, they were.

Q. Can I ask you about a point in time in June 2015?
A. Yeah. So, I had my Year 11 exams coming up which at the time was a really big stress for me, and I wasn't getting any better with the help from Headspace and my GP, the sessions were starting to run out, and I just wasn't getting any better.

And then one day I came home from school and I attempted suicide. I ended up calling the ambulance myself because I saw my dog and I thought, "What are you gonna do without me?" My nana lived down the road and she came down and sat with me while I waited for the ambulance. And, the ambulance came probably about 20 minutes later and took me to the hospital.

Q. Can you just describe what that was like then arriving at the hospital?
A. So, I arrived in the emergency department and I had, you know, my vitals done and blood taken and all that kind of thing, which was pretty distressing, and we were put in a room - me and my mum. I was kind of in and out of consciousness a little bit, but I remember the hospital staff kind of calling just about every psych ward in Victoria trying to find me a bed, but there was nothing available, and I ended up just being sent to the general

children's ward overnight.

Q. The next morning you were seen by a mental health worker?
A. Yeah. So, I think my mum had gone to get breakfast, so I saw this worker by myself. I felt very dismissed by him. He refused to give me a referral to any sort of psychiatric ward. I got the impression that he thought I was really just being a dramatic teenage girl and I wanted attention, and I just got the feeling he didn't think I was serious enough for a bed in a psych ward when I'd had a suicide attempt the night before.

I'm not quite sure how much more serious you can get, but I was dismissed and, yeah, there wasn't really any solution offered. We ended up having to go ourselves to a different doctor to get a referral to a psychiatric ward.

Q. You ended up getting a referral to a private psychiatric ward?
A. Yes.

Q. And that was in Melbourne?
A. Yeah. So, it was three days before they had a bed available, so I was discharged the morning after I was admitted from the hospital and just kind of sent home with my mum; she had to look after me for those three days.

She couldn't go to work because I couldn't be left alone. She had to hide my medication and give it to me whenever I needed it. I had to sleep in her room, and there wasn't really - I don't think the hospital contacted her at all in those three days. They might have after I was admitted to the psychiatric ward, but by then I was out of the house so that wasn't of much use to her.

So, on 4 June I was admitted to a psychiatric hospital in Melbourne.

Q. How far away was that from your family home?
A. So, that was about two hours from my home, and from my school, so I was quite isolated. My family couldn't come and visit me until the weekend, which was my 17th birthday.

I was initially in the ICU, which was just basically a big room with beds and curtains in between. I was in there with adults of different ages and genders with just a

curtain around my bed. There was no kind of privacy, all my things were locked in a cupboard and I was only able to have one book out at a time, and I had to ask whenever I wanted my clothes.

When I was on the phone to a friend a couple of times I got told I needed to be quiet because I was disturbing the other patients. And for my birthday I'd gotten a, like, a heat pack that was a dog from my nana, but they wouldn't heat it up for me; so, it was a pretty awful experience when I was in the ICU for those few days.

Q. And, after that, you were moved to the drug and alcohol ward?
A. Yes, for a couple of days I was on the drug and alcohol ward until they could find - until there was a bed free in another ward that was more suited to me.

Q. Once you ended up in that more suitable ward, was there some sort of group therapy that you were able to attend?
A. Yeah, so the hospital run a group therapy program, but unfortunately it was very adult-centred and not really relevant to my problems as a 17-year-old. There was a lot of stuff about managing your job and stuff about your relationships with your family and your children, which really wasn't relevant to me as a 17-year-old at all.

There was a young person's program once a week, but pretty soon after I was admitted it was put on hold so that they could restructure it and I don't think it was brought back until about a year later.

I felt very disengaged from the group therapies because they weren't relevant to me at all. They, as I said, were very adult-centred and there wasn't anything about problems I was facing. I was surrounded by a lot of older people, there were not many people my age in the hospital at all, which really contributed to my feelings of isolation and I felt very abnormal.

When I thought about what I thought being 17 was gonna be like, it definitely wasn't what I was experiencing. I had pretty restricted access to my phone because I wasn't allowed a charger so I had to give it in to be charged every couple of hours, so that really restricted my ability to talk to my friends, which made me feel even more

abnormal. I felt very out of control and, yeah, it was just very isolating.

Obviously, my friends and family were two hours away, they could only come and visit me on the weekends because of work and school, so I was really alone.

Q. Can I ask you about medications that you were given during that stay?
A. Yeah. So, I kind of cycled through quite a few different medications and none of them seemed to work for me. A lot of them had pretty awful side-effects. There was one that made me vomit for about a week straight, I couldn't really keep any food down. So, they were all pretty awful, I didn't have a great experience with them.

Q. And then, in around August 2015, you began receiving TMS treatment?
A. Yeah, so that involved - it's non-invasive. As I understand it, it involves the use of a magnet to stimulate neurotransmitters in your brain. We had to get permission, I think, from the hospital board because it hadn't been fully researched on under 18-year-olds yet. But I did end up having it and it made a huge difference to me, it allowed me to stabilise enough that I was able to be discharged and go home.

Q. So you had a stay at this private psychiatric hospital that you've described of a period of three months?
A. Yeah, about two and a half months.

Q. And then you were discharged, but still required to go back every couple of months to receive this TMS treatment?
A. Yeah. So, I went back, probably the first time after that was a few weeks later, and kind of in between those two admissions I had one Skype appointment with the hospital psychiatrist, but that was it.

And then, after that, I had to go back every couple of months to receive TMS. I would do it in the school holidays because at the start of 2016 I went back to school, competed my Year 12 over two years. So, I'd go into hospital to have TMS every holidays, but I never really had any contact with the hospital in between my admissions. There was no communication.

When I was discharged every time I was given the exact

same discharge summary self care plan that was very general. No-one ever really went through it with me, and it wasn't helpful to me because it had stuff about, I think, like, exercising, going for a run, and I hate running, so it was really quite general and not helpful to me.

And, every time I was discharged it would kind of be like, hand in your TV remote and go. I took public transport to get home a lot of the time, but I don't think - a lot of the time they didn't really ask how I was getting home, so that was difficult.

Q. Can I take you to 2018, and you moved to Melbourne to study?
A. Yeah. So, I moved to Melbourne to start Uni and the hospital began to offer outpatient TMS which meant I didn't have to be admitted as an inpatient for a 45 minute session every day which worked around my life a lot better because I couldn't work while I was in hospital.

So, I'd organised that but when I was on the way to the appointment I was getting all these phone calls saying that, "Oh, have you got your referral?" And I asked, "What referral?" Because the referral had always been done internally when I had it as an inpatient. They said I should have gotten a referral for the TMS but I could just go to the GP tomorrow and get one and I'd still be able to have TMS that day.

Unfortunately, the calls in the next half an hour kind of kept coming and the goalposts kept being moved. Then it was, you need one from a psychiatrist, you need one from a psychiatrist before you can have it today; your psychiatrist in the hospital won't give you one; you're just gonna have to wait until you can get the referral.

So, when I was told I couldn't have it I was actually in an Uber on the way to the hospital. I think we passed it when they told me that I couldn't have it, so I kind of just had to go home and wait until the next week to have it, which was very inconvenient as I'd moved the due dates of all my Uni assignments to the next week when I thought that I'd have had TMS and it would be a lot easier to deal with, and now, they were all due when I was supposed to be having TMS.

I'd kind of re-organised my life, taken time - moved my work hours around and, yeah, felt like the goalposts just kind of kept being moved.

Q. Can I ask you about some specific problems that you've encountered with the mental health system. Starting with the idea that, when you asked for help, it wasn't there?
A. Yeah, so I think there's a lot of public attention, media attention on the fact that - and I know I used to think this - that you should just ask for help and everything will be better and people have acute mental illness because they just haven't asked for help and, once you do that, it will be all sunshine and rainbows and be great. But unfortunately that wasn't my experience.

When I took that really, really difficult step, that really heartbreaking step of trying to ask for help, there was really nothing there for me. I was kind of greeted with silence in return. So, that's just really distressing when you take that very difficult step of asking for help, and there is just nothing there; it makes you feel very hopeless and like you're really never gonna get better.

Q. In terms of your interaction with Headspace, it was insufficient to meet your needs?
A. Yeah. So, I think Headspace has a good role, I think it does help a lot of young people with maybe every day stressors or mild, more mild mental illness than what I experienced, but for me it just wasn't enough; I needed more intensive care but I found there was nothing for me between the GP, Headspace and the emergency room.

There was a real gap, especially youth-specific services. I think even just after Headspace there's nothing tailored to young people and their needs, so that was a real problem I faced.

I think Headspace has a good role but it just wasn't enough for me, but there was nothing else.

Q. What about how you were treated by health professionals in terms of whether you're taken seriously or whether you were dismissed?
A. Yeah, so as I've touched on, I did feel very dismissed by a lot of health professionals. I think a lot of them didn't take me seriously or, kind of, downplayed what I was going through, invalidated my feelings. That's not to say

I haven't had good experiences, but unfortunately I've had a lot of bad ones, and you shouldn't really be having any bad ones.

Q. In terms of recommendations for change, you've touched on this already in terms of the gap between GP or Headspace and then emergency care. What do you want to say about that?
A. Yeah, so I think that there needs to be, obviously, something in between there. My mum's a diabetic and they wouldn't make her wait until her foot had gangrene before they did something about it, whereas unfortunately with mental illness, I think that what happens is that, if you can get help, it just maybe stabilises you enough that you are not in immediate danger to yourself and then you're kind of just left on your own.

I feel like I've really had to fight very hard to get the help I've just needed to survive. I don't think I really know what it feels like to be thriving and be happy. I think that the help I have gotten has just been enough to get me stable and enable me to stay alive, but not really more than that.

So, I think there is a real gap in those services between primary care and the emergency room. And, the primary care that you can access usually just stabilises you.

Especially I think the Medicare ten sessions is really just not enough; that's less than one a month if you want to stretch it out over the whole year, and so, it's really not enough to enable you to be functional and be happy and live your best life, I guess. It's not even enough to enable people to survive sometimes, so I think there needs to be something to address that gap in between primary care and the emergency room and primary care also probably needs to be more accessible and there needs to be more of it.

Q. Just in terms of, you've talked about your experience of being in a regional area and how difficult access was being outside of a city.
A. Yeah, so obviously, as I touched on, the services that I could access were very far away, I was reliant on my mum to take me there, take me back. I had to take time off school because the opening hours were such that I couldn't go to appointments outside of school hours. Because, even

if I had one after school, I would have to leave school early to make that appointment anyway.

So I think, if I hadn't had the family support that I did, I wouldn't have been able to access anything except the local GP. I'm really lucky that I had a supportive family, but not everyone does, and those people are kind of left by themselves because they can't access the few services that there are, like, practically.

Q. Just picking up on that point, you're talking about needs for support for families as well?
A. Yeah. So, I think the whole experience for my family was obviously very distressing, but there wasn't really any support offered for them. I think one of my sisters sought their own help, but they kind of had to do that themselves; that wasn't brought up by anyone around me.

And my sisters were 13 and 15, so it was a lot for them to deal with as, you know, young teenagers/children really, so there really wasn't anything. There wasn't anything for my mum, there wasn't anything for my dad, there wasn't anything for my nana, it was just - they were just kind of left to deal with it themselves and to manage me themselves was so difficult let alone manage their own feelings, I guess.

Q. One of the others things that you've raised in the course of your evidence is about the need for there to be better contact and follow-up after a hospital stay?
A. Yeah. So, in between my hospital admissions there was - I think I had one Skype appointment with my psychiatrist. There wasn't really any communication in between the sessions. If I had TMS booked in, the staff would kind of call me to organise that when it was coming up, but that was it and that was kind of something they had to do anyway, there wasn't really any communication in between then.

Really, I could have died in between admissions and no-one would have known because there was just no contact and, on discharge, it was kind of like I was just cut loose and left to go by myself, which was really hard for me; you know, I had to organise all my post discharge stuff and, yeah, it was just quite abrupt when I was discharged, it was just like a sudden cut off.

Q. Just finally, in the course of your evidence you've talked about, that services need to be adjusted to better meet the needs of young people?
A. Yeah, so I think, especially as a young person, the care I could access wasn't suited to me: the group therapy in the hospitals was adult-centred, I was surrounded by a lot of adults which made it really difficult for me, it really kind of reinforced those feelings that I was very abnormal, and I was very lonely, and I was a freak.

That was how I was feeling at that time and I feel like maybe, if I had been around other people close to my age, I wouldn't have felt that so acutely, because it would have shown me that this was okay and that there wasn't anything wrong with me. Well, I was sick, but it wasn't a personal fault and it wasn't anything I'd done and it wasn't something that made me different.

And I think, yeah, the other thing was the support I could access through the GP, I guess, especially being a rural area, wasn't youth-centred or youth-focused. It was, you know, the only recommendation was the anxiety course which was for over 18-year-olds, and there wasn't kind of any support about what I should be doing about school.

Luckily, my school was very, very supportive, I'm glad I had those supports in place, and I was very lucky to have that, but I also don't think that's a role my school should have had to take on.

Yeah, there was no support from mental health services and how to access that or how to manage my friendships or anything like that that would have helped me in that stage of my life. And things like opening hours of Headspace as well; like, if they'd had an evening session once a week, that would have made such a huge difference to me.

So, yeah, I think definitely services could change to better meet the needs of young people

MS COGHLAN: Thank you, Amelia. Chair, are there any questions from the Commissioners.

CHAIR: No, thank you very much, Amelia, for taking the time to share your reflections with us, thank you.

MS COGHLAN: Thank you. May Amelia be excused?

CHAIR: Yes.

<**THE WITNESS WITHDREW**

MS COGHLAN: The next witness is Dr Gaynor Blankley, and I call her now.

<GAYNOR BLANKLEY, affirmed and examined: [10.33am]

MS COGHLAN: Q. Thank you, doctor. You've provided a statement with the assistance of the Royal Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0002.0005.0001] You are the Deputy Clinical Services Director, Mercy Mental Health, and head of Perinatal Mental Health?
A. Yes, I am.

Q. And you hold qualifications of a Bachelor of Medicine and Bachelor of Surgery?
A. I do, yes.

Q. And also a Master of Psychological Medicine?
A. I do, yes.

Q. Just in terms of your current role as Deputy Clinical Services Director, Mercy Mental Health and head of Perinatal Mental Health, can you just briefly outline the key aspects of that role?
A. Okay. So, that role is four days a week and half of that time is clinical service delivery, so I'm a clinician in clinics in that role. And then the role also involves, I guess, coordinating, heading up and running the service in conjunction with a manager, and the service also involves some teaching; that's teaching of doctors who are studying to be psychiatrists in Perinatal Mental Health or general psychiatry; maternity care doctors, so obstetricians and gynaecology trainees, midwives in the hospital; and also medical students; and also to GPs, maternal and child health nurses in the community. And the role also involves some research, but that's a small component of it.

Q. Okay. I'm just going to ask you in a moment what is meant by "perinatal mental health", but firstly, can I just ask you, why is it important? Why do you view it as an

important thing?
A. Look, 50 per cent of the population are women, and there's a significant number of years in a woman's life when she is either planning - for a lot of women, most women - thinking, planning or being pregnant or raising very young children, and so, I actually think that perinatal mental health, at one level we need to have some subspecialty knowledge, but at another level it should just be a part of mental health services mainstream and it be sort of woven into the, I think, the fabric of all mental health care services.

Q. Can I ask you now what is meant by perinatal mental health?
A. So, specifically perinatal mental health does refer to the time in a woman's life when she's either planning a pregnancy, or is pregnant, or in the postnatal period. Generally speaking with respect to services, it's up to 12 months postnatally but, I mean, it can be considered longer as well.

The key aspects of perinatal mental health are actually the mother's mental health, but also her relationship with her infant who at that stage of their lives is wholly dependent usually on the mother as a primary caregiver but not necessarily. But at that stage of either the unborn infant's life or the newborn infant's life their development is very much experience expectant and dependent. That means that, as they're developing, they need experiences, they need the environment, and also the environment, either the pregnancy-related environment, so the health of their body and wellbeing while they're carrying - while they're pregnant, or else the environment that they're able to provide postnatally also impacts on the infant's growth, development and wellbeing.

Q. There's two things there: you're talking about not only the mental health of the mother?
A. Yes, that's right.

Q. You're also talking about the impact on the child?
A. That's right, yeah.

Q. I'll ask you more about that a bit later. Can I just ask you this at the moment: the perinatal period is considered to be a high risk period of illness?
A. Yeah.

Q. For either onset, relapse or exacerbation?
A. Yeah.

Q. Can you just expand on that, please?
A. So, at some levels the rate of having a mental health disorder in the perinatal period is no different to other times in one's life, except that there are a few factors that can change the course of the illness during that time.

Some of those factors are that during that time in your life, in one's life, there are - you're much more likely to have physical illnesses or physical conditions that are pregnancy-related or postnatally-related. There are also a whole range of changes in the way that you see yourself, identity changes.

So, for example, at this point in time I see myself as a doctor and also there are other aspects of my life, but it's coming to terms with, how do I manage all these things in my life, how am I going to be a mum?

So there are identity changes, there are social changes: some of those are financially-related, some of those are relationships with either the father of the baby or your partner, they're frequently different people.

There are also changes at times to - I mean, generally changes to income and financial stressors, and often there are also changes in relationships with family as well and in-laws or out-laws as well. And these are all stressful and these are known to be stressors with respect to the onset of anxiety, depression or a mental health disorder of any kind.

Q. Okay. So, can I just ask you now, in terms of the types of treatments or interventions that are provided as part of perinatal mental health care, just in terms of principles rather than going into the specific treatments, just briefly?
A. Okay. So, I mean, the principles of treatment should always begin, I think, with prevention and prevention goes right back to thinking about what are the factors that we can do in the community at large to prevent, and then early identification of illness, so that you can prevent the length or duration - getting into early treatment and prevent the sequelae of illness.

So, prevention, and then there's early intervention, so early onset of treatments, and the treatments in perinatal mental health are in some respects the same as the treatments for all mental health disorders, but you actually have to consider the impact of treatment on pregnancy and the infant, on the unborn infant, and also the impact of treatments when you're - if you're breastfeeding.

So, you do need to understand the physiology, that's the changes in a woman's body when she's pregnant; with respect to choice of treatment, you need to understand the risks and impact of treatments on the unborn infant in particular.

