Royal Commission
into Family Violence

WITNESS STATEMENT OF PROFESSOR PATRICK DENNISTOUN MCGORRY

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

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

Current roles

2. I am the Executive Director of Orygen, the National Centre of Excellence in Youth Mental Health, Professor of Youth Mental Health at the University of Melbourne, and a Founding Director of the Board of the National Youth Mental Health Foundation (**headspace**).

3. I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists, a Fellow of the Academy of the Social Sciences in Australia and the Editor-in-Chief of Early Intervention in Psychiatry.

4. I am also the President of the Society for Mental Health Research, and the President-Elect of the Schizophrenia International Research Society.

Background and qualifications

5. I received my medical degree from the University of Sydney and my doctorates from Monash University and the University of Melbourne in Victoria.

6. I have over 30 years experience working as a clinician, researcher, and reformer based in the Victorian public mental health system in the areas of early psychosis, early intervention and youth mental health.

7. Since becoming an academic, I have published over 500 peer-reviewed papers and reviews, and over 50 book chapters. I have also edited 6 books. Attached to

this statement and marked '**PMc 1**' is a copy of my curriculum vitae which includes my publication record

Overview of mental health landscape for young people and need for service reform

8. The mental health of adolescents and young adults has long been my focus, and in that sense bridging the period from puberty to mature adulthood is a bit atypical from the way the health system has been structured (i.e. with its a split focus on paediatrics and older adults).

9. I have been an advocate for change in this regard, because from about puberty through to a person's mid-twenties, there is a huge increase in mental health problems, at least of the potentially more enduring adult type.

10. While younger children, below the age of 12, do have mental health problems (e.g. autism) they constitute approximately 7 per cent of children in that age group. From puberty to the time people reach their early twenties (i.e. in the 18-24 age group), that percentage of people experiencing mental health issues increases to approximately 26 per cent each year.

11. In the modern context, the transition (culturally and developmentally) to adulthood begins much earlier than it used to and does not finish until the age of about 25 or later in some.

12. Historically, adolescence was a much shorter period because people tended to assume adult responsibilities from almost as soon as they left school and at least by the age of 18.

13. Today's extended transition to adulthood is a consequence of social and economic factors, as well as developmental factors. In the 19th century the period of adolescence was brief and the transition to adulthood short. The stretching of this transition with variable patterns of maturation is mirrored by the remodelling and continued maturation of the brain which continues actively until the mid-20s. The prefrontal region is the last part of the brain to mature and this explains the reduction of impulsivity and risk taking by the mid-20s in most young people as planning and judgement capacity tends to increase. Some family violence and aggression seen towards parents from young adolescents and emerging adults still living at home and struggling is due to mental ill health in these young men.

14. For a whole range of reasons, the incidence and prevalence of mental ill-health is at its peak during this life stage and it has, traditionally, been very poorly addressed. The health system has tended to focus on younger children and older adults since this is where the greatest demand for physical health care occurs. The neglect of mental health care in resourcing and design of services has meant that there has been extremely poor access to mental health services for adolescents and young adults, indeed the worst across the lifespan for any group. The health system is weakest where it needs to be strongest for young people. Even if they do gain access to traditional primary care and specialist services, adolescents and young adults have had such an inadequate response that they fail to engage or are even frequently harmed by such contact.

15. We have, together with a range of colleagues both in Melbourne and interstate and with Federal government support, begun to build an evidence-based reform of mental health services to better serve the needs of vulnerable young people. It involves creating the right culture so that young people engage in it and also so that families are included. This is known as headspace and in north western Melbourne we have its precursor service – Orygen. Orygen is not yet available as a model across the State.

16. Families and especially parents are a key resource as they represent the scaffolding for young adults, and yet because of issues such as confidentiality and (largely reasonable) efforts to focus on the autonomy of a young person, parents are often pushed into the background when they should be considered as part of the solution.

17. These reforms, notably Orygen and headspace, represent a progressive growth project in mental health. They are based, in part, around the idea of early intervention, which had been missing in mental health until the last 20 years or so.

18. Early intervention is essential in order to ensure that people receive appropriate expert intervention and support at the right times. We have had to advocate very strongly for broader recognition of the fact that 75 per cent of mental disorders appear by the age of 25. The health system has historically revolved around non-communicable physical illnesses, which in contrast tend to occur in older people.