Q. Okay, we'll come back to that just in a moment. Can I ask you about education awareness, screening and prevention?
A. Yes, I mean, that's a topic that I actually think is really, really important and it probably is something that shows the whole fragmentation of, not just - of our whole mental health care system going right back to primary care.

I think, thinking about women and - sorry, what was your question, it was about?

Q. So, in relation to the topic of education?
A. Oh, education, that's right.

Q. Awareness, screening and prevention.
A. So, going back to education: I mean, I think there are choices of medications - if we focus on medication, there are actually choices of medications that could be prescribed or not prescribed to women at the onset - at the outset, that is, before they're even thinking of having a baby.

So, education to primary care around prescribing practices for women is absolutely fundamental and essential. Education to decrease stigma, because stigma is a huge issue that has been found for women in the perinatal period.

Q. Can you just expand on that?
A. I think that, actually you can look at organisations, peer organisations, like in Victoria it's PANDA, the

Perinatal Anxiety & Depression Network. And pregnancy and childbirth, it's meant to be a period of great joy and hope and there's particular stigma for women around feeling - becoming anxious and depressed during that period of time.

So a particular feeling: you know, I'm meant to be happy, and also, if you - women can feel very ashamed as well that they're not enjoying or they're not able to meet the needs of their young baby, so there's a lot of stigma. And, I think education can really help raise community awareness as well as the awareness in primary care and also actually in mental health care services.

So education in mental health care services is an enormous need, because actually, once women - if a woman - one of the big issues is a lack of understanding of what it's actually like to have a mental health disorder when you're trying to care for a baby.

So for example, if I had a mental health care disorder and I went to seek care I might be given two weeks off work, and I could go home and have some support perhaps, but not have to work, not have to think, not have to concentrate. You can't do that with a baby, you can't put a baby aside for two weeks while you're waiting for your treatment to benefit for you and to kick in.

Also in perinatal health care the threshold for what is considered a crisis is much lower than in the community at large, so there needs to be education within the system around those sorts of issues as well.

Q. Can you just flesh that out please, in terms of what you're talking about in that crisis, the context of that kind of crisis?
A. Yeah, so I think - I don't actually have data on this, a lot of this will come from experience within the service. But the majority of mental health disorders in the perinatal period are what are called the high prevalence, low acuity disorders: anxiety and depression. I mean, I don't particularly like those turns of phrases but that's what they're called.

So, they're managed in the primary care setting, so women attend their GPs and then maybe referred to a psychologist or a psychiatrist in the community in which they're living. But they do also have to care for a baby,

and if they find that they're unable to care for a baby, they can feel really - that can be - they can feel a lot of shame or they can feel a lot of guilt and that can actually make their illness worse.

So, frequently they would then benefit from having some time in an inpatient setting, but it can be very difficult to sort of navigate - get a woman admitted through the access into a mental health care system for inpatient care because it can be considered at that point in time when a clinician in primary care rings and tries to access the service, that their illness isn't acute enough, they're not unwell enough.

And the fact that they're not able to attend to their infant's needs, or finding that extremely difficult, isn't considered to be as big a risk factor as it should be.

Q. Can I ask you then about the idea of screening and what that involves?
A. So screening: screening is sort of like throwing out a net into the - like, you go out and ask everybody who is - whether: screening is a process by which you ask everybody particular questions or give them a particular questionnaire to sort of see whether or not they reach a threshold point in response to those questions.

Q. And so, who administers that screening?
A. Okay, sorry, yeah. So, screening can be done antenatally in antenatal clinics or by obstetricians, by midwives and by GPs, and then postnatally screening can also be done by GPs and by - at postnatal checks and cares, at the postnatal check.

And screening can be done by - there's a couple of tools that are very well ratified worldwide that can be used for screening, and what they do is, they provide a sort of an indication that this person should have further clinical evaluation. They're not diagnostic, they just pick up that this person looks like they are at risk of having an illness.

Q. And so, I'll ask you about this later, but then in terms of the treatment pathway that might follow, is that working effectively at the moment?
A. I think it's really, really sporadic, I really do. I think in some areas it might work quite well and then in

other areas - you know, it really depends on whether there are services as to whether that works well.

Q. I'll ask you more about that later. So, in summary, there is this screening process to identify potential risk?
A. Yep, yep.

Q. But the process for then managing that risk is sporadic?
A. That's right, very sporadic, yep.

Q. I want to ask you something very specific about treatments.
A. Yep.

Q. There are a number of treatments that might be available depending on a person's needs?
A. Yes, that's right.

Q. If I could just ask you about medication, and really, the challenges that might be posed with the use of medication: you've talked about during pregnancy, during breastfeeding. Can you just expand on that, please?
A. Okay. So, when a woman is pregnant and she's being prescribed medication, you really need to think about medication in terms of - or even before she's planning a pregnancy - will this medication impact on her fertility at all? Is it likely to increase risk of pregnancy loss? Is it likely to cause an increase in malformations to her infant? Is it likely to cause any risks across pregnancy in terms of foetal growth and development across pregnancy, or length of pregnancy? And then is it likely to cause any impact for the infant when it's a newborn? And is it likely to cause any impact for the infant in terms of longer term development? And how much of that medication is likely to be expressed in the breast milk? What percentage of it will be in the breast milk? And so, therefore, you know, can it be used in breastfeeding?

So these risks or these issues need to be considered.

The other issue that needs to be considered with respect to medication is the fact that across pregnancy a woman's blood system is sort of one and a half times the volume that it is normally - like pre-pregnancy or postnatally, so there's a dilution effect of medications, and also - and some of these factors are not actually known

well enough at all, but we just know that these are issues with respect to how we manage medication in pregnancy and postnatally

Q. Can I move on to ask you about the setting of treatment?

A. Yep.

Q. Again just briefly, if you explain the tiers, just in brief terms?

A. Okay, so Australia' got a primary tier - a primary, secondary, tertiary healthcare network. Primary care is like general practitioners, psychologists, maternal and child health nurses. Secondary will be private psychiatrists, psychologists as well and an outpatient service, and then tertiary will be inpatient services.

Q. I'll come to ask you later about the interaction between those three tiers but, before we get to that, can you just indicate when perinatal mental health treatment might be indicated?

A. So really, it's indicated for any woman, I think, from potentially planning a pregnancy through to when her infant is born and crossed the first year of life, and so, it's indicated in women who have a pre-existing mental health illness that they're living with who are wanting pre-conception planning and how to manage their illness across that period of time.

It's indicated in women who develop an illness in pregnancy for the first time and they may go on and have an illness further on across - that may be the start of an illness that is ongoing. And, there are some specific pregnancy-related illnesses that it's indicated in as well that develop late in pregnancy and early in the postnatal period.

Q. Are you talking about mental illnesses or physical illnesses?

A. Mental illnesses, yeah, sorry.

Q. Which groups in the Victorian community are the most at risk?

A. So, the groups in Victoria that are most at risk will be women who have a pre-existing major mental illness, so women living with schizophrenia or a bipolar illness, also women with personality disorders, particularly severe personality disorders. Women from - Aboriginal and Torres

Strait Islander women are at greater risk of accessing services. Women who are - sorry, I've lost my train of thought.

Q. Some other examples might be women who don't have a home?
A. That's right, yes. Women without a home and I think I listed a few: women who are --

Q. From culturally and linguistically diverse backgrounds?
A. Culturally diverse backgrounds, yeah.

Q. Also LGBTI?
A. That's right, LGBTI women as well.

Q. As well as women living in situations of family violence?
A. That's correct, yes.

Q. Who have experienced childhood trauma?
A. Yes, that's right.

Q. And also those who may have also experienced sexual assault previously?
A. These groups of women, yes, these are the groups of women who are at higher risk.

Q. And then finally, also women living with alcohol and illicit substance abuse disorders?
A. Yes, that's right.

Q. Substance use disorders, I should say. Why are they then particularly more at risk?
A. As a group, and for different reasons within that group of within, within those different groups of women, they frequently have had really difficult experiences in the past accessing either authoritative services - and they can see the health care service as authoritative.

They also have had a lot of shame and stigma, and there's a lot of fear within these different groups of women about being judged about - in some of these groups of women there's a lot of fear that, if they present and ask for help, that they will have their babies removed, and so, a lot of these groups of women - so Aboriginal and Torres Strait Islander women have that fear, so do women who are

homeless, so do women who have grown up with a lot of services, like, under the child protection system themselves, so have come from violent backgrounds. So, these groups of women are fearful of accessing services, that it will mean that their children will be removed from their care.

There's a lot of shame, and the services as well are often just not organised practically - logistically to sort of meet their needs as well. Sometimes the timing of appointments are very specific and, if you don't turn up, then you've missed your appointment, and so, that can be very difficult.

Certainly, those groups of women find it very difficult to access primary care because of those logistical reasons, and cost, and secondary care as well, because of cost.

Q. Can I ask you about the importance of mental health care in the perinatal period, about that topic, and I'll ask you some specific questions?
A. Okay, yeah.

Q. In your statement you say:

"The importance varies across the various phases of the perinatal period."

So, for example, if you consider pre-conception care, prenatal care and then postnatal care, can you just briefly address those three areas?
A. Okay. Preconception care is an opportunity to plan with a woman living with a mental health disorder how she might best manage her pregnancy with respect to her mental health. So, that can be planning for medication treatments, which is like planning to be on the - what we say as being the minimum effective treatment of the least risky medication in pregnancy.

Q. Yes.
A. So, you can plan that ahead of time. Just like when women are planning a pregnancy and they go to see the doctor regarding, you know, have I had all my immunisations, or should I take Elevit, which is to make sure your physically well in pregnancy, you can do that prenatally.

Also, you can actually discuss with a woman what's going on in her life and how she might best have supports in place, what are just community supports, so that's with prenatal care.

In the early stages of pregnancy - and also it's really important, if possible, to do that planning because you can make some specific medication changes if medications are ones that maybe are more risky and you can really think about making some changes there.

Across pregnancy, early treatment is really important. I mean, a high percentage of women do suffer from anxiety/depressive illnesses in pregnancy. So it's really important to get services in place at that point in time, and to begin early treatment, and it can assist with preventing secondary problems associated with suffering from a mental health disorder in that time of life, and also plan for services.

And postnatally early intervention is essential because of the impact that untreated mental health disorders can particularly have both on the mother and on the mother-infant relationship. And then also on her relationship with partner and her family and the wider community.

Q. Can I just pick up on that, the impact that you've just raised and ask you about specifically the impact on the infant.
A. Uh-huh.

Q. And then secondly, the impact of the infant. If you consider it that way: so the impact of maternal mental health on the infant, if you could just address that, please?
A. Okay. So, we're born very immature as human beings, and in particular our brains are very, very experience expectant and independent, I've used that turn of phrase before.

Q. Sorry, can you just break that down, what are the words you're using?
A. I use the words experience expectant and dependent. So, the actual growth development, and I guess I'd say wiring of our brain - I'd use, say, a wiring metaphor for

that - depends on the experiences that we have, and our brain's wiring pathways actually literally sprout out and grow and are looking for connections.

Perhaps it's easier to use the visual cortex, visual part of our brain. When infants are born, they cannot really process what's coming in through their eyes, but over the first year of their life or ten months or so of their life, they actually make sense of material that's coming in, like, through their eyes and it goes to their brain, and their brain develops in response to the information that they are taking in.

That's the same with a whole range of growth development and experiences for an infant. So, treatment of the mother's mental health is really, really important across the early period of an infant's life, really important, because she can't - if she's really quite depressed and she can't - and it's very hard to sort of interact and play with her infant, it is actually - the infant learns that the world isn't such a happy, joyful place so to speak and it actually has been shown to impact on language development and behavioural development down the track for those infants if depression isn't treated and intervened with early.

Q. And so, what about then - you previously touched on this - but the impact of the infant on the mother?
A. So, the infant can - I mean, just in terms of some medications used there can be an impact there, but also, infants do wake up a lot at night and so interrupt sleep and that can actually impact on the capacity to recover. You can't just put an infant aside for a week or two while you recover, unless somebody can come in and assist you, so you can't, say, rest and recuperate so easily.

Also, you can experience - women describe experiencing an enormous amount of guilt about not being able to give their infants what they'd like to give them and really want to give them, and then that kind of interacts back and is a stress in its own right, that feeds back into becoming more anxious or more depressed and impacting on a sense of self, and so complicates actually the personal recovery process, if that make - yeah, the personal recovery process as well.

Q. Can I move on to ask you briefly about data or research?

A. Yes.

Q. What do you say about there being data available that provides evidence for the effectiveness of perinatal mental health care?
A. So, that's a really difficult area to discuss, and I think in some ways science let's us down. Because, if the focus is too much on data, and if the focus is too much on quantitative data, one of the problems is that then you can end up - we've ended up with, you know, hundreds of studies that sort of can amalgamate sometimes to, if you look at them individually to say, well, this one shows this small effect and this one shows that small effect and then you put them all together and you can say, well, there's not enough evidence.

So, it's really important with the data to try to make sense of it in terms of trends and to also look at it from a qualitative point of view as well as a quantitative point of view. So quality is experiences of and think about the data, not just actually look at the hard numbers.

We do have quite a bit of data around medications and individual medications and their impact on which medications to use or not to use, but it's really difficult to actually say which - there's not a specific treatment that should occur in this way for all the different aspects of perinatal mental health care.

What we do know, though, is that you really need to focus on understanding the woman, her relationship with her infant, what it's like for her in the context of her life that she's living in and put that all together, understand her sort of situation. And there's data globally to kind of - for that and the importance of treatment in terms of her ongoing wellbeing and the infant.

Q. So that person-centred approach?
A. Yes.

Q. I asked you earlier about the tiers of mental health care in Victoria, and you described those. I just want to ask you now about, how are they operating in Victoria at the moment to meet the needs of pregnant women?
A. I think that the services are really - at one level there's quite a few services in Victoria, but at another level they're - I think they're not funded well enough

overall and they're quite sort of, they're quite sort of fragmented.

So the pathway for a woman from being unwell in the community to accessing primary care with her GP, a psychologist, and I think we've heard from other people that the number of psychology sessions available are absolutely inadequate: I mean, tens sessions is less than one a month, and then GPs are really busy.

To then secondary health care: the freeze on psychiatry sessions through Medicare has meant that there's quite a gap in Medicare rebates for women, so cost is actually an issue in terms of accessing care; through to accessing inpatient services if they are required. It's very fragmented, and it depends a little bit on where you live and it shouldn't be like that and I think --

Q. Sorry, go on, I don't want to cut you off. Go on.
A. I actually think that the notion of just having separate perinatal mental health services is actually not a helpful one or a useful one. It goes back to what I said at the start, where 50 per cent of the population are women, women become pregnant, women have infants, and I actually think that there should be clinician and stakeholder-led funding from above and that perinatal mental health services should be embedded in all area mental health services and funded, not sort of, okay, now you have to do that and add that in to what you're doing out of current funding, but they should be specifically focused on and funded so that the access to care through to all areas is available.

Q. What do you say then about the interaction between the services that currently exist? And I mean that in terms of the various tiers.
A. I think it can be very difficult to sort of access services from primary health care through to inpatient care or area mental health services if required, and so, it can be very difficult if you require admission to get into hospital, and it can be very difficult to access - yeah, so it's very difficult if you get into hospital and I think also if you've been in hospital, often there's not a step down - there's nowhere to step down to, so you go straight from hospital back to an occasional visit to your GP, which is just - there's huge gaps in the service delivery.

Q. And so, just in terms of best practice from your point of view, what does that look like?
A. I think best practice should be led by clinicians, stakeholders; I mean, there needs to be an understanding of costs, serve, care, but it definitely should be led by clinicians and peers, and that --

Q. Do you mean by that that there's a hierarchy?
A. Yes, I do, I mean a hierarchy and that actually --

Q. And how would that hierarchy work?
A. So, I think that the hierarchy, like, there needs to be: these are the practices that we think should be implemented clinically, both in terms of actual clinical guidelines, and also these are the pathways that need to be followed and these are the access points.

Pathways and services should be mapped out and they can be mapped out; I mean, it's a bit of a task, but really literally mapping out from pre-primary care, so when someone's just living in the environment and perhaps feeling stressed, to primary care, to then secondary care, to tertiary care. And actually looking at access points, where the blockages are and sort of gap filling there.

And I think this should be implemented from above so that it's expected, so that it's the standard of care and that it's not idiosyncratic and individualistic, so that this person does this and this person does that and that person does this.

I also think it should be funded, this funding shouldn't be sporadic, it should be actually an integrated model of care. I think actually it's really important not to just look - even as I'm speaking, like, as I'm here as a witness on perinatal mental health, I don't think perinatal mental health should be isolated as just a subspecialty. There needs to be a bit of a subspecialty component and understanding, you need to have leaders and people who understand it, but it actually needs to be woven into the substrate of the system.

And I also think there needs to be an educational component that goes from community through to primary care, secondary care, and also a research component as well to really understand what it is that we need to deliver

MS COGHLAN: Thank you, doctor. Chair, are there any questions from the Commissioners?

CHAIR: Q. I'd like to ask one, thank you very much. In relation to the feedback that you receive from the women that you're working with about the complexity of navigating that system, what do they say to you?
A. I think, I mean, they do find it really difficult and complex. Cost is a huge issue. A lot of feedback that we'd get would be around cost: that it's too expensive to have care in the primary care setting in the private setting, and so, you know, they budget out their appointments.

And also, accessing services at times of crises as well, and that the crisis point is lower. When I say "lower", it's different. I don't mean it's lower, it is a crisis point, but it's different and not always recognised or frequently not recognised.

Q. I think that's an important point you made in the statement a few times, that you felt people underestimated the risks that there were for the mother and the infant at this point of time?
A. Absolutely.

Q. And hence the importance of them getting access to treatment. Can you just make sure we understand that clearly, what you're saying there?
A. So, I mean, there's obvious crises of - first of all, the worst and the most tragic is loss of mother and loss of an infant; that's the most tragic and is rare but it occurs. There's a myth that, if a mother has a baby then she's at less risk of, say, taking her life and that's not true. So, that's one thing. I think - I lost track of your question.

Q. I think you were saying people underestimate the urgency of access to care.
A. Yes, that's right. The next thing is that people underestimate that the long-term need, if you are looking after an infant, that it's not just the mum, there is an infant there and that infant is really dependent on her, largely speaking. But then there's also a family network, and you can't just - there are not necessarily people who can just jump in and support a person - a mother at home with an infant.

I think when an individual adult is anxious, depressed or has an illness, you can sometimes manage individual adults in the community for longer, because you can sort of touch base with them, you can make sure that they're looking after themselves; you can actually do that and check in with them. But I think when there's an infant it's actually - she can't just go away and put the infant in the spare room for three hours while she has a bit of a break - or he. I mean, it's mainly women that we're talking about.

So, I think that that's often not recognised, that that's actually a really, really important point, both for the mother's wellbeing and her recovery, but also for the infant's development and wellbeing.

Q. Can I just ask how well placed you think the maternal and child health nurse network is to respond to mental health issues?
A. I don't think they're well placed at all. They do a fantastic job, they really do, but maternity and child health nurses are not trained in mental health disorders. They're a really excellent part of our overall service of health care, but the maternity and child health network now are funded much less than they used to be, so there's specific appointment times - I mean, numbers of appointments that women can access maternity and child health nurses.

Maternity and child health nurses - this is feedback that we receive - but they express often feeling an enormous amount of work stress, just like, in terms of the load that's placed on them because they don't - they're not trained in mental health care at all.

I actually think it's - I think it's not right for us as a - thinking mental health care - to put too much on to maternity and child health nurses. They're a really important part of the system but not, you know, not - we shouldn't be pushing down onto them

CHAIR: Thank you.

MS COGHLAN: Thank you. May the doctor be excused, please?

CHAIR: Yes, thank you very much.

<**THE WITNESS WITHDREW**

MS COGHLAN: Chair, is now a convenient time for a short break.

CHAIR: Yes, let's adjourn.

SHORT ADJOURNMENT

MS COGHLAN: The next witness to be called is Shaun McClare. I call him now.

<SHAUN DANIEL MCCLARE, affirmed and examined: [11.36am]

MS COGHLAN: Q. Thank you, Mr McClare. You've provided a statement to the Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0003.0009.0007] You're a principal of Kalinda Primary School?
A. Yes, that's correct.

Q. Whereabouts is Kalinda Primary School?
A. In Ringwood.

Q. How many students do you have there?
A. Approximately 580 students.

Q. Just in terms of the types of issues or challenges that the students might face at that school, is there anything particular about what they might experience?
A. Yep. So Kalinda is a fairly middle-class school. The data suggests that socioeconomically students are reasonably advantaged, with a small pocket of families from English as a second language background.

However, just like any primary school, we have students who face issues such as depression, anxiety, a small number of students with suicidal ideation. The issues faced by the students at Kalinda are quite typical of students across the state.

Q. In your statement you say:

"Much of our work [and this means your work

at the school] in mental health is focused on building a child's resilience to help them when they may encounter greater challenges when they get to high school."

A. Absolutely. So, the issues to do with mental health come out a lot more within a secondary setting and the challenges are a lot greater. Part of the role of a primary school is to, in the best possible way we can as educators, prepare our students for those challenges that are ahead, and developing their sense of resilience and giving them the wellbeing skills and capacities to be able to face those challenges and seek help and seek advice and get through challenges in high school and beyond, is a really important part of our role as primary school educators and educators across the whole system.

Q. Can I ask you specifically about the Maroondah Positive Education Network?

A. So, in about 2016 the Maroondah Principals Network, which comprises of principals of public, primary and secondary schools in the Maroondah region, along with the Maroondah City Council and the Department of Education, formed a partnership to work on improving the wellbeing outcomes for young people throughout the Maroondah area.

This work came off the back of a Maroondah youth wellbeing survey which was commissioned by the Maroondah City Council, was done in conjunction with the University of Melbourne, and the survey was implemented across schools, so the data coming out of that survey was one of the big drivers to actually getting the network formed and that partnership developed.

Q. What was the nature of that data that led to those developments?

A. The data showed - and the survey collected data from students from Year 5 through to the end of high school - and it showed there was increasing levels across all schools in the area, increasing levels of anxiety, depression, other health issues such as lack of sleep, stress, issues with worsening attendances as students got older through school; they were some of the general issues that were identified in the survey.

Q. What did that give rise to, if you can focus on the Maroondah Positive Education?

A. So, the Maroondah Positive Education - the Maroondah principals really came together, and as a group of principals, formed a collective vision of working on improving the wellbeing of all students within Maroondah schools and this led to the partnership, where we're actually being able to do some proactive work in developing the skills and capacities of our skills to improve the wellbeing of these students.

Q. Is that what the Maroondah Positive Education Network is?
A. Yes, absolutely.

Q. And so, that's about increasing wellbeing and educational outcomes for students?
A. Yes, it is. Yes, it is.

Q. That's through implementation of a Positive Education program?
A. Yep, so the Maroondah Positive Education Network, which was formed in approximately 2016, worked together to implement Positive Education throughout the network. 26 schools, along with the Maroondah City Council and the Department of Education, were dedicated to implementing Positive Education throughout all of our schools.

Positive Education is an approach to look at wellbeing of students where we're not just focusing on students who have high levels of need when it comes to wellbeing or mental health, but looking at the overall mental wellbeing of all students and staff in a proactive way through developing wellbeing literacy of staff members, through being able to develop a culture within the schools where wellbeing outcomes are valued just as highly as academic outcomes, and that it's really important that we see the two as intrinsically interwoven; that when we improve wellbeing outcomes, that will improve academic outcomes, and when we're doing things better academically, it also improves wellbeing outcomes.

So, it's trying to move for the schools in the Maroondah network, the focus from not just focusing on numeracy and literacy outcomes, but really making sure wellbeing has an equal footing with the importance in what we do and the work we do with our staff and the professional learning we focus on.

Q. So, you're looking at the way in which education is delivered rather than implementing a program; is that right?
A. Absolutely. So, Positive Education gives us a framework for how we deliver wellbeing and how we teach throughout our schools. It is not a program where you can just learn how to do Positive Education and go in and do a half hour class once a week.

It gives us a framework to focus on things that are really important for student wellbeing, such as positive relationships, meaning, gratitude, positive emotions, developing those skills and capacities amongst staff members, and then each school looking at their own unique setting and circumstances and being able to then develop curriculum and programs that are going to meet the needs for their students under the umbrella of Positive Education.

Q. Okay, so the needs of Kalinda Primary School for example might be different to the needs of a different primary school?
A. Absolutely. Whilst there will be a lot of crossover and there will be a lot of similarities - it may be the size of the school, it may be the demographics of the school are different - so it's important that we are able to work together collaboratively, because there's a lot of power in that, there's a lot of sharing of experience and expertise, but at the same time we have to really focus on what we need to deliver in each school and where the correct starting point is with the work.

Q. And so, there are various modules that you can focus on?
A. Absolutely. So, initially we worked with Geelong Grammar; Geelong Grammar has a lot of experience with Positive Education and we looked at doing a lot of training with them in looking at a number of different models, and I might refer to my statement about the modules that were developed to focus on.

So, the modules that we looked at developing were on: character strengths, positive emotions, engagement, growth mindset, positive relationships, meaning and purpose, strength-based coaching, health including sleep and nutrition, and brain breaks.

So these modules were developed and then schools are able to access and work with their own staff in professional development to build expertise amongst their staff members in these different areas, and then schools are able to develop plans and build curriculum around those areas.

Q. And so, one of the focuses is on building staff wellbeing, which then is perceived to have a positive impact or the children?
A. Absolutely. So, since the start of the work we did in the Maroondah Positive Education Network, we certainly had a strong focus on having a focus on learning it, living it and then leading it.

So we knew that it was really important to have staff being able to see the impact of particular strategies around wellbeing and how it could impact on their own lives before they were actually going ahead and looking at educating their students about these strategies.

Also, on the other hand, we know that, if staff have a higher level of wellbeing, that will create a culture and an atmosphere which is going to enhance the wellbeing of all students throughout the school.

I think what is a really powerful part of what we're doing in the network and what we're continuing to do, is that, we are not ignoring the wellbeing needs of the staff and, just like in any career, there are lots of unique challenges that come in education and, if we can really support our staff and support their wellbeing and their mental health, that's going to create a better environment for all students and have a great impact in the long run.

Q. And so, Kalinda Primary School has had Positive Education influencing its program since 2016?
A. Correct.

Q. You haven't been there that whole time?
A. No, I've been working in the network since 2016. Prior to Kalinda Primary School I was at Marlborough Primary School, so I had been working in the network but I've only been at Kalinda Primary School since April this year.

Q. So, what have you seen though in terms of the impacts

on either the previous school or at Kalinda?
A. Firstly to my previous school, Marlborough Primary School, I saw a real change in the language that staff used; a focus on a strengths-based approach to wellbeing issues.

So, it wasn't focusing entirely on the negative issues that were faced with students, it was looking at how we could build their strengths and their level of resilience to focus on, you know, facing the challenges that lay ahead in life.

At Kalinda Primary School, being there a term so far, I can see there's a really strong focus on wellbeing in line with the focus on, you know, academic performance at the school.

We have two HOPE Leaders, so that's Head of Positive Education Leaders throughout the school, we have wellbeing leaders amongst our students, and there are a number of fantastic programs that are going on underneath the umbrella of Positive Education that shows that at Kalinda we're really focusing on wellbeing in a very broad yet, I'd say, well researched and strategic way.

Q. Can I ask you about two particular programs?
A. Yes, absolutely. So, at Kalinda at the moment a couple of programs that are going on under that umbrella: one of them is, in the last 12 months we've implemented the Play is the Way program at the school. Play is the Way is a program where students take part in games and role playing activities that put them inside challenging situations. Then, during those games, a teacher is able to pause the game and have the students reflect on how they reacted emotionally to the challenges.

The students then are able to discuss how they could approach that challenge differently in the future; what the particular game or challenge really - how it impacted on them, how it impacted on those around them, and then we can focus on the students' ability of resilience and wellbeing and also student relationships, so it's a fantastic program that can look at some of those big umbrella items within Positive Education about positive emotions and positive relationships.

That's implemented for all students throughout the

school, so that's across every classroom from Foundation through to Year 6 and is part of our curriculum and part of our timetable part of what we deliver.

Another program we started recently throughout the last term is the Rock and Water program. This program is delivered for 60 students, so it's a much more discrete students. Those students have been selected for a variety of different reasons. It may be that they are students who are facing some wellbeing challenges, they may be showing a lack of resilience, they may be having trouble with their relationships out in the yard. But then there's also some students in there, it may be that they show fantastic leadership capacity and skills.

So there's a wide variety of students but they're being selected for specific reasons. That program uses a range of physical activities loosely based on martial arts, so that really builds students' resilience, leadership and relationship-solving issues

MS COGHLAN: Thank you. Chair, are there any questions from the Commissioners?

CHAIR: Professor McSherry.

COMMISSIONER McSHERRY: Q. Just one question. I was just wondering whether you were working with some of the researchers to evaluate the framework and some of the programs that you are doing?
A. Yes, absolutely. So, with Melbourne University, so with the youth wellbeing survey that was implemented, just in the last month we've also completed that survey again so we'll be looking at the data there.

That's a tricky one because it's still in its first few years so we don't really have a great amount of data to see the success and the impact, and we know that cultural and practice change within a school can be long, slow work. But certainly, with everything that we do, we are always collecting data and analysing that data too, to make sure that we're being rigorous and we're not just - we're not just having a go, we're making sure we're doing the right work when we put the effort in.

CHAIR: Dr Cockram.

COMMISSIONER COCKRAM: Q. Hi, Mr McClare. Yesterday, and I'm not sure if you're aware of the evidence we heard yesterday from Georgie Harman, CEO of Beyond Blue, but she talked about what I think is an alternative program that's operating within the Education Department and across different schools called Be You.

This sounds like quite a different program, what you're describing to us today. Can you just articulate the differences between the programs and why you and the group of schools that you're working with chose Positive Education?

A. That's a good question. So, I'm not that familiar with the Be You program to be honest, but the rationale behind choosing Positive Education was, there were a number of principals within the network who had experience with Positive Education in the past. Out of the work that Martin Seligman has done with positive psychology and then has been implemented into work such as Places at Geelong Grammar, there's quite a lot of research and evidence out there that shows that work has had a high impact, so the decision was to head down that path as a network.

As a network of schools, we were very mindful of the fact that, you know, we've got special development schools, small primary schools, large primary schools, smaller high schools, larger high schools, so whilst we're from the same region, there still is quite a lot of diversity throughout the schools so we're very mindful of not just getting a program that we could fit in, we wanted to really work on Positive Education as a framework for wellbeing, that each school could then develop their plan, which could include programs, and it can include lots of different programs that are then put into the schools, but it's making sure that, as a whole, we've got a framework with which we look at wellbeing throughout the school.

MS COGHLAN: Thank you.

CHAIR: I've just got a few other questions I'd like to clarify, thank you very much, Mr McClare. The first one is, in the survey that you describe gave rise to this initiative, I think it was for students aged in those higher years of primary school and into high school, but in terms of the issues you've identified as the principal and with your colleagues, for children experiencing what you've described as increased incidents of anxiety and depression

and a small number of students with suicidal ideations, has that been across the whole continuum of primary school years, from Prep to Year 6, that you see those issues or are they concentrated in the latter years of primary school?
A. I would say through my own experience but not with any actual data, but through my experience it is in the latter half. So, it really is in those later years of primary school that we generally see those issues, yes.

Q. Can I just ask then, for those students for whom you might be concerned about their wellbeing, as well as building the overall resilience for all students, typically what access to additional support and assistance would you be able to seek for those students?
A. Absolutely. So, you know, as educators we don't think that our teachers are mental health experts in any way, and also as a principal I'm not as well, so it's really important that we're able to access support from experts to really help when there are students who are presenting with mental health issues that are really concerning to us.

So, the first point of call generally within a government primary or secondary school is to, in conjunction with the parents of that student, is to put a referral in to student support officers who work within the department, so that can be psychologists, speech therapists, a range of different services that are there. They can then look at assessing a student and helping that student and the family access further services as required.

Q. Do they also provide secondary consultation to you or the classroom teacher about making sure you adopt appropriate practices in relation to individual students?
A. Absolutely. So, the SSO officers come in and work with schools and have established ongoing relationships with the schools, so it's quite typical that you would have the same psychologist, for example, come in and work at your school one day per week, so you know this person quite well, they're an established part of your staff.

And absolutely part of the work you're doing there is, of course, assessment of a student, but then, it's educating teachers to be able to give appropriate responses and have the correct supports that are there to make sure we can, you know, do our part in looking after the wellbeing of those young people who may be at risk.

As with all sectors, we would always love more support and more resources, and that's part of the ongoing nature of things, but there's a very clear process there for us to follow.

CHAIR: Great, thank you very much.

MS COGHLAN: Thank you, may the witness be excused?

CHAIR: Yes.

<**THE WITNESS WITHDREW**

MS COGHLAN: The next witness is Dr Richard Haslam and I call him now.

<RICHARD HASLAM, affirmed and examined: [11.56am]

MS COGHLAN: Q. Dr Haslam, I speak pretty quickly, and I fear that you might too, so let's try and keep the pace at one that can be followed. You've provided a statement to the Commission?
A. Yes, indeed.

Q. I tender that statement. [WIT.0002.0006.0001] Can you please state what your qualifications are?
A. I have a basic medical degree, the Bachelor of Medicine, Bachelor of Surgery, postgraduate qualifications in child and adolescent psychiatry, and in child and adolescent mental health. I'm qualified as a consultant paediatrician.

Q. What is your current role?
A. I'm Director of Mental Health, which is the department involved in mental health at the Royal Children's Hospital.

Q. Can I start by something you about CAMHS; that's a term that the Commissioners have heard and is often used. First of all, what does it stand for?
A. CAMHS stands for child and adolescent mental health services.

Q. And, what are they?
A. CAMHS services are team-based services made up of a number of disciplines set up to deliver care for children and adolescents, and indeed infants, with severe and

complex mental disorders.

Q. What age group do they service?
A. 0-18.

Q. How many regionalised CAMHS are there in Victoria?
A. There are 13 regionalised CAMHS services each with a catchment area, eight of them regional and five metropolitan.

Q. And all of them, apart from the Royal Children's Hospital, are aligned with and governed by health services that also provide adult mental health services?
A. That's correct.

Q. Another term that the Commission has heard is CYMHS. Can you just tell us what CYMHS is?
A. So, over about the last 20 years a youth model of mental health has come into place in Victoria and it offers a focus on young people aged 15-25 years. It's evolved from adult mental health models and is a significant modification of those. Amongst other things, it aims to improve access for a group of young people who have traditionally had difficulties in gaining access to mental health services.

CYMHS is a term for CAMHS services which have incorporated youth mental health, and to differing degrees, but which essentially cover an age range of 0-25.

Q. I'll come back to ask you about that later. Can we just focus on, for the moment, the Royal Children's Hospital and the breadth of services provided by the Royal Children's. If you could just outline what they are.
A. Certainly. So, I guess we might use two umbrellas: one is clinical and the other is collaborations. So, we provide a very broad range of clinical services, from inpatient care for young people 13-18 years of age, with serious or highly risky mental health conditions.

We provide community mental health care based from three clinics around Western and Northern Melbourne, which is probably the predominant means by which Child and Adolescent Mental Health Services are delivered.

We offer a fairly wide range of specialist clinics based at the Children's, many of which have a state-wide

remit, for example infant mental health, gender services, eating disorders, neurodevelopment and so forth.

We provide mental health care for children who are inpatients of the hospital, including the emergency department where we've seen a remarkable rise in the rate of presentations of young people with mental disorders and mental health symptoms, particularly after hours.

From a collaborative point of view, and I guess this is something we'll talk about a little more later, we have a number of services that we take pride in. We, for example, offer a School Refusal Program in partnership with the Travancore School, which is called Inter-School. We provide, like many other CAMHS services, the CASEA program, C-A-S-E-A, which is a universal targeted and specific, if you like, intervention for children in Prep to Grade 3 in primary schools aimed to reduce the incidence of conduct problems and conduct disorders.

We have collaborations with, say for example, maternal and child health nurses in our new program called "Bubs in Mind" in two Local Government areas.

We also take part in mental health promotion, which is sort of right up the other end of the spectrum, if you like, and we're very proud of the 21 years of our Festival For Health Living which provides mental health promotion and building resilience through the arts.

Q. There's also some new collaborations that are occurring at the moment?
A. Yeah, our CAMHS service was fortunate to receive growth funding over the last couple of years, and we dedicated most of that to a range of programs which were, again, about capacity building and collaboration.