Mental ill-health common in adolescents and young adults

19. Adolescents and young adults experiencing mental ill-health do not fall into neat categories. Instead they have often comorbid or blends of "syndromes", being a reflection of symptoms like depression and anxiety, which are the most common -

especially in young women. Depression and anxiety are experienced by young men as well but often disguised by drug and alcohol and behavioural problems. Young men frequently turn to substance (mis)use as a way of dealing with the same experience of internal distress. They can manifest their distress and impairments in family violence as can some young women as well.

20. These types of symptoms can affect young adults' personality development, relationships and sense of identity. As a result, we also see behavioural disturbances, which are often seen in judgemental terms. For example, young men experiencing these symptoms repeatedly find themselves in trouble with teachers and the law and are viewed as aggressive or irritable, when what is driving their behaviour is what is going on internally. Again violence can be the end result and is preventable.

21. Some of the more serious disorders that we see in young people include:

(a) severe eating disorders (like Anorexia);

(b) Borderline Personality Disorder, which is very serious and where child abuse or neglect is often a factor;

(c) Schizophrenia and other forms of psychosis;

(d) substance use disorders; and

(e) complex and persistent mood and anxiety disorders.

22. We observe a difference in males' and females' experience of the symptoms and expression of mental ill health set out above, for example:

(a) the depression and anxiety spectrum, deliberate self-harm and Borderline Personality Disorder are more common in females; and

(b) psychosis, drug and alcohol problems and anti-social behaviours are more common in males.

(c) These gender differences are trends, there is some overlap of course there is not a clearcut divide.

23. We see a similar age of onset, except in the case of Schizophrenia, which has a later onset in females. This is largely explained by a second peak, which I believe maybe supported by evidence indicating a relationship with hormone changes that a woman experiences in the menopausal period. In younger people

Schizophrenia is more common in men and if you do get an early onset in a female, it is most likely to be around the same age as if you were male provided the second female peak is taken out.

Intersection between issues of mental ill-health and family violence

24. In the general mental health system, in terms of a therapeutic response, the focus is typically a narrow one on the individual person presenting in front of a health practitioner. The family and friends and the social context tend to be excluded from involvement and rarely offered sufficient support or intervention themselves. I was trained in the 1980s, at which time there was a much more systemic or family focus. With today's more individualised approach, I do not believe that most practitioners would be family focused or routinely assessing for family violence, or necessarily giving it much attention.

25. Many of the young patients that we see at headspace and Orygen have grown up with a parent who has a mental illness or alcohol and drug issues and, in my experience, that is not really inquired into carefully enough by practitioners or taken into account in managing the situation. Often the parents and siblings need mental health care themselves and do not get it or have not been able to access it. It is very difficult with current funding models and systems of care to mobilise the broad range of resources required to address the family and wider issues adequately.

26. To emphasise this further, family violence is an issue that mental health practitioners largely do not attend to, but a proper assessment of the family, and intervening decisively and effectively, working with the family as a whole, is not really possible given the way the health and medical systems are currently funded.

27. Family violence is the result of multiple factors including untreated or poorly treated mental illness and/or substance misuse. These are potent causal factors which have been very poorly responded to in terms of preventive care. Recent highly publicised cases appear to be among the best examples of this failure of care. The focus has typically been on the violence that resulted in tragic deaths within families rather than the preventable underlying causes ie treating more effectively mental ill health and substance misuse in a much more effective manner. That is certainly not to say that mental illness is always behind family violence. Just that even when it is the mental illness may be covered up or downplayed.

28. The previous point is very significant and while there is no intention to make any excuses for criminal behaviour or over simplify the drivers of violence, there seems to be a reluctance to even discuss or highlight the obvious facts in some of these high profile cases. There is therefore a risk that a purely judgemental approach might be applied across the board rather than a health or broader social perspective at least in a percentage of cases.

Systemic issue in terms of the delivery of mental health service

29. Mental health services are being progressively defunded by State governments relative to physical health care and to level of genuine need right around Australia and particularly in Victoria which has dropped from the top of the list in per capita funding for mental health to the bottom. This has been disguised recently by allocating transient project-based funding for fashionable yet poorly evidence based programs, giving the impression to the public that the government is doing something, and yet distracting attention from the serious and progressive decline in scale and quality that has occurred in Victorian specialist public mental health care, that has seen it slide from being the jewel in the crown nationally to a shadow of its former self. This is causing major demotivation among the clinical workforce and distressingly frequent life threatening situations to occur as patients and families are being let down, often with tragic consequences including many preventable suicides and also violent incidents and homicides.