So, for example, with the Wadja Family Place, which is an Aboriginal Mental Health Service within the Royal Children's Hospital, children with developmental disabilities, children who are from a refugee background and who have suffered trauma, children who were in out-of-home care. So, we targeted those collaborations and that clinical work to really reach into and build mental health capacity in those really under-serviced areas.

Q. Can I ask you specifically about one of the specialist

services that you mentioned, and it was the - I think it's the Infant Mental Health Team; is that the correct name?
A. That's correct.

Q. You said earlier on that CAMHS provide services to children aged 0-18 years, or it has the capacity to. But is it the case that, in the past, little attention has been paid to that 0-4 age bracket?
A. Yeah, I think that's very true. Probably in the community, but perhaps also amongst health providers, there's a neglect or a lack of appreciation of the presence and the severity of mental illnesses and symptoms of mental health problems which are present in infants. And by infants I'm using the term for 0-4, but it could equally be applied for 0-2 as well.

Q. And so, how has the Royal Children's Hospital responded to that?
A. So our response, and I'd like to think that we're really world-leading in infant mental health, our response over time has been one of clinical services. So, we provide clinical services for children in the hospital and who have left the hospital who've suffered from, what we use the term of medical trauma, which is the result of often very severe congenital or medical problems early in life. And, as you can imagine, the stress for children, infants, and also for their parents, is enormous with some of the required medical interventions and surgical interventions that infants might experience.

We've also provided care for children who have suffered from what we call adverse childhood experiences, if you like, and so, they might have been born in a family where there is substance use, parental mental illness, family relationship difficulties, family violence, these sorts of things. So, children in that kind of environment are far more likely to experience traumatic symptoms as well as anxiety and depression.

And we also see infants who develop anxiety and depression just like children, just like adolescents and just like adults. So, we provide those clinical services and, as well as that, we've provided training for paediatricians, for child psychologists, and widespread training for a number of other disciplines as well.

Q. Is that just within the Royal Children's Hospital

context or is that training more broad?
A. The training is state-wide and we run, for example, a two-day training each year which is widely subscribed to and typically sells out.

Q. Can I turn now to ask you about some challenges that might be faced in this sphere, particularly in relation to the Child and Adolescent Service model. Can we start with the idea that there's a mismatch between inpatient care and community service providers, or the provision of services in the community. Can you just expand on that?
A. Okay. So, there are four inpatient units for adolescents, essentially aged 13 to their 18th birthday in metropolitan Melbourne which provides services for Victoria. There are also two inpatient units for children under the age of 13 in Victoria. There are also youth mental health wards for an older age group.

To an extent there's a mismatch between the provision of outpatient care and inpatient care. A good example is the ward at the Royal Children's where, because of catchment - well, because of age cutoffs that exist for outpatient care, the vast majority of young people admitted to our ward are receiving the community care from either Orygen Youth Health if they're over the age of 15, or from regional providers; so, we provide inpatient care for three large parts of western and southern Victoria.

So in fact, most of the young people in our Banksia ward, our adolescent ward, are receiving community treatment from another service, whether it's a youth mental health service, a CYMHS or a CAMHS. And that's a problem because inpatient care really is generally a small period of time in a course of outpatient treatment. The definitive treatment of most child and adolescent mental disorders is outpatient treatment.

So, it's important that there's coherence between the models of care, and also there's clear communication between inpatient and outpatient, and that's not well set up in arrangements such as we have at the Children's and to some extent in other services.

Q. Just moving on then to another challenge; this is in terms of the way that perhaps CAMHS were initially established, and the idea that they're really bolted on to a system that's designed for adults. Can you just explain

that?
A. Yes. So, I guess that CAMHS services, apart from the Royal Children's, CAMHS services are part of, and typically all ages, mental health service that's regionalised, so there's a logic in terms of a catchment area, but the result, in my view, is a rather fragmented and devolved system of CAMHS services.

I think that the delivery of mental health services in Victoria is really predicated on adult mental health models and adult mental disorders, mental illnesses in the first instance. So, in my view, structural issues like catchment areas and models like the recovery model or a case management model are devised predominantly for adult mental health services and then there's an attempt to make them work for child and adolescent mental health services.

Certainly, we see that funding opportunities and funding guidelines are typically directed for the much larger adult mental health services; and quite often funding initiatives, such as the Multiple and Complex Needs Initiative, is specifically only for people over the age of 16 or over the age of 18 in some other policies.

Q. Can I ask you also, and just picking up on something you've said in your statement, that you consider that there are three dimensions which represent the range of mental health problems for children and adolescents and therefore represent the needs of the system. Can you just elaborate, first of all, on what those three dimensions are?
A. Sure. So, if one pictures a cube in one's mind's eye: so, what we have is a range of ages: clearly we have children, we have infants, we have children, we have adolescents, all with very different settings, all with very different needs, all with very different degrees of independence. Clearly, devising a mental health system for infants will be in some ways very different from the way one might devise it if one has the patient or the young person in mind, very different from that for a 15-year-old or an 18-year-old. So, that's one of the dimensions, if you like.

The second would be that there are a range of conditions or disorders, or symptoms which present in childhood: anxiety and depression, for example, eating disorders, psychoses, conduct problems, neurodevelopmental difficulties like attention deficit hyperactivity disorder

or autism spectrum disorder. So, there's actually a very broad range of the sorts of conditions which fall into mental health and mental ill-health.

Then the third dimension, if you like, is that of severity. So, we see great degrees of range in severity: we might see a child with anxiety who has difficulty speaking in front of class, we might have another child with anxiety who's been unable to go to school for two years. So, we've got a range of ages, we've got a range of conditions, and we've got a range of severity.

Q. You say in your statement, in relation to those three dimensions you've described, that they're "a challenge to developing a service system for mental disorders in isolation." So, can you just expand on that please?
A. Yeah, I might just make the point that, as we've seen from the second and most recent national survey of child and adolescent mental health and wellbeing, that somewhere close to 15 per cent of children will have symptoms of a mental disorder or a mental illness. So, a specialist mental health service system simply won't be able to manage with that degree of prevalence.

If we think about a cone or a triangle with the specialist services at the top or the top part of that, 15 per cent is an enormous number of children and adolescents, so that's probably the context I might add.

In terms of the severity, most of the young people with mental health problems, mental illnesses or mental disorders will have the milder or more moderate difficulties, and so, a mental health service system, a specialist system in isolation isn't going to be designed for that large - which is a large number - of children who have mild and moderate difficulties.

Q. What about the expression of the child's voice and the parent's voice, and how a model responds to that?
A. Yeah, I touched on this in talking about infants, but I think that the child's voice when it comes to mental health problems is, again, often a little minimised. We know that generally the best informant, the best person to explain the degree and nature of anxiety and depression is the person themselves; in contrast to behavioural difficulties, like conduct problems, where probably the best informant is going to be educators or parents.

So I think there is to an extent a minimising of mental health problems in childhood as part of growing up, and so, I guess the child's voice isn't well represented because they're so dependent and because there's this perhaps systematic underplaying of the nature and degree of mental health problems that children and adolescents might experience.

Q. You see that in some parents, for example, there's a perception that their child might grow out of a certain problem they're experiencing?
A. Yeah, this is compelling results from the National Child Health Poll which the RCH conducted or continues to conduct, but conducted in mental health last year, that many parents feel that infants don't have mental health problems and children - and they struggle to appreciate that children might also experience enduring mental health difficulties, and certainly they report that they wouldn't know where to turn in a significant minority of this representative sample of Australian parents.

Q. Can I ask you about that in terms of knowing where to turn and ask you some further questions about difficulty accessing services when needed. Can I start by asking you about this prevalence issue you've already raised. Do you agree with this proposition: that the prevalence is too high for 13 CAMHS to meet, for example?
A. I do.

Q. What about waiting times?
A. So, my observation would be that, in a situation - and we'll possibly talk about this later - of what I term "the missing middle", an absence of --

Q. That's next.
A. Great. An absence of providers who can meet the demand for and feel authorised and supported to meet the demand for addressing mental health problems that are of a mild and moderate severity, CAMHS services, what we see in health is that the work sort of moves upwards if there's nowhere for it to be met in the first place, so children and adolescents will be presented to CAMHS services even with mild difficulties, and CAMHS services will spend a significant amount of their time triaging or sorting through, finding pathways for children with mild or more moderate difficulties.

Q. And, what's the result of that for CAMHS?
A. So, the result is that we see, I guess, rationing; we see catchment areas being strictly adhered to; we see referral criteria that rely on severity and acuity. So, children are able to access a CAMHS service in an emergency or in an urgent situation, but waiting times might be as long as 12, 16, 18, weeks for a regular referral of a child who's even got over that referral bar.

Q. In terms of this missing middle, what should be there?
A. So, at the moment the middle, if you like, is predominantly Federally funded, a Commonwealth funded fee for service providers, like paediatricians, Better Access psychologists and a range of other providers, and my observation is that there's a maldistribution of those, such that it's really not a system, it's a series of providers each in isolation.

So, the missing middle is the lack of or the paucity of, but also the maldistribution of solo providers of child health and child mental health, such as paediatricians, psychologists, and of course school welfare staff and school counsellors, school psychologists and so forth. There's a shortage of them, but also a maldistribution.

What we know is that the rates of mental health problems, mental illnesses, differ in different parts of Victoria. And we know that where, for example, there's lower socio-economic predominance, that there are much higher rates of mental health problems, and yet, we don't see what we call proportionate universalism where services are provided in proportion with need. Instead we see CAMHS services provided on a more or less per capita basis and then a Federally funded system or series of providers which attempt to meet the middle.

Q. Just picking up on that funding question, what do you say then about the adequacy of funding in the context of prevalence that you've raised?
A. So, I think it's demonstrated, from the recent Victorian Auditor-General's Office audit of child and youth mental health services, and indeed access to mental health services, that funding is really insufficient, even for the prevalence of serious, severe mental illnesses in all ages.

So, even for the most pointy end if you like, or

serious, the funding is insufficient. But, as I said, the presence of and the affordability of private providers is really quite variable across Victoria, and I suspect is - they're even more difficult to access in regional Victoria than they are in metropolitan Melbourne.

Q. What about monitoring in terms of, what monitoring is there for CAMHS?
A. Predominantly CAMHS are funded on the basis of input, so activity, and it's a little bit like the fee for service system, that one is reimbursed from MBS for the time taken rather than the outcomes that ensue.

Q. So what's your view then on whether it should be outcome-based?
A. So I think measurement-based care and funding on the basis of notions such as access for vulnerable groups, outcomes, the use of evidence-based interventions, these are all things which are likely to lead to a much more effective and impactful CAMHS service.

Q. Does it then offer the best means to improve services?
A. Yes, I do. I think that funding for outcomes - as I said, access for vulnerable groups, collaboration with that middle, the missing middle, with other providers, with health providers/schools, these are all things which, if there are funding targets attached then it's far more likely that services will evolve to develop those services, even if we have a devolved system of 13 CAMHS.

Q. Can I take you now to some specific recommendations in relation to system design. Before I get to that though, can I just ask you about the importance of early intervention. You say in your statement that:

> "Mental disorders tend to be persistent or recurrent, and accumulative. There is a snowballing effect when mental disorders develop and accrete with other medical, mental health and social difficulties."

Can you just expand on that in terms of looking at an effective system?

A. I think there are powerful reasons to intervene early which are probably pretty obvious to all of us, but there are - as well as the cost-effectiveness of intervening

early, for example through parenting interventions or more simpler shorter interventions because of less - a lower severity, I think there's an economic impact from failing to intervene early - children become adults and become parents, of course.

What we typically see is that, as I think as other testimonies have provided, we see that there's an accumulation of difficulties. So, again, adverse childhood experiences, mental health difficulties that might also be present in other members of the family. So, intervening early for children whose voice is not often easily heard is valuable for a whole lot of reasons.

Q. Taking you now to specific recommendations, one of the things that you've already touched on is the idea of this missing middle, and an alignment with primary care system and building capacity. Is that one key change that you would recommend?
A. Yeah, I think that, rather than having a specialist service that's potentially a little bit isolated, I think a proportion of CAMHS or CYMHS services time should be specifically around building capacity. There's a range of things I could refer to, and I think I have in my witness statement, that the Children's is seeking to do and is doing, but I think there has to be a devotion to and a commitment to building the capacity and providing available support for, for example, paediatricians, and I've cited the example of the Massachusetts Child Psychiatry Access program providing direct sustainable supervision, consultation for paediatricians dealing with these sorts of difficulties.

Q. Can you just expand on that, that example?
A. Yeah, so the MCPAP's been running for probably 10 or 20 years. It obviously started in Massachusetts but it's used in a number of states now. One of the parts of that is that there are child and adolescent psychiatrists who are available for consultation generally within 30 minutes for paediatricians who might have a - who are essentially primary care providers in the US.

Q. Is that a phone contact, do you mean?
A. Yes.

Q. Sorry, go on.
A. So, to be able to provide advice and recommendations,

for example about medications or therapies or treatment pathways.

Q. So, would that include referrals?
A. Sure, yep.

Q. Just in relation to, like, a further recommendation: the idea that there needs to be greater recognition of the special needs of child and adolescent mental health in system design; if you could just expand on that?
A. As I mentioned earlier, I think conveying the voice of children, the participation of children, in the care that's provided and the way the system's designed is something that we need to purposefully do. It's something that's been done quite well in youth mental health services, and indeed there are paid peer support workers in adult services, but I think we can do better to present the needs of children for children.

Q. One of the things you say in your statement is:

> "While the community may now better understand mental disorders for those aged. Between 15 to 18 years old as well as issues such as youth suicide and drug use, the impairment of mental illnesses occurring early in life are often minimised and misunderstood."

So, is what you're saying seeking to address that area that is minimised and misunderstood?
A. Yeah, I think we can strengthen both in health providers and in the community the understanding of the impact and the presence of mental illnesses and mental health problems in children; children who might have other adverse experiences, might have health problems, or might simply have a range of mental health difficulties. So, we can simply do better with that. The term is used of "mental health literacy for the community".

There are a range of resources such as the Raise Your Children Network which provide, you know, evidence-based and useful information for parents, but there's much more that we could do to support parents to appreciate and understand mental health difficulties in their children, and the same goes for educators and the same goes for health and welfare providers.

Q. Can I ask you now about the point of view that you have which is to amalgamate CAMHS. So, if you can just explain that, please?
A. So, I think a devolved or essentially fragmented system of 13 separately governed CAMHS services is probably not how you would design things if you wanted to have consistency, if you wanted to have workforce development, if you wanted to have evidence-based care spread across all of those services.

So, I think we've found ourselves with 13 separate CAMHS services, but I think that there are problems with that. I think there's a gradient of services that are available across catchment areas, and I think in terms of critical mass for the workforce and from the point of view of introducing evidence-based interventions, common pathways, consistency of care, it would make much more sense to pattern from, for example, children's cancer or paediatric rehabilitation where we've approached things from a state-wide perspective.

I do think that the missing middle is child and adolescent providers, health providers, paediatricians, general practitioners, psychologists and so forth, and the better that CAMHS services are aligned, or a single infant, child and adolescent mental health service is aligned with those services, the better for children.

Q. In terms of evidence-based interventions in child and adolescent mental health, one of the things you refer to in your statement is the example of what's going on in Canada, in Ontario. Can you just explain that?
A. Yes, I've referred to the Ontario Centre of Excellence in Child and Youth Mental Health, which is really a remarkable organisation. Ontario has a population of nearly 15 million, and the Centre of Excellence is partly about knowledge translation and partly about disseminating and implementing evidence-based treatments, but it's very much involved in that implementation part.

So there's developing policies, policy advice, there's developing evidence and then there's making sure that it's implemented using meaningful outcomes and having them employed in mental health services. So, it's really a centre for the whole state to improve the uptake of evidence-based interventions which, after all, are the most

likely things to help children and youth.

Q. Can I ask you about your thoughts on the resolution of the youth mental health model, and what I'm referring to there is, you've given evidence about the CAMHS service covering children 0-18 years, but also the CYMHS service which is, is it 15-25 focused?
A. The CYMHS would technically be 0-25 in most cases, yes.

Q. Zero. Can you just explain what you mean by resolving, if there is tension, between those two services?
A. So, I think there's a - as I mentioned earlier, there's been the presence of a youth mental health model in Victoria for probably 20 years, and to some extent it's been taken up in the use of, for example, child and youth mental health services in a number of other ways, and certainly interventions, or services like Headspace are a great example of that.

I think it's laudable that there's been attention to the mental health needs of people over the age of 15.

I think that it hasn't entirely been resolved, and certainly in the case of a paediatric or a child and adolescent model there are still - there's an extent to which there are unresolved inconsistencies. And so, the example of the inpatients and the outpatient care in the North and Western Melbourne was one that I gave a little earlier.

So I think it's really important that the community care is aligned with inpatient care, and at the moment that isn't necessarily the situation that we have.

I think that, from a paediatric perspective, child health and children in families, which is most young people under the age of 18, is to some extent, if not at odds, then in some sort of creative tension with a youth mental health model.

I think that one of the things that I'm aware of in my region, or in my department, is that the acuity or the severity or the risk of young people presenting with mental health problems who are perhaps over 15 tends to be more acute and more risky; so, for example, if you think about suicidal behaviour.

So, the result is that, if one has a service where there are choices to be made about allocation of funding, inevitably there will be an allocation of funding to where that risk sits; so that's something that we've done with funding emergency department mental health staff where we might otherwise have devoted that to community outpatient care.

So, I think it would be interesting to examine, in say for example a child and youth system, which is 0-25, the extent to which young people, children and adolescents who are in the younger age bracket, are continuing to receive parity of service and continue to have their various and particular needs met.

It's very important that all ages are able to gain access to appropriate settings and services and trained providers with evidence-based treatments and measurement of outcomes and so forth. But it's also very important that, if we're having a 0-25 model, that we make sure that we recognise the various needs and the nature of serious mental illnesses in children and adolescents at the same time as the serious and impairing mental disorders that might present themselves in young people; that is to say, people over 15.

Q. Thank you, doctor. Are there any other key recommendations that you'd like to voice before the Commissioners?

A. We've touched on it a little, but I think that general practitioners, schools, paediatricians are very much at the frontline of this very high prevalence of mental health problems, and I think that it's important that - you know, we use the phrase "no health without mental health" - I think it's really important that general health providers are supported to see mental health as part of their work, not as something for another discipline or another area.

It's very important, given the prevalence and the overlap of medical and mental health difficulties, or physical and mental health difficulties I should say, that those service providers, those health providers see mental health as very much part of what they do.

And I think CAMHS or CYMHS as specialist mental health, as I said earlier, really needs to be expected and

tasked to support, like that Massachusetts program I mentioned, to support those paediatricians and others.

I also think that there's a case that could be made for community paediatricians, as there are in other jurisdictions in Australia which are co-located with mental health providers, so salaried paediatricians, if you like, to provide accessible services for children and families.

Q. Can you give an example of where else they're provided?
A. New South Wales, would be an example.

Q. Thank you. Anything further, doctor?
A. That's all.

MS COGHLAN: Thank you. Chair, any questions from the Commissioners?

COMMISSIONER COCKRAM: Q. Dr Haslam, I just want to revisit this issue of the youth model and the CAHMS model. It's, as you say, quite a contested space and just getting further clarity from you on your thinking.

In a model where you're suggesting an amalgamated CAMHS service, and in a further description you were describing the increased need for resources around over 15-year-olds, the impact that has on the rest of the system, is it your suggestion, let's say, rather than recommendation, that there is something important about that 15-year-old point, noting that there is no age point which will be universally appropriate for any community, but are you describing that as being potentially a significant point in the developmental experience of children and adolescents and in service system design?
A. It is indeed contested, and I suppose my conceptual proposition is that fragmented child and adolescent mental health services, or a devolved system as we have, is probably not the way you would design things for consistent and best practice.

I think the age of 15 is probably conceived because around 14 to 15 is where psychotic disorders start to become a lot more common. I'm not sure of any particular reason why 15 otherwise is a particularly logical seam or separation point, but I completely agree that there is no single age. You know, we think of adolescence as going

right through, and brain development of course right through into the early 20s, so in many ways any age that is sort of selected will be supportable and also could be criticised.

From a paediatric point of view, there's not really something that happens at 15 that's any different, and so, chronic medical disorders and medical difficulties don't really - you know, the physical phenomena of illnesses don't change.

What is also different at 15, is that, that's around when we're starting to contend with issues of capacity and consent for treatment and so forth. So, to that extent, I think as well as the onset of psychotic disorders, I think that 15 has some sort of face validity or some merit. But from a paediatric health point of view, from the training of practitioners, child and adolescent psychologists, child and adolescent psychiatrists, 15 doesn't particularly make a whole lot of sense.

I think there'd be a lot to be said for having fewer - a lesser emphasis on catchment areas and a much lesser emphasis on strict ages, and more on what's the right service for this young person who's presented in this way.

I just think it's important to recognise that many of the young people who might present to specialist mental health services around 15 or 16 have actually had unrecognised mental health difficulties such as anxiety and depression, ADHD and so forth, in earlier life; it's just that they've presented to mental health services for the first time with perhaps a psychosis or a depression or self-harm or something of that sort

COMMISSIONER COCKRAM: Thank you.

CHAIR: Q. Dr Haslam, I've got three issues I'd like us to address. The first is, in your statement to us you talked about, "The prevalence of low to moderate severity mental illnesses has been fairly stable, but there is a clear rise in presentations of depression and anxiety in adolescents which is associated with increasing rates of self-harm and suicide", and you talked, I think, about "the gains we've made has declined" in terms of that.

But you also went on to say that this increasing

presentation and the presentations at EDs is contemporaneous with the arrival of the smartphone. Could you just talk a little to what you think about that issue and the challenge that it poses?
A. Sure. So, it's really - this is opinion rather than, you know, substantiated fact: we have certainly seen a rapid increase, probably 9 to 10 per cent a year, of presentations to our emergency department of predominantly teenagers with - that's an old-fashioned word - of adolescents with depression, anxiety, self-harm, difficulties with emotional regulation, conflict, sometimes substance abuse and so forth. So, there's certainly been an increase in presentation.

The problem that we have is that it's quite infrequent that prevalence of mental disorders is assessed. The last time in Australia it was 2014 and before that a long time before, and the same in the UK, so we don't really have very good epidemiological data to show that there's clearly an increase in depression and anxiety in teenagers, but there's certainly an increase in presentations.

And I think that there is a - there's certainly a timing with the onset of the smartphone and the prevalence of the internet and mobile internet in particular; it's just really something that I guess I and others wonder about. We're certainly all conscious of the risks and benefits of having access to the internet for young people and for adults as well.

There are certainly plenty of instances at a clinical level, at an individual level, that I'm aware of that young people have experienced, for example cyberbullying and have had difficulties in relation to social media. So, I think that it's part of the context but it might be that there's, you know, a lot more to it than that.

Q. So that might be an area of further study in your view?
A. I'd assume.

Q. Can I take you to another issue that you raised in your statement which was about the fact that you said that you were aware that there were paediatricians in parts of Victoria who closed their books to children and adolescents with mental illness. Can you just talk a little about what's the implication of the closing of their books, what

happens as a result of that?
A. I mean, I think - you know, this is probably a sort of a plea for the availability of mental health care where young people, children and adolescents need it and when they need it. I think it's important, as I said, no health without mental health, and I think paediatricians, general practitioners, we should all be seeing mental health as part of health.

I think it's problematic, from where I sit anyway, to have paediatric health providers who are able to see certain sorts of conditions and not others, but I think, you know, that's partly because they're predominantly private practitioners, and so, I think if we had community paediatricians who were, you know, salaried, then we might find that we can be clearer about the sorts of range of conditions that might be seen.

I do make reference in my statement to the disincentives to treating mental illnesses in, for example, a paediatric practice: the MBS items, the requirement typically for the child to be in the room, but in fact many of the interventions for children are best delivered in an evidence-based fashion with parents, and the lack of support that paediatricians in private practice, for example, experience when they might have mental health - young people with mental health difficulties.

Q. And then my final issue I wanted to ask you about was in relation to telehealth and telepsychiatry. In your statement you make the point that it's not widely used. Can you talk a little: is there a reason why, or is it just about the availability and familiarity of that as a new medium from which to deliver?
A. Once again, I have to be clear, I don't have data on the rates of telepsychiatry, but I'm not aware of a great deal of it going on. It's perhaps symptomatic that there may well be a great deal of telepsychiatry going on in CAMHS and CYMHS services but, because there isn't a collaboration between those CAMHS and CYMHS services, other CAMHS and CYMHS services wouldn't be aware of that.

Telepsychiatry is really ideal for reach for regional consumers who might have to travel a long way, but there's also a lot of children who, for example - and we haven't really talked about this group - children who might have developmental disabilities who in fact coming to a clinic

or coming to a hospital is very difficult and in fact distressing. So, the availability of mental health care, which may not necessarily require the practitioner to be in the room, into the home of children and families I think would be an enormous advance.

CHAIR: Thank you very much.

MS COGHLAN: Thank you, Chair. May the doctor be excused, please?

CHAIR: Yes.

<**THE WITNESS WITHDREW**

MS COGHLAN: Is now a convenient time to break for lunch? The next witness will be called at 2 pm.

CHAIR: Yes, let's break for lunch.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH:

MS NICHOLS: Commissioners, I call Professor Patrick McGorry to give evidence.

<PATRICK DENNISTON MCGORRY, sworn and examined: [2.01pm]

MS NICHOLS: Q. Professor McGorry, have you, with the assistance of the Royal Commission, prepared a statement about the opinion you give in relation to the questions we've asked you?
A. Yes.

Q. I tender the statement. [WIT.0001.0023.0001] Professor McGorry, you probably won't need to, but if you do need to refer to your statement when I'm asking you questions, you may do so. Do you have a copy of it there?
A. I do, thank you.

Q. Are you the Professor of Youth Mental Health at the University of Melbourne?
A. Yes.

Q. Are you the Executive Director of Orygen, The National Centre of Excellence in Youth Mental Health?

A. Yes.

Q. Were you a Founding Director of the Board of the National Youth Mental Health Foundation, otherwise known as Headspace?
A. Yes.

Q. Are you a Fellow of the Australian Academy of Science and the Australian Academy of Health and Medical Sciences?
A. Yes.

Q. Are you President of the International Association for Youth Mental Health?
A. Yes.

Q. I won't ask you any more questions, but we have your very long and impressive CV, thank you, Professor McGorry.
A. Thank you.

Q. Can I start by asking you about the notion of staged care. In your statement provided to the Commission you've said, "Mental health services need to provide staged care", and you used the expression "Right care, right time, right intensity."

Can you explained what you mean by "staged care" and how, if at all, that's different from what is presently embodied in Victoria's mental health system?
A. Yes, sure. Well, staged care - staging is a concept which we've really borrowed from other areas of medicine; probably most people are familiar with it in cancer but it's used in many other potentially persistent or chronic conditions, and it's a way of actually refining diagnosis so that you deliver the appropriate type of care according to the stage of illness that the person is at.

So, I'll just give an example. If someone presents with breast cancer and it's in a very, very early stage, you would not be doing radical surgery and intensive chemotherapy and radiotherapy, which you would do if the cancer had spread throughout the body and it was a more serious situation.

So, in psychiatry we've tended to just ignore stage of illness and just offer treatment, you know, to whatever the label or diagnosis actually was, so this is a way of refining treatment.

The other beauty of staging as an idea is that you try to get ahead of the game. It's different from step care, where you wait for treatment to fail and then you respond; it's like playing catch-up. Staged care is where you anticipate the problem may get worse, it may not get worse of course, there's always - the great thing here is hope and we're trying to maximise the chance of remission, cure and recovery, those sorts of more ambitious goals, and that means the treatment has to be a bit more proactive than you would just expect, but not overtreatment.

So, at every stage of illness you have to balance the risks and the benefits of treatment, and you can't expose the patient to more risks than benefit, and that's the way we've gone about our research, that's the way we've gone about structuring the new types of clinical services that we've actually developed.

Q. Yes, and when you talk about anticipation in that context, does that imply that the person being treated has a continuity of care and carers?
A. Absolutely. That would be the ideal situation, that you would want to have continuity - hopefully the person would go into remission and remain well at any stage, but if they did progress or if they had an ongoing need for monitoring and support and care, that that would be done ideally with the same clinical team and the certain person, because the relationship's so important, and certainly within the same system as seamless as possible across the different stages.

Q. In that model, is prevention described as stage 0?
A. I guess so. I mean, prevention can be - preventative approaches can be delivered at almost any stage of illness, but certainly the conventional view of prevention, as in primary prevention or universal prevention, is stage 0 when the person has no symptoms but might have a level of risk.

Q. Using the treatment of cancer as an analogy as you have done, is it correct that a staged care model has these features: first, the need to diagnose at the earliest signs of potentially serious illness?
A. Yes.

Q. The need to get immediate access to care when there is a diagnosis of serious illness?

A. Yes.

Q. And the need to sustain treatment efforts for as long as necessary using the best available evidence?
A. Absolutely.

Q. And the need to keep people well or in remission and, if the illness progresses, to limit its impact?
A. Yes.

Q. Alright. So, is it correct that a key goal of staged care is to reduce the risks of progression from one stage to the next?
A. Yes.

Q. I take it, you say that what we don't have embodied in the mental health system in Victoria is a model of staged care?
A. We don't have it, no, even though that there's really good evidence from, I suppose, oases of programs, or programs that have been set up that can show that it's actually possible; it's absolutely possible in mental health just as it is in other areas of health care, but it hasn't been scaled up so as to make it possible for everybody.

Q. Do you say that, in contrast to a model of staged care, you have a model within which people are treated within silos moving up to the next stage of care when their condition has worsened?
A. Yes, and even then they cannot get access to care; even when the condition has worsened considerably, that people can still not get access to the next level of care.

Q. I want to turn your focus to young people, if we may. Yesterday, Professor Helen Herrman gave some evidence that the peak age of onset of depression, anxiety and psychosis is between 15 and 25 years of age; I take it, you agree with that evidence?
A. Not precisely, it probably is a little bit more nuanced than that. I would say, you know, some disorders have their onset in childhood. We heard from Dr Haslam this morning about that, disorders like ADHD for example. But then around puberty you see this rise in anxiety and depression in early adolescence actually, and then perhaps disorders like psychoses, bipolar disorder maybe towards later adolescence, but by 25, 75 per cent of the major

disorders of adult life have emerged for the first time.

Q. I'm going to ask you some questions about young people, and in terms of how they are addressed as a group in your statement, what do you mean when you say young people? What age range?
A. We're talking about puberty, around, say, 10-12, that sort of period for the reasons I've just mentioned, and probably around the age of 25, the mid-20s. But I agree with Dr Haslam, that you want to have fairly flexible rules about the bottom and the top end, but where I disagree is that the age of 18 as a dividing line is, this is probably the worst possible time to have a division in service provision.

Q. Yes, I'll ask you some more questions about that shortly. But first, can you tell the Commissioners what are some of the key reasons why young people are particularly vulnerable to and often seriously impacted by the onset of mental illness?
A. Well, it's not possible to answer that question in an absolutely definitive way.

Q. Of course not.
A. But the major thinking behind this is that, first of all, as their physical development is dramatically changing from puberty through to, let's say late teens, early 20s, so is the brain; the brain is actually developing in a very quiet but dramatic way during that period and that does not complete until around the mid-20s, that process of brain evolution.

Obviously, the social environment, the developmental challenges that young people face, and I'm sure everyone in the room can remember or relate to that; the challenging developmental tasks you have to face when you are making a transition from childhood to adulthood: identity, social relationship, peer groups, vocational pathways, developing a sense of independence from the family, all of those things are very, very challenging for any person, and I think probably the interaction of these forces actually creates an increased risk for poor mental health at some point, and we know that 50 per cent of these young people do develop a period of poor mental health during that transition.

Q. Can I just stop you there. When you say "50 per cent

of these young people", to which group are you referring?
A. At some point during, let's say the beginning of high school and the age of 25-30, 50 per cent at least of young people will meet the criteria for a diagnosable mental disorder during that period, there have been a number of longitudinal studies that have shown that.

Q. When you say "diagnosable mental disorder", just to be clear, do you include the entire range of mental disorders including the high prevalence mental disorders?
A. Yes, I do include them, although I really think that's a very unfortunate term, "high prevalence disorders".

Q. I accept that. Can I ask you this: does the evidence show that young people have difficulty help-seeking in relation to getting help for mental illness?
A. They have had a difficulty help-seeking, but that's partly due to, I suppose, characteristics within the young person, but it's particularly due to the fact that there isn't - or there hasn't been until recently - the kind of place where they would feel comfortable in seeking help or engaged in seeking help.

Q. Yes, I'll ask you about that in a moment. Do you know how the rates of prevalence of mental illness in young people compare with the rates at which they do access help?
A. Well, we have good information on that up to a point in Australia because we have had national mental health surveys, although we seem to think we only need them every 10 or 15 years.

But the last one that looked at this, there was a child and adolescent one which stopped at 18 recently which was mentioned this morning, but the last major one which covered the young adult period to show that the highest prevalence across the whole life-span was in this 18-24 age group where the prevalence was 26 per cent in any given year, which is the highest across the life-span.

Q. So, if the highest prevalence is 26 per cent - sorry, that's for seeking help, accessing help, sorry?
A. And of the proportion of that 26 per cent that sought help, 13 per cent of the young men that had a mental disorder back in 2007, and 31 per cent of the young women who had a diagnosable disorder were able to access any kind of help; and that included things like school counsellors or GPs, it didn't even mention mental health professionals

particularly.

Q. How does that compare with the percentage in adults, if you know?
A. Well, if you look at middle-aged people in the same survey, the proportion able to access some kind of help was about 45-50 per cent, so still seriously inadequate, but much better than the prospects for the young people at that time.

Q. Just back on the statistics relating to youth, did those services include psycho-social support services or did they include - yes, did they include psycho-social support services?
A. Yes, they would have included all kinds of health professionals really; wouldn't have to be mental health professionals even.

Q. Do you know whether the rates at which young people are accessing help are improving?
A. Well, we're not totally clear about that. The child and adolescent survey showed there was some improvement in the under 18 group, in about a seven-year period since that previous survey, and we know from the Headspace evaluations that there's been a very significant improvement in access in relation to what Headspace provides, so there has been some improvement, it's still not where we want to be, but it's definitely a step forward.

Q. What in your experience are some of the factors that contribute to young people's disengagement with the mental health system?
A. If we're looking at the whole mental health system --

Q. Yes.
A. -- there just isn't a mental health system beyond the primary care level for the vast majority of young people. There was extensive discussion this morning about the missing middle; well, that's a very significant number of young people and it's only a very tiny percentage that actually get to the more tertiary end of the system.

Q. Is there a question about stigmatisation that's relevant to that?
A. I think stigma is actually on the decline, actually, especially in young people. If you talk to young people these days - and I know the Commission has heard from young

people - stigma is a much less serious issue amongst young people these days. It's still not beaten, it still exists and it probably exists for some disorders much more strongly than others, but young people are much more open and, you know, I think less affected by it, even in the last ten years, so there's been some great improvements in that. Where there hasn't been improvement is the response when they go actually seeking help.

Q. I see, so they're more willing to seek help?
A. Yep.

Q. But no more likely to get it; is that right?
A. They're somewhat more likely to get it but only at a very mild level, as I say, and beyond that if it's a more complex problem that needs longer term or more intensive or specialised care, that's where the big problems are now.

Q. Do young people from culturally and linguistically diverse backgrounds have other threshold problems that they encounter in seeking and obtaining help?
A. Yeah, I think if you look at the Headspace data, it's very strong in providing access for indigenous and for LGBTIQ populations, extremely trusted, and access and engagement is good there. From CALD communities less so, so that's another sort of area where Headspace and that primary care level needs to be strengthened and do a lot better.

Q. Can I ask you about the inter-relationship between paediatric services, youth services, to the extent they exist and adult mental health services. Firstly, if you can firstly generalise across different services, what are the cut-off points for access to paediatric mental health services?
A. Well, if you just look - take a step back a bit and look at the history of how these services have developed. Child psychiatry is quite a recent development within the mental health field and it's struggled around the world to actually get much traction. In many countries it doesn't even cover the full range, even up to 18.

So, the conventional boundaries are 0-18, and then we have 18 or 16-65 as the adult system. And I think this has been adopted without any thought; it's just been transplanted from the general medical system, where the pattern of morbidity is very different from what you see in

mental health, and it's been assumed that's going to work just as well for mental health. Whereas, in the mental health area, the pattern of onset of disorder is the mirror image of what you see in physical medicine.

Q. Can you elaborate on that, please?
A. Yeah. So, if you look at the pattern of Global Burden of Disease data, there's a lot of serious physical illnesses in little kids, in kids under 12, maybe even up to the early teens.

And then, from the teenage years through young adulthood and even into middle age, people have never been healthier in human history, you know, from a physical point of view, so the health system isn't really needing to be strong from a physical health point of view in that space.

But in terms of mental health you see this surge of morbidity, particularly from puberty through to the early 20s, of mental ill-health with a whole lot of comorbidity amassing around it, and the system is incredibly weak, it's weakest where it needs to be strongest.

And, if you have a paediatric adult model, if the paediatric model peters out in the late teens and then the adult system - medical system sort of kicks in around 50 or something, so it's just - it's the wrong way of designing it. No thought was given to that when we mainstreamed mental health care into the physical health system.

Q. So, in mainstreaming, do you have this phenomenon where a child or paediatric services is sort of reaching up to encompass youth, and adult services are reaching down?
A. Yeah, well, people have tried to tackle this in either of those two ways, and in a way it doesn't matter as long as you have a system that's able to cover that, that sort of transitional zone.

In Europe they call it transition psychiatry, this 12-25 sort of focus. We call it youth psychiatry in Australia, and our college has got a section of youth psychiatry now and thinking about having a faculty of youth psychiatry, so I think there's been two approaches.

In Victoria about ten years ago there was a notional effort to create a 0-25 service which you've heard about this morning but it wasn't resourced, so didn't actually

function as a 0-25 service.

And, you know, there were supposed to be two zones, a 0-12 and a 12-25 zone, but that never really happened I don't think.

Q. Can you say something about the ways in which access criteria to adult mental health services either fit or don't fit the needs of young people seeking access to those services?
A. Well, again, you have to look at this historically. You had the child psychiatry system coming out of the child guidance clinics which were really about younger children, and they gradually tried to move into the adolescent space, but with a kind of a family approach, with a developmental approach, which was very appropriate actually.

Then you had an adult system which was created out of the old asylum system, which I trained in, I trained in that system, which was totally focused on people with chronic, severe mental illness, mostly schizophrenia and related sort of conditions. And the adult system was moved out of that system about 25 years ago and dumped into the acute general system without really any evolution since, except decline, and that was looking after a completely different clientele.

And so, if you had an early stage illness of an adult type, or if you were a graduate of Child and Adolescent Service into the adult, it was like oil and water, not mixing. And, there are studies from Europe and the UK showing that the transition of patients from one system to the other nearly always failed. In 95 per cent of cases the transition would fail because the clientele were different. And, if they did get in they wished they didn't get in because it was not a present experience.

Q. You were speaking in the past tense. Is that deliberate?
A. No, I think that's actually still the case, sadly.

Q. Still the case, and what do you say about the discontinuity between the services occurring at the age of 16-18?
A. It's lethal.

Q. What do you mean by that?

A. Well, people have died because of this.

Q. I'm not going to ask you about individual cases, but from a systematic perspective, what do you say about it?
A. Well, it's a massive design flaw.

Q. What's flawed about it, I'd just like to tease this out a little bit if, I may?
A. What's caused the design flaw?

Q. What's flawed about it?
A. Oh, flawed, sorry. Well, it just doesn't work. Access - first of all, the scale of the systems are not to scale, but you've got to focus on the needs of the client group, and there's been no thought to that actually, in the design of that part of the system.

Now, the needs of the people in middle age in the main adult system, that's different, you have to design that part of the system for the needs of those patients, some of whom are new patients too.

But in this transitional zone, you know, we put a lot of effort in research and other ways into actually mapping what the needs of the patients actually are in that stage, including involving them in this process, and it's very clear, you need a culture of care and a range of expertise that is relevant to the needs of the people trying to use the system.

We've also tried to link it, as I think Dr Haslam said this morning, to primary care because of the volume of cases needed. We were operating services in the northwestern Melbourne about 20 years ago and we were trying to create a youth mental health service then. We realised we were treating 800 patients a year, and there were 50,000 patients in that catchment area who needed some kind of mental health response.

So, you have to have a high volume system that is capable of actually responding to the very large prevalence and the incidence, and then a system that's able to then take them through more intensive steps of care or stages of care according to their needs, and that was never done. It's kind of - the system has evolved from these historical origins without anyone really designing it according to its needs.

Q. What you're speaking about is an instance of the philosophy of person-centred design; is that right?
A. Absolutely.

Q. One of the things you mentioned earlier was what happens with young people is an important blend of comorbidities of variable intensity, including substance abuse issues. Is that important?
A. It is. Because we've learned a lot in the last 15 years or so by working right from the beginning of these illnesses and problems, and obviously a lot of young people get better and they recover, but the people who come in for the first time with the need for care, they often have what we call micro phenotypes, meaning they've got fragments of symptoms: some anxiety, some depression which fluctuate. They might then self-medicate in different ways or self-harm, but it's not clear what's actually happening and it's not a stable picture.

And the picture, it might actually fade and they might recover, or they progress and then they might develop other features; you know, perhaps eating disorders, perhaps psychotic symptoms, and their personality development is affected too, so they get labelled with a personality disorder diagnosis then too, so their complexity increases if they don't get better, and their needs increase and the skill level to actually get them better then increases too.

Q. Can I ask you now about early intervention more generally. In professional and academic discourse, how is that expression defined?
A. Well, I think our local Health Department confused everyone by using it in several different ways: you know, this early in episode, early in life and early in illness type; but in the research and the professional literature we define it - and I did a journal called Early Intervention Psychiatry - we define it as early in the illness course, that's what we mean it to be.

Q. So, does that mean intervention once the signs of an illness have first emerged?
A. Yeah. So, again, going back to the staging model, the earliest clinical stage, and there's been obviously debate about this in the general public and the media: what is the earliest point at which you can say someone needs care? And it doesn't necessarily align with classic DSM and other

diagnoses. It's when there's a level of distress that prompts help-seeking in a person, and often that's associated with functional impairment but not always, but that actually ought to be left up to the patient.

No-one tells you in physical medicine that you can't go and see the GP; no-one says you're wasting everyone's time by going to the GP. If you feel unwell, if you've got a sore throat and it's not getting better, or of you've got a stomach upset, no-one says, "Sorry, you can't see the GP until it gets worse." But that's what we've tended to do in psychiatry. We've tried to say somehow that's harmful to people to seek help at those earlier stages because they might get labelled, they might get stigmatised.

But that's not the case actually. Because in primary care settings we can actually create settings that are very stigma free, and they can actually get the appropriate help without having to be put into a hard label or a diagnosis that's going to stick with them, they can just get help.

Q. Just while we're on that topic, you mentioned before that you thought stigma was declining amongst young people; is that a reflection of the experience you've had in the settings in which you work, which affirmatively works to reduce stigmatising factors?
A. I think it's both actually. I think the young people themselves have actually been very good, they've actually helped to destigmatise in a great way. So, that's happening independently to some extent, but we've definitely worked really hard with them to create settings where stigma is just not an issue.

Q. In relation to early diagnosis and prevention in fact, you have drawn an analogy in your statement with cancer prevention and cancer treatment. Can you explain that analogy and why you think it's instructive?
A. Yeah, some people might think cancer is, like, too - what's the word - deterministic. So, I could say that it also applies to other areas too.

Q. Or whatever it is that you think, yep.
A. But what (indistinct) medicine say. I just think it's very interesting because in those areas they have actually reduced the burden of disease. In cancer they - you've got much better prospects of survival in many cancer areas and if you don't - if the cancer's not cured you can live for

longer, so they've done so many things right: they've done prevention where they can, and we can do a lot more in prevention in mental health, so reduce the risk in some areas.

They diagnose it early, as early as possible, and then if they get the person well, into remission, they do everything they can to keep that person well. And even if the person has this more recurrent and deteriorating illness, they actually provide much better palliative care too. So, all of those things have helped greatly and, as a former Director of NIMH, Tom Insel, used to say, they bent the curve, they bent the curve of morbidity and mortality and we haven't been able to do that in mental illness. It's not because we don't have the interventions or the evidence-based treatments or the capacity to do it, but we just have not implemented it, we have not actually built a system that delivers what we already know effectively.

I could given about ten different examples of treatments that I've seen developed in my time in psychiatry, new treatments, drug therapies and also psycho-social treatments, including many that we've developed here in Victoria, that are simply not available to people; they're not what the system delivers. The system delivers this very basic generic case management and risk management system; it doesn't deliver all the things that we already have at our disposal in an effective way.

If we did those things and if we did them according to that framework I just mentioned with cardiovascular and cancer with, you know, those four elements, we would transform the outcomes for people with mental illness even without a single new discovery.

Q. Later on I'm going to ask you why you think we don't do that, but before we go there, I'm going to ask you a little bit more about early intervention. It's comprised of two parts, you say; the first being early detection. From a systems perspective, how do you think we can achieve early detection better?

A. Well, a lot of the evidence for this conference about those statements comes from the period in which we were developing early intervention for psychosis, for psychotic disorders like schizophrenia, which was the precursor to our broader work transdiagnostically in youth mental health.

I'm thinking in particular of the work of a group in Norway who carried out the TIPS study. One of the big problems with schizophrenia and psychosis was that it was being diagnosed very late, often after years of illness, certainly on average after about a year or two of psychotic symptoms when the person's life was absolutely in ruins by the time they actually got the first help.

As you would imagine with any potentially serious illness, that makes it very, very difficult to achieve recovery if the person's that unwell. So, shortening the clay in treatment was a crucial strategy.

They showed that, by very widespread community education, spending a lot of money on educating the public about recognition of the early signs of psychosis, and the leader of that study used the analogy with a local supermarket which he said spent more on advertising Coca-Cola than mental health services spent on advertising their services. So, doing that, so very sophisticated public advertising campaign.

Q. Can I just stop you there. If you know, what were the elements of the very sophisticated public campaign?
A. Okay. So, it was cinema ads, this is the 90s, so you know could be different these days. But cinema ads, newspaper advertisements, public hoardings, bus shelters covered with information about psychosis, information in schools, lots of ways of educating the public about how to recognise the early signs of psychotic illness.

And that, combined with a telephone number that they could call and a team would go out and see that young person wherever they were, whether it was in the school, the primary care setting, the home. So, the team would respond immediately to a referral where there was a suspicion that psychosis might be present.

Q. So you needed both things?
A. You needed both things.

Q. Or they established you needed both awareness and someone to respond when people took steps to seek help?
A. Yes, and they did very skilled research which showed that both of those elements were necessary, and they showed that you could reduce the delay in treatment from two years

down to a matter of a few weeks.

Q. This was Scandinavian; in which country?
A. Norway.

Q. And it was the TIPS study, did you say?
A. The TIPS study.

Q. You said in your statement that early intervention includes first early detection, and second, staged-linked multidisciplinary clinical care to cover the years of illness post-diagnosis. Now, you may have covered some of this already, but can you just tell the Commissioners in your view what are the key points or what are the key attributes of multidisciplinary clinical care?
A. So, when we first started doing this work, what would happen to a first episode patient with psychosis would be, they would come in late in the piece, they'd be patched up and sent back out again after probably just a few weeks of treatment and hoping that the person would be okay, probably the GP or maybe a community clinic would be looking after them.

But the second component in terms of changing the outcome was much more extended and much more intensive and comprehensive multimodal clinical care to maximise the level of recovery and then make sure the person remained well at least for the first couple of years after diagnosis.

Q. What do you mean by multimodal in that context?
A. Well, much more careful use of medication, because patients were being overmedicated in those days. So, low dose medication but carefully - and, if they weren't getting better, early use of clozapine as a drug therapy.

And then a whole range of psycho-social treatments which were actually developed, you know, many of them here in Victoria but some in other parts of the world to be offered to - so, things like family intervention, vocational recovery programs, CBT, a range of strategies like that to help the person make a more complete recovery.

Q. Yes. And, is the length of time over which treatments and services are provided particularly important?
A. Well, it was called "the critical period" by early psychosis researchers, especially like Max Birchwood.

Initially we thought it was about two years, but further research has shown that it's actually the first five years of illness that's important. And, after that, there's a tendency for things to get significantly better, you know, in a more naturalistic way actually, that's what we're seeing. So I think we can shrink the proportion of patients that actually end up with a more chronic and severe outcome; the research is really pointing us strongly in that direction now.

Q. Do you think that there is an indication that the research in the area of psychosis is potentially generalisable to - or applicable to other disorders?
A. Well, that's what we've been trying to do, I would say, for the last 15 years or so. Expand the thinking of early intervention so it includes all the potentially serious mental disorders of adult life: mood disorders, eating disorders, personality disorders, substance use disorders. Of course, they often tend to be mixed up together, so that's the proposition, and we are getting some increasing data showing that is likely to be the case.

But the fact that we could do it for the most serious form of mental disorder in this age group, schizophrenia and psychosis, is very encouraging for the prospects for other disorders too.

Q. Can I ask you some questions about what we know about what early intervention is capable of achieving. It's right, isn't it, that early intervention isn't always capable of preventing development of a mental health condition?
A. Yes, that's absolutely true.

Q. In the evaluation of the work that you've been doing, there were a couple of conclusions that you discuss in your statement. The first type is the capacity to delay the first onset of illness where there are warning signs, and the second is the ability to improve outcomes over the first two years where there is in fact a first episode of psychosis. Is that right?
A. Yes. For those two statements there is now what we call Cochrane level one evidence, meaning the top level of scientific evidence suggesting that that should be available to everybody.

So, Alison Yung and I back in the early 90s,

operational as the criteria for what we called the at risk mental state or the clinical high risk state for psychosis, and these were subthreshold psychotic symptoms, so warning signs of fully-fledged psychosis. What we have now is probably about 15 or 16 randomised clinical trials showing that the transition from that state into first episode of psychosis can be delayed by at least one year, maybe two years, maybe even longer.

It doesn't mean that we're necessarily able to cure the illness, but we can certainly delay the onset, which it should be something that we are celebrating all over the world because, if that's possible in diabetes - there was a paper just recently saying that they think they can delay the onset of diabetes, and that attracted a lot of attention. We can do that already with schizophrenia and psychosis.

Q. Would you accept that, starting with the proposition that psychotic illness is an umbrella term of which schizophrenia is one type, would you accept that in the literature and in the scientific community there is a debate about the conclusions in relation to schizophrenia in particular?
A. The debate was more about whether we would do more harm than good trying to intervene at that stage of illness, and I think the debate strayed a long way from the data, is my perspective on it. The data is absolutely clear. As I say we have these metaanalyses now that show - the facts show that it's possible to do that. We've done a lot of rigorous research.

We've done five of these trials here in Melbourne and the latest one funded by the National Institute of Mental Health in Washington has just been completed now. So, there's a lot of experience and data. You can have debates about things but then there are facts.

Q. Can I ask you this: in terms of the importance of early intervention from a systems perspective in your opinion, is it a very important investment notwithstanding that not every instance of psychotic illness or other mental illness will be able to be prevented?
A. M'mm.

Q. You talk about some evaluations that have been done of the work at Headspace and you say this in your statement,

that:

> "Outcomes are modestly improved for mild to moderately ill young people and access is greatly enhanced, as is satisfaction with the care received."

Can I just tease out the elements in that statement?

A. Sure.

Q. The first one is, "Outcomes are modestly improved for mild to moderately ill young people". Can you explain what you mean by that, both in relation to outcomes being modestly improved and mild to moderately ill young people?

A. Sure. So, could I just make it clear that we've now moved off the topic of early psychosis and we're moving to more generally transdiagnostic patients?

Q. We are, sorry, I should have made that clear.

A. No, that's fine. Can I just say one more thing about psychosis before I answer that?

Q. Sure.

A. So the second part of your earlier question was about people who then have established psychosis and trying to improve the outcome over the first couple of years for those patients. That's another meta-analysis that was published last year in JAMA Psychiatry by Christoph Correll and colleagues, and that looked at 10 RCTs of first episode psychosis care which showed, again, that the outcomes were substantially better on about ten different outcome measures for the first two years, and that has led to the US Congress signing funding for these programs to be rolled out across the US. So, they are now in 280 settings across the US. So, that second staged care is now highly evidence-based and being implemented in a very widespread way.

Q. Thank you. Alright, let's return to --

A. Headspace.

Q. -- the more general proposition about the outcomes across the board and the statement that "outcomes are modestly improved for mild to moderately ill young people".

We'll come to access in a minute but can you just explain what is meant by that statement?

A. So the government has done two evaluations independently of Headspace since it was commenced in 2005. The first one was very early on and descriptive. The second one looked more at what outcome data was available, and you have to understand these Federal Government evaluations are done with very little funding actually, they're not proper health services research studies. So, the people at the University of New South Wales who did this evaluation, did the best they could with the data they had.

What they concluded was that, in terms of outcome, about 60 per cent of the patients that came to Headspace were helped significantly by it compared to standard care. It's very hard to find a comparison group of standard care for these patients because hardly any of those patients were treated in standard care before, so that's like a caveat there.

But as best as they could determine, about 60 per cent were doing well as a result or better because of the interventions compared to what they would have had in different forms of care.

Another 40 per cent were either treading water or deteriorating. And, you know, Headspace being a primary care service is not capable of helping people who have got more moderate-to-severe conditions, and yet, there's nowhere else for them to go in most parts of Australia. Very few of them would make it into specialist services, so we think that that 40 per cent are the ones that are not doing well and that's why we need this next tier of care.

Q. You also say that "access is greatly enhanced", and by that do you mean that a great deal many more people get access to help of any kind?
A. That's what the University of New South Wales group concluded, that access was dramatically improved, and also the satisfaction levels and the engagement levels of the young people with the services was greatly improved as well, and that's what we find. Because the youth participation, youth engagement model within Headspace has created a youth-friendly culture which young people can engage with.

Q. You mentioned the concerns about over-medicalisation a

few moments ago. Would you agree that, in a clinical staging model properly designed, that the overtreatment and premature use of medications is guarded against?
A. Well, that's the whole purpose of it actually, to make sure you don't undertreat or overtreat patients. You make the treatment of the person proportional to the stage of illness that they're at.

When I first started in psychiatry, I saw massive over-treatment of people who basically were at an early stage of illness and they were being treated as if they had stage 4 illness essentially and they were getting huge amounts of medication and nothing else really, so absolutely the staging model guards against that as its purpose.

The other thing that guards against it I think in the Headspace setting is that, we try to make these settings not overtly clinical; they should have a youth café feel almost at the entry point but with the clinical expertise sitting within the system so that it's available but it's not thrust in the face of the young person.

And also make sure that the psycho-social treatments are offered as the first step and not overtreatment with medication at the first step.

Q. Yes, I was going to ask you about this and I want to ask your opinion more generally, not confined to the Headspace model, but what do you say, on the basis of your experience, is the importance of psycho-social treatments and programs in dealing with mental illness?
A. Well, since the beginning of my career I've put a lot of my own research effort into the development of psycho-social treatments, and so, I think it's very, very important.

I was struck back in those days at a lack of sophistication and the lack of evidence-based treatment of that kind: whether they were psychological or more, I suppose, social forms of treatment.

I think the situation's been greatly improved since those days, with the advent of forms of CBT that are tailored for different types of problems, even for psychotic illnesses now, from vocational interventions like the Individual Placement and Support Model which

dramatically improves the prospects for people with mental illness to get back into education and into employment. Those are just some examples.

And I suppose, we could do more. I mean we have now virtual reality which can actually add a lot of potency and attractiveness to the psychosocial treatments or the psychological treatments.

Q. Can you say a few words about virtual reality, what you know about it, the extent to which it's been implemented and what kind of promise it shows?
A. Yeah. It's already being offered and it's more developed in Europe and the UK for a range of conditions. We have facilities in Melbourne now where we're getting it off the ground as well but probably a little bit slow to embrace it actually.

But the sort of conditions that it would be used for would be PTSD, would be anxiety, it can also be used in psychotic illnesses to in vivo, in real life almost, deal with paranoia and actually help people in a cognitive sense deal with paranoid thinking and experiences, so it's got a huge amount of potential to transform the office spaced therapies that we currently do, which are pretty boring a lot of the time for patients, to actually make it a lot more real and a lot more effective.

Q. Is it fair to say that the work with virtual reality is currently in experimental stages, at least in Australia?
A. Yeah, I think that's fair to say. It's a research technique now which, that's what we do at Orygen, we try to bring these research techniques into the real world. But in countries like the Netherlands and the UK, they're already doing that.

Q. Is the use of virtual reality an example of application, mostly of cognitive behavioural therapy?
A. Yeah, I think that's fair to say at the moment, although there might be other more creative ways to use it as well.

Q. Can we switch topics, Professor McGorry. I'm going to ask you about the group of people who you have called "the missing middle". In the context of mental health, who are they?
A. We've already touched on it, but these are the people

who have needs beyond what the primary care system - so your standard GP/Better Access or Headspace - can provide. And yet, they cannot reach the very high bar that has to be reached for access to State Government funded tertiary services.

You could divide them up into two groups. You could say, it's a significant proportion of the moderately ill, mentally ill group, and it's even a proportion of the severely mentally ill group which the state service are not currently covering. In my statement I put percentages on that, so it's probably between 8 and 10 per cent of the public.

Q. Have you done the numbers on what that means?
A. Yes.
Q. How many thousands of people?
A. I think it's about 300,000 in Victoria, around about that number.

Q. Are, what, missing out on services altogether?
A. Yeah. So, if you think about 20 per cent of the Victorian population roughly needing some kind of mental health care, that's about 1.5 million, in my rough calculation, and so the missing middle, if it's about 6-8 per cent, that sort of ballpark, it's a few hundred thousand. And when you look at the number of people who are getting services in Victoria for mental health, it's a hell of a long way short of that.

Q. Yes, and what kinds of services are available to the people who fall within that group?
A. Well, some of those people - and I'm sure the figures could be assembled on this - would have access to private psychiatrists. But, as we all know, there's very significant financial barriers and geographic barriers to accessing those services, and in my view those services are very poorly designed as well: they're single office-based practitioners, they're highly trained, but they are not working in teams by and large, and so they're not really meeting the needs of these patients as well as they could.

But there would be a percentage of the missing middle that are accessing those services, but I guess we see and hear about all the people that cannot do that, especially in public mental health care.

Q. Does access to the mental health care system often only occur when those people find themselves in real crisis?
A. Or dead. I mean, these people can only get access when it's a life-threatening situation, and that's the way it seems; or when they're causing so much disturbance because of their illness that they end up being brought to an emergency department, or worse still, into police custody and in prison.

Q. You've talked in your statement about what you call a community-based model of care that links to primary care and provides access to services for more complex cases and allowing upstream access to emergency departments. What you've said is that:

> "Structures like this, if funded to operate around the clock, could dramatically reduce the flow of acutely mentally ill patients into emergency departments and reduce attempted and completed suicide substantially."

I'd like you to say some words about this model, recognising that it's a model rather than an embodied reality at the moment. You have kindly answered my request to create a diagram representing it. Can I have that diagram shown, please?

There are a lot of elements in here, and can you first step us through, without going into detail, the four different parts on the four corners of the diagram?
A. Sure. I mean, could I just first say that, I think when the system in the 1990s was designed to replace the old asylum system, that was the intention, to actually set up strong proactive community mental health services that would allow us to cope with a dramatic reduction in acute beds. And that did start to work at first, because those services did do those things up to a point; the CAT teams did actually turn up, the CAT teams did actually visit people even up to two or three times a day to keep them well in the home, and that started off on the right foot, I would say.

So this is just more like a 20 year later version of what we should design with the benefit of hindsight over the last 20-odd years.

Q. Yes, understood.
A. A couple of things to say about it - very, very important. We assumed at that time it was a good idea to link the community mental health services with the acute hospital and put it onto the governance of the acute hospital. Because it made sense that you want to have continuity of care across, you know, inpatient and community.

But the trouble is, that was a big anomaly for the hospital systems. The hospital systems otherwise did none of that, they just did inpatients' work, so the idea of looking after services in the community wasn't really something that they ever really embraced, and so, that was a fundamental flaw in my view. Now, maybe not everyone agrees with that, but that's certainly my very clear view now.

So, how we finance and govern these systems is absolutely crucial to allow them to sort of meet scale and to operate.

Q. I'm going to ask you some questions a bit later about all of those really big points, including governance, but let's just have a look at your model. [RES.0001.0009.0681]
A. Focus on this model.

Q. I note that the four quadrants are divided by reference to age.
A. Yes.

Q. Over in the top right-hand quadrant there's - I don't know what to call it, I don't want to call it a silo, I think that would be a mistake, but there's a section for 0-11 years.
A. Okay, so this is meant to be what a region, you know, would need. There may be other elements that a whole city like Melbourne might still need which I haven't put in there, like for example beds for younger children, inpatient beds. But let's say a modestly sized region of Melbourne could support this type of structure.

I probably shouldn't start off talking about the inpatient bit first because it's the least important bit numerically, but you need several types of inpatient facilities in such a region. We believe that the youth

beds should be separate from the adult beds, and you probably need several types of adult beds. You need a standard sort of psychiatric acute inpatient unit. You obviously need a secure one too because there's a small group of patients who are extremely aggressive and violent by the time they become ill at this stage and you don't want those patients being looked after in the same setting as a more therapeutic sort of inpatient unit of the more general type.

Q. And those are the ones listed in the centre of the diagram, is that right?
A. Yes. And then there are youth versions of those, a mother and baby at the top there, and also addiction units for detoxification in a highly supervised medical way, which we've moved away from that in some ways. These are life-threatening conditions these phases of detoxification so you want to have addiction specialists in charge of those units, not lay people. So, that's another element of the whole thing.

How those units relate to the psychiatric units obviously needs more thinking, because there's so much comorbidity as well. So, those are basically the notional elements of that part.

Outside of that, rather than having an emergency department that, where psychiatric and acute medical patients are triaged in the same way, I think there's a strong feeling that we should have separate spaces that have got a completely different ambience and a completely different skill set and time course. Not, you know, short-term admission stays either, we're talking about more a lounge or a café style place which is calming but still got the capacity with expertise to respond to, you know, very unstable situations as well. That also would need a lot of design and thinking to actually set that up in a safe and effective way.

So moving back out into the community, and we then probably need several types of missing middle type services which are these community hubs or one stop shops that have been described here. And they're designed according to stages of life, if you want to call it that. You need different cultures of care, we think, for younger children, so up to 11; it has to be a very different sort of type of environment for kids of that age.

And also, the professionals that are needed to work in that sort of setting are different types of people from the sort of people that want to work with the adolescents and emerging adults on the one hand and the middle-aged adults on the other. So, that's the case we're making, that you need these highly specialised, dynamic places which should operate around the clock. They should have the capacity to actually do outreach work around the clock, home-based treatment around the clock, not just up until 11 clock at night.

And they should have expertise during the day and during extended hours in a range of domains which are listed there, things like physical medicine, addiction, different mental health professional disciplines there, obviously psychiatrists as well; the evidence-based treatments that we have for that more specialised stage of illness. And we think that they should be embedded much more with primary care than with hospitals. That's what the World Health Organisation says about mental health care, it should be very nested with primary care, not so much with institutions and hospitals.

Q. While you're there, if we take the 0-11 years as an example, there are links going out to primary schools, early childhood centres and maternal health and childhood centres, among others. So, is the linkage in that pretty important?

A. Yeah, well, that's really the concept of primary care, you could say, and community for those more specialised services. That's where they have - they have to provide a back-up for those services and a portal, and that will also make them much less stigmatised than if they were associated with more traditional psychiatric-type clinics which are very narrow. This is a holistic model that we're talking about here, not just purely psychiatrically or mental health driven. And physical health is obviously a key part of it, and GPs in particular are important there.

Q. Could I ask you a couple of questions about the model. You have a grouping on the upper left-hand quadrant of 12-25 years. What do you say about grouping that age group all together and the risk that those in the earlier part of that age group will miss out and not receive sufficient attention?

A. Well, I heard Dr Haslam talking about that this

morning. I think that's an issue for inpatient care; you have to create zones in inpatient care where, you know, that spectrum of age is handled in slightly different ways.

But we have, you know, over 12 years of experience now with Headspace of actually providing mental health care in enhanced primary care platforms for that age group and it works extremely well. There's no problem in mixing 12-year-olds with 24-year-olds in that setting; it's extremely effective I think.

And so, what we're saying here is that those Headspace centres could be built upon, they could be expanded and have this more specialised and multidisciplinary sort of back-up system either built on to Headspace platforms or built in association with these platforms and other primary care and educational structures as it's described there.

There are a few options there about how to do that. The advantage of actually integrating it fully with primary care is that you don't have any barriers or triage systems or transfer barriers getting in the way. We've been piloting that in the northwest of Melbourne through our Orygen and Headspace system.

Q. Do the younger age group, 12, 13, 14 not have very different needs to the upper end of that group?
A. There are differences in needs, but what they have in common - I don't know if anyone in the room has been to a music concert lately targeted at that age group, but even in the cultural setting they mix very well. So, we have had no problems with that whatsoever.

You can obviously focus on the needs of the person in front of you, and there are different developmental issues in early adolescence, from late adolescence of course, but in terms of how comfortable they feel; and we've asked them, I mean, every Headspace Centre has got a youth advisory group and this has been a stable phenomenon for over a decade. People thought that might be a problem when we first started doing this, but it actually hasn't been.

Q. Can I ask you where the elderly fit into this model?
A. Well, we've had some debate in the advisory group and the Commission about this, how engaged should we be about aged care and aged psychiatry. I think we have to say something about that, because obviously there are mental

disorders in the elderly, but you know, as you're aware, this version is probably version 1 of a more definitive sort of thing.

Q. Of course, and can I thank you for preparing version 1 of this model at our request. I want to change topics now and ask you to elaborate on some of the views you've given us in your statement, firstly about the current state of the mental health system. You've said quite a bit about it already but I'll try and ask you questions which don't involve repeating what's already been said.

You start by talking about a very significant opportunity, and you say that:

> "The greatest unrealised opportunity in Victoria's public health system is to reduce the mortality and morbidity caused by mental illness and, in contrast to improvements in cancer and cardiovascular disease, improvements in mental health by these metrics have been negligible in recent decades, indeed there's evidence that these measures are getting worse."

How do those metrics compare?

A. Well, I guess, you know, everyone's aware that the suicide toll is increasing in Australia. I think over 600 people in Victoria are currently dying every year. I've certainly seen, in the part of Melbourne that I work, the suicide rate in the age group that we try to treat with our state funded Orygen Youth Health Service just climb year after year.

Back 15 years ago we might have lost maybe one young person every year or two, which was bad enough and when it happened we went into major soul-searching about what we should actually do to reduce that and everyone was motivated to do that, we didn't accept that anyone should die.

I've seen years now in the last few years where eight or nine people have died in one year, which is absolutely devastating because you know every single one of those lives could have been saved if they'd had the right type of help. So, there's the anecdotal but there's the numerical, and I think NorthWestern Mental Health have actually mapped

the numbers of people who have actually died, not just from suicides but homicides as well over that period.

It's devastating, and yet you know that we could do an awful lot better if we implemented what we - if we were resourced and if we implemented what we could do in that regard.

Q. You've used the expression "the soft bigotry of low expectations" in your statement, you've probably used it elsewhere too. Can you say what you mean by that?

A. I think I've stolen that from George Bush's speech writer; I think he was the first person to use that, which is kind of strange.

How it's applicable in psychiatry is not just about the deaths but about the low expectations that we've been forced to have for recovery in our patients. Recovery is a wonderful concept that the consumer movement has embraced and we started thinking about it in the late 80s because we believed people could recover. When I started psychiatry people with schizophrenia were told you're never going to recover, but we've seen large numbers of people with schizophrenia recover if they get the right help, and even with their own natural resilience in overcoming the illness.

But the system is forced into just accepting that the best that you can do for a patient is that they can be not acutely unwell and bothering the emergency department, that's essentially a good outcome as far as our mental health system in Victoria is at the moment. If they're not actually in your face in the emergency department, then that's great.

And more subtly, if they're just at home and they're reasonably happy and not suicidal or depressed, but not working and just languishing, that's also okay. Whereas so many more of those patients could actually have been having what, you know, the National Mental Health Commission called a contributing life, they could actually be much more engaged socially, occupationally, vocationally if they got the right sort of help, and the expectations that people have for them, you know, that people believe that that could be the case.

So, that's what I mean by "the soft bigotry of low expectations". And it applies especially to illnesses like

schizophrenia, but it applies to a lot of people with mental illness more generally.

Q. Earlier on you talked about the fact that the system was envisaged in the 1990s as having a really strong community-based mental health service. What are your views about why that didn't get implemented in the manner it was intended?
A. Well, I don't think governments realise the scale of the problem. Essentially what kind of happened in the first wave was, it was a question of just looking after the same people but in a different setting; in other words, the people who were the patients in the old mental hospital system, people with more severe and enduring mental illness, and the idea of new cohorts of patients coming in with a different set of possibilities didn't seem to occur to the people who were funding the initial wave of reform.

If I can use an analogy, I think the way it felt at the time was that, we'd suddenly gone from a 19th Century Alexander Bell phone system, and we suddenly got a first generation mobile phone, which was a bit of a brick but actually it was a big advance, and then we never went through the iPhone, iPhone 2, iPhone 3, iPhone 4, which is the only way that we would have actually done what they've done in cancer and the other areas of health care: constant improvement, constant - but the thing was not built to scale and --

Q. Can you say what you mean by that?
A. Well, you know, no-one did the numbers on, you know, like we're doing today: how many people in this catchment area have a need for care? How is it going to be provided? So population health planning. If there's 50,000 young people in the western suburbs that need some kind of mental health care and we're providing care for 800, what about the other 49,200? What's happening to them? Out of that 49,000 are going to come the next wave of 800 more severely ill. No-one thought that way, and you have to think that way if you're going to have a system that's going to work and keep people alive and recovering.

Q. Yes. You've said that "the quality of care provided in acute inpatient is limited largely to risk management and the acuity of the patients that can access the units is high." Why do you think there's a focus on risk management?

A. Well, I think it's not the fault of the people operating those services; they realise that the only people that get into hospital these days are absolutely in life-threatening situations, and you're forced to deal with the risk then, aren't you, because the risk has appeared. But it means that it's impossible to do the sort of things that used to happen in patient units, where people could stay long enough until they were actually better and there was some improvement in their condition. So, people are discharged all the time now with very little improvement in their condition.

I often think, you know, I was very motivated when I worked in those old mental hospitals - people felt a bit horrified by the way they were, but I don't think it's any better, you know, those inpatient settings that I see now, which is very, very disappointing to say that after all this time.

But, you know, we thought it would be much better to have very strong community services, like people didn't have to spend weeks in hospital, which is what we were trying to do. But now we've done neither, we've sort of allowed the community system to sort of implode, and that means that the residual acute system is under just such enormous pressure that all they do is really try to keep people alive and, it's a desperate situation actually, I'm sure you've heard that from many other people.

Q. What do you think are the key things missing from the community mental health services?
A. I think the freedom. I mean, they have become very institutionalised as well in this - I think I used in my statement, the idea of an iceberg sitting in the middle of these hospital networks that just slowly melted over the last 20 years. In those settings they don't even operate efficiently because they're worried about risk, they've got about 15 forms to fill in for every patient that they see.

I contrast it when I work in that system with when I work in Headspace. I spend about five minutes at the end of seeing a patient writing the notes, filling in a brief evaluation. That's not the experience of people working in the public mental health system, they're covering their backs all the time because they know something's going to go wrong with the patients and they're forced to do so by the managers of those systems.

So, the system's not efficient, the morale has sunk, the leadership has ground down over the years, I would say. I've seen these people, directors of services that are struggling to sort of, you know - an impossible job really. So, it isn't even operating as well as it could with the level of resourcing that it has because of these other cultural factors which, you know, have not been addressed.

Q. You've used the expression "sitting there like an iceberg which has slowly melted", do you mean to say by that that it's never been properly integrated?
A. Yeah, I don't think it's been integrated, but integration has been seen through the hospital lens rather than the community lens. So, the community system should have been integrated with the community and with primary care, not with, you know, emergency departments; it's gone the other way.

Q. If you take a bit of a broader lens to the mental health system as a whole, how has its progress since the 1990s compared with progress in the treatment and management of other non-communicable diseases?
A. Well, it's very stagnant, I think. I think, if I can quote Christine Kilpatrick, the current CEO of Melbourne Health, she went to the Children's for ten years, came back to Melbourne Health, and said nothing had really changed in mental health, if anything it had got worse. And contrasted with the progress that she'd seen in cancer and cardiovascular medicine and all these other things.

One of the reasons for that is because they respect expertise in those specialities, they respect research, and they try to get the latest research advances translated to real people.

In mental health, the culture of mental health care resists all that, it's suspicious of research, it's suspicious of expertise, and we've got to make sure that the things that work and the things that will get people better are supported by everybody, and so that the consumers are involved in that and they understand how that's going to benefit them and they can help us do the research.

We do that at Orygen, we have a research council of young people that help us design studies so that we're

doing relevant things, and also that they will then be accepted and embraced by the patients; just like you see in cancer where, you know, patients are very supportive of research and very supportive of expertise.

Q. Why do you think there are such big differences between the way in which general health has developed and the way in which mental health has developed?
A. I think it's just a pure matter of discrimination and stigma.

Q. What do you mean by that?
A. Well, the stigma's rife within the health professions, it's rife within the medical research environment. We don't get a fair deal. The patients that - the people who experience mental illness are discriminated against, but so are we as mental health professions.

Q. Are you referring to a sort of institutionalised stigma?
A. Yeah.

Q. I said I was going to ask you before why it was that you said "we're just not delivering even the really good things that we have available, they're not reaching people", why do you think that is?
A. Well, in medicine generally there's this implementation failure problem and, you know, our colleagues in other branches of health care would say that's an issue as well; you know, the delay between an advance and when it's actually implemented in the real world.

But people make huge efforts to accelerate that in other areas of health care. Every time a new cancer drug comes on the scene there's tremendous pressure on the Health Minister to tick it off and finance it. It doesn't matter if it's hundreds of millions of dollars, it will be approved very, very quickly and that's not the case with us.

I'll give you one example, TMS, for treatment of resistant depression.

Q. Can you say what TMS is?
A. Transcranial magnetic stimulation. Very safe, it sounds a bit science fiction, but it's actually very safe

and it improves brain plasticity. If someone hasn't responded to CBT and antidepressants, rather than trying lots of different antidepressants, the next step should be, the success rate is much better if you go to TMS. But that is not funded, it's not supported, it's not available, it's been known about for many years, and this is one example.

Q. Speaking about funding on a broader scale, you said earlier that the system was not scaled or designed for scale when it was changed in the early 1990s. You've said also that it was not funded to address the scale of the problem. What's the significance of the funding gap in all of the difficulties that you've been talking about?
A. Well, there was a landmark publication in October last year from the Lancet which is on the global - the Global Mental Health Commission, it's called, and it sort of mapped the treatment gap all around the world and it showed that governments around the world generally spend about 2 per cent of the health budget on mental health care and it's variable, but anywhere from 12-15 per cent of the burden of disease. So, this is a massive issue across the whole world. Yeah, it's just the shortfall between what the need is and what the level of funding provision there is.

And, you know, in Australia it's probably about 6 per cent of the health budget; people debate that. The most accurate estimate in Australia is about 14.6 per cent of the health burden so that means a treatment gap.

In Victoria, as you know, it's in common knowledge now, that we're covering about 1 per cent of the Victorian population with state government resources, and if you believe they're supposed to cover 3 per cent, that's the treatment gap right there for the seriously mentally ill. That doesn't exist in cancer and other health areas in the same way.

Q. And so, you're saying there's a very good economic case for changing that?
A. Yeah, I mean, the beauty - the best news and the best thing we could focus on, which the Productivity Commission is obviously focusing on, is that we are different in a very good way from the rest of health care.

Because, you know, obviously we want to keep treating cancer in a very good way. We're definitely not saying,

it's not cancer envy we're talking about here, it's cancer admiration in a way. But treating cancer is a highly cost-ineffective thing to do, because it's mostly older people who are beyond - or not totally beyond, but many of them are beyond the productive phase of their life and yet we still want to care for them and treat them. But it's not going to be a great investment in terms of cost-effectiveness.

Mental illness, because it strikes in the prime productive years of life in young people on the threshold of productive life, and people across the adult years of life, it's a massive opportunity. Because, if you get even a substantially higher proportion of people well and productive, which is very achievable, it's going to pay for itself several times over.

We ourselves have done cost-effectiveness studies of treatment of psychosis, early intervention for psychosis, and there's a whole range of evidence suggesting that if mental illness was treated more effectively it would pay for itself several times over through reduced welfare payments, reduced expenditure on a whole range of other government activities, including prisons, homelessness and so on.

Q. Can I ask you a couple of questions about governance. You said in your statement that the:

> "The governance and financial model underpinning the current system exposed it to major vulnerability at the hands of general hospital administrators."

What do you mean by that?

A. Well, we've already talked about the issue of it not being funded to scale and us not having appropriate financial models, like for example the NDIS, to drive the sort of level of investment that we really need. But even the amount of money that was allocated or has been allocated to public mental health care in Victoria has not always found its way to the mentally ill because of the way that the money is given in a block-funded way to large hospital networks; it's not activity-based, so it's sitting there like a big cash cow in the hospital network.

And obviously, when pressures come in other parts of

the health system the CO is very tempted to find ways to divert some of that funding into other forms of mental health care. It absolutely happens.

The other thing, to blame the Health Department as well as the hospitals, the Health Department has underfunded the bed day rate for many years and that meant that the hospital CO had to subsidise the bed day rate somehow and they would do that through raiding the community mental health resources, which then destabilised a very fragile system even further and helped to cause it to implode. So, they would freeze positions in the community or collapsed them so that funding could be diverted more easily. We've seen this happen in many settings

Q. So you're saying there's both a funding shortfall and a structural funding design problem?
A. Yeah, and the Health Department is aware of this and is apparently powerless to stop it with the current governance model.

Q. Can you say a little bit more about the current governance model and specifically in that context. Sorry, when you say governance model, governance of what?
A. Governance of the inpatient beds and the community mental health clinics and community resources.

Q. Yes.
A. So that's currently run through acute hospital networks basically, all of that. And it's a bit of an anomaly as I said earlier, the community resources being under the wing of those sort of structures, because they really do very little of that apart from mental health.

Q. Alright. We have asked you, not just what is wrong but what are the critical elements of a well functioning mental health system and you've said this:

> "Much more effective and mandated professional leadership is needed from senior psychiatrists who should be empowered to oversee the clinical governance of the whole system they lead."

Can you please elaborate on that?
A. Well, back when, I suppose, things were looking a

little bit more optimistic, a lot of the leadership of these systems was people who had often a dual clinical and academic background, so they were clinical experts but they also had research credibility and status so they were respected and they were in charge of the service; and the manager would report to them for the budget, so the leadership was content-based.

That was gradually split and so the managers were in control, and gradually the medical role was marginalised to just looking after the medical staff; not even the other clinical staff. So, that is not the way they run, you know, cardiology or neurology or other structures like that as I understand it, and so, that had a lot of negative consequences.

And so, the person that was left with the Mental Health Act responsibilities as the authorised psychiatrist and the medical leader carried all the risk and all the pressure but none of the ability to actually influence as much what was done within the service, so that was definitely a negative.

So I think somehow we've got to make those leadership positions more attractive, and also, to actually train and recruit and groom and nurture the next generation of leadership, because the current generation has wilted in the face of these sorts of pressures.

Q. On governance you also say that:

> "The governance of community mental health services needs to be separated and fully protected from the governance of acute systems of care.

A. Well, this is a tricky one because, I think it's very important that mental health care remains a health system issue and doesn't just become consigned to a purely social view of things. I mean, the social thing is very, very important in psychiatry and mental health, and so, you want a holistic model that includes, you know, psycho-social and integrates them with the medical and the biological side of things. But you do not want to remove the medical and the scientific perspective from the thing, so it has to be somehow kept within the health realm, but I would like to see a much broader health realm so it's holistic so it's

got other much broader foci.

But I think what I'm trying to say, is that, putting that in the hands of hospital-centric thinking, it's really the tail wagging the dog, because most of the care of people with mental ill-health has to happen in their communities, where they live, and integrated with the primary care and other social structures. So how to do that is a challenge, you know.

Q. Can I ask you finally, Professor McGorry, apart from the specific work you're doing in Headspace and Orygen, what about the - what features or feature of the mental health system makes you even a little bit optimistic that we can change positively?
A. I'm incredibly optimistic. I think we're at a point now where the whole community, as we can see through this Royal Commission is - it's an authorising environment, I think I heard the CEO say yesterday.

We're empowered now, and the community is empowering this change, and it's happening all around the world. We have contracts with the World Economic Forum in globalising the Youth Mental Health Model I've been talking about here.

We have the Lancet, the very important Medical Journal in the UK, producing commissions on mental health, on depression, on youth mental health, we're embarking on that now.

We've got the Productivity Commission looking at the cost of not spending enough money on mental health care - that's the way I like to look at what they're doing. And we've got this Royal Commission here which is actually telling the truth about what's been happening in Victoria for the last 15 years or so and exposing that truth, but in a way that's solution-focused.

We have the ability to design, create and resource a new way of doing things. It has to be new. Everything that I've done in psychiatry has been creating something new, not trying to patch up some old system. So, moving out of the older asylums into EPPIC, and now into Headspace, creating new cultures of care within the health system, within the health and social system, but not actually trying to, you know, defend the indefensible and do things that don't work.

And so, I do feel very optimistic but it has to be a real sea-change. We, among all countries in the world and in all states in Australia, have got the ability to do that. Victoria, I've seen it happen before, all the innovations in mental health in Australia have come out of this state, and yet, they haven't been nurtured. But we have got the ability here to do this and we've got the support of the public generally and, you know, I feel very confident and optimistic that something positive should happen now.

MS NICHOLS: Thank you very much, Professor McGorry. Chair, do the Commissioners have questions?

COMMISSIONER McSHERRY: Q. Thanks very much for your advice and your statement. I'd just like to ask a little bit more about your model because I think it's really important for us to get some ideas of the alternatives that might exist to the current system. We've been hearing a lot about what's not working.

So, can I just, for a point of clarification, are you dividing these cohorts up into three main age groups? Because I see that there's the over 25s is mentioned twice, and I'm not quite sure why?
A. I think that's meant to depict within a region of Melbourne you might need a couple of these adult platforms and maybe only one of the youth and child ones. So, it's really just a - what's the word - a proportional thing.

Q. I see.
A. And I don't meant to suggest that these things should be impermeable either. I totally agree with what Ric Haslam said this morning, that these boundaries should be a little bit more flexible, so not just rigid necessarily chronological age, but if someone's deemed to be developmentally different, then you should have some leeway. And so, the under-resourcing has led to absolute rigidity about these sort of things in the past.

Q. How would such a model work in regional areas?
A. That's a good question. I think you can get things down to a reasonable population size with this type of model, I would say, but not probably below 50,000 or 100,000 people; so, smaller. We've already seen this with Headspace, that Headspace probably needs a population base

of about 20,000 or 30,000 before it becomes unviable, and then you need a more flexible outreach type model beyond that.

So, it is more of a challenge in regional, and this is really, I suppose, what we've provided so far is more like a metro or suburban sort of model or maybe a large regional town, but we would have to do some more designing to try to work out how we could link, you know, more rural and remote areas into such a model.

Q. I'm also thinking it would have to be adaptable to certain communities, you know, particularly for CALD groups?
A. Yeah.

Q. But, you know, LGBTIQ groups that may not want to go to just a one-stop shop, but it might be community-led one-stop shops, things like that?
A. Flexibility is always good, but having that said, with Headspace LGBTIQ is probably about maybe 13 per cent nationally of the clientele in Headspace. But there are some Headspaces like in Collingwood where it's 45 per cent, but still the basic elements of Headspace work but the culture is obviously tailored then in a different way, so you have to have flexibility, I agree.

COMMISSIONER McSHERRY: Thanks for that clarification.

COMMISSIONER COCKRAM: Q. Thank you, Professor McGorry. I wanted to continue to explore the model. My first question really was about the growing interest and evidence around peer-led models and peer-led workforce.

I see a statement in each of these, but how do you see actually the role in a leadership way of peer-led models in this community-based design?
A. Thank you for that question. I think it's incredibly important because we've had such positive experiences with peer - or with youth engagement within the Headspace system. It couldn't have been developed successfully without that, actually.

We now have youth peer workers in Headspace and that's a growing thing, but they were involved in the design and also every Headspace has a youth advisory group, and I think more could be done in terms of - as you're alluding

to - in terms of leadership as well. We would like to see young people in the youth mental health model involved in management and also on boards as well, so definitely that's the direction it's heading in.

Q. One of the other things I was wanting to ask about is that, the residential component of this looks very much like an inpatient environment. Do you think there's a place for other residential models in community?
A. Well, what we've termed there "therapeutic residential unit" is really modeled on the PARC idea, which we think has been a piece of progress. But one way we think that PARC could be improved is by having more therapeutic programs within them, so they're not just residential programs, they actually have the sort of therapeutic expertise that some of the Scandinavian models that we've seen in the past can offer.

So, there's a way that PARC can be improved further, but it's essentially, I suppose, a subacute longer stay model that's meant to indicate building on the PARC experience.

Q. One final question from me. In Victoria we have the benefit of having a community health model. We've talked about the relationship between some of this design and Headspace models. Where do you see the community health model fitting in here?
A. Yeah, I think it's a great question too. I mean, in a way these hubs should be like community health centres, because you want to have physical health totally integrated within them, and that also helps with stigma as well, I think, if they're more holistic.

But I suppose the trick is going to be, how do you get the really high quality mental health expertise available within such models? So exploring how that could relate to community health would be a great way to take this further.

COMMISSIONER COCKRAM: Thank you.

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. Thanks very much for your excellent witness statement as well as your evidence. I was about to ask the same question as Dr Cockram, but just to follow it through on the therapeutic residential unit.

I suppose there's also some longer term residential needs of people with long-term mental illness. Do you have any thoughts on that?
A. Absolutely. And I think we tried to indicate that with the continuing care unit at the top.

Q. Ah, yes.
A. So that's meant to be - and there may be a need for much greater resourcing of that too, because these currently do exist but they're probably in short supply, so I think that's absolutely (indistinct). Because when the old institutions were closed there were a lot of people who had a need for that sort of service and that was - it was actually constrained probably to a much greater extent than it should have been.

Q. One other brief thing. You expressed some optimism about the attitudes of younger people being improved in the stigma dimension. We heard some evidence, talking about the general population, that attitudes don't seem to have improved, they may have got a little bit worse with respect to schizophrenia and serious forms of illness. Do you have any impressions whether this improvement in the younger generation extends to people with serious mental illness?
A. Yeah, I think it has, and that's because we've kind of softened the kind of - what's the word - the stereotype of schizophrenia. I mean, we deliberately did that with the early psychosis movement. We tried to say, schizophrenia is just a subtype of psychosis and something you'll hear about, but we tried to take that, I suppose, that toxic message that was built into the schizophrenia concept, that you couldn't recover.

I can't tell you how many times I've heard stories of psychiatrists telling patients that you've got schizophrenia, you're not going to be able to work, you've got to have a more - so that's the soft bigotry of low expectations again.

So I think in young people that's been quite successful in terms of softening the whole idea about - and having a much more optimistic approach to psychotic illnesses, that recovery is more possible.

I think you're right, though, in the general population there's been a lot of success in reducing the stigma across all ages for anxiety and depression, but very

little effort's been put into destigmatising terms like borderline and schizophrenia and more serious forms of mental illness.

I mean, when you spend tens of millions of dollars on anxiety and depression - Beyond Blue, but virtually nothing, you know, through SANE and other organisations for the other types of mental illness, then that's probably inevitable, isn't it? So, a much bigger effort needs to be put into that, if that's what's behind your question.

COMMISSIONER FELS: Yes, thank you.

CHAIR: Q. Professor McGorry, one other thing from me. In terms of material that's come before us and you also reference this in your witness statement, a lot of the current mental health system is balanced around brief episodes of care, and sometimes we've heard, and even today we heard about one night's admission to an inpatient unit, or ten episodes of psychological assistance, and for many consumers we hear them say that raises great anxiety, about what happens if I'm not fixed in that period of time or I need ongoing care.

You do reference that some people will need longer term team-based care, and even go on in your witness statement to suggest some might also need a concept of "mobile assertive outreach in the community". Can you talk about how in the models of the future you think we reconcile these tensions between brief episodes of care and longer term care models that might be required?
A. Yeah, thank you, that's a really, really important question. Well, as you say, I mean, the episode of care for acute inpatient care is maybe about eight or ten days; you know, way too short for most people.

But then, when they're discharged to the current community clinics, their half-life - if I can use that term - is about six to 12 months across Victoria. So, you get a few months of after care, basically, and then you get sent back to the GP until the next relapse occurs, so even that episode of care is too short.

And in our services at Orygen, originally arising out of the Epic model, we managed to guarantee two years of care, that was when we had enough resources to provide when we called it "the critical period" which I was referring to

before. So, that was an advance on what adult services could provide, generally speaking, but it's still not enough for a significant minority of the patients; maybe over 50 per cent need up to five years, and maybe 10 per cent or more, 20 per cent, need very long-term care. And they should have access to expert care, not just general practice - that's the problem.

So, when you're talking about episodes of care, it's at what level of care you can get. Probably everyone's got access to general practice - so, if that's an episode of care, that could be long-term, but it's insufficient for what these patients need, and so, I think in that sense - and the other thing I'm sure that the consumers have been saying in the Commission is. We want to have the same person to look after us all that time, you know.

I've looked after patients in the west of Melbourne, for some of them for over 30 years, and the value of that is - you can't put a price on it, you know, the relationship that you have with a person over that time. So, those are really important things.

In terms of the assertive community treatment and the home-based treatment, those are very powerful strategies. I've worked in those teams, it's a joy to work in those teams, that's a fantastic way to work if they're well resourced and if you've got the right type of skilled, gifted people working in those teams. So, we've got to put a lot of effort into finding those wonderful people to work in those teams who are skilled and properly supported.

I think all of these things are achievable with money and with the right leadership and planning.

MS NICHOLS: May Professor McGorry be excused?

CHAIR: Thank you.

<**THE WITNESS WITHDREW**

MS NICHOLS: That concludes the evidence for today, Commissioners.

AT 3.40PM THE COMMISSION WAS ADJOURNED TO MONDAY, 8 JULY 2019 AT 10.00AM

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