30. This has particularly been the case over the past 4-5 years and notably for our own State funded service; In 2013-14, Orygen had reductions in funding of approximately $800,000, a loss which abruptly reduced services and staff morale, and coincided with a sharp spike in suicide and homicide rates among our young patients to levels never previously seen. This reduction in funding continues into this current financial year with $500,000 of further "savings" to be found. This means another one hundred seriously ill young people will be turned away from access to care. This is in the face of Orygen covering a catchment area with some of the highest population growth rates in Victoria, and indeed Australia. Orygen is not alone in this. The public mental health system i.e. the core clinical system state-wide and especially the community mental health system, is steadily shrinking, with regular funding reductions, even though the population is rapidly growing especially in key growth corridors. This is due to a combination of central departmental reductions in funds, combined with diversion of funds at the general hospital level, and means that community mental health services are effectively

under intolerable pressures and unable to respond proactively. This results in the first point of contact for people suffering from mental ill-health typically being the police, the ambulance service and the Emergency Department. It is truly a situation where the ambulances have moved to the bottom of the cliff, and it is a steep cliff indeed.

31. Going back 15 or so years, if there was an acute mental health incident the crisis assessment and treatment teams (**CATT**) would go to the home or elsewhere in the community to assess and provide care. Now the situation is that often police or an ambulance attend the incident and the CATT team is not able to do so due to a combination of funding cuts, restructuring and a redefinition of work practice. CATT teams haven't been resourced to respond proactively but they have also redefined their role as no longer first responders. In some health care systems they have been reabsorbed into generic community mental health teams or relocated in Emergency Departments.

32. In the early to mid-nineties the traditional asylum system was replaced by general public hospital inpatient units and a base camp or first generation model of community mental health care. This seemed a positive concept but it has not flourished or grown to keep pace with demand and population growth. Mental health care is block funded in a different way to the activity-based method for acute health so the acute and community resources for mental health care sit within cash strapped general hospitals and are very vulnerable. As a result of deinstitutionalisation, mental health is the only element of the public health service that is financially governed from the acute hospital but which also has had a substantial community component. The latter however is governed within a health system and governance model that is solely bed focused, and hence the community resources are not seen as core business and are typically used to prop up bed-based care in mental health and furthermore these funds are diverted to other clinical services through complex and arbitrary internal taxing schemes. This adds further insult to the injury of chronic structural underfunding of mental health care. The end result is that mental health care is only delivered when it can no longer be avoided. The result for patients has been likened by some consumers to a form of "medical apartheid" – that is they receive a second class service for their mental health needs compared to their physical health needs. Hence quite unlike the situation in, say, heart disease where people with chest pain are encouraged not to delay and to seek help immediately, people even with severe and life-threatening symptoms of mental ill health are actively discouraged and regularly turned away or discharged prematurely if they do manage to gain

entry to care. Continuing community care is at a premium and very difficult to access and rarely for an adequate period. As a result, mental health is now a very demoralised, dysfunctional service system within our public mental hospital system. Funding wise and operationally, despite the best efforts of a host of dedicated mental health professionals, the predicament of community mental health care is akin to being chained to the deck of a health system "Titanic" . That is it cannot survive under these conditions. The result will inevitably be more and more crises with associated risks of violence, self harm and suicide. It should be noted that around 500 largely preventable deaths occur annually in Victoria from suicide which can be compared to the level of equally preventable and tragic deaths as a result of family violence. Both need to be urgently addressed and there is likely to be some overlap.

33. About ten years ago, Victoria was by far the best State in the country in terms of its innovative and optimistic approach to improving mental health services. However, now in terms of per-capita funding, Victoria is at the lowest level of any State of Australia.

34. On the other hand, this has occurred largely at the complex and severe end of the spectrum. Primary mental health care has improved in mental health over the past decade and especially so for young people with the early stages of mild to moderate mental ill health. Specifically the federal government has funded Better Access for all age groups and notably "headspace", which is a youth friendly, primary care, 'one stop shop' that covers 12 to 25 year olds.

35. headspace centres are located across metropolitan, regional and rural areas of Australia in soon to be 100 locations. Centres are built and designed with input from young people so they do not have the same look or feel as other clinical services. They provide young people with access to a general practitioner, psychologist, social worker, alcohol and drug worker, counsellor, vocational worker or youth worker. A number of centres also have Aboriginal and Torres Strait Islander health workers, welfare workers and family therapists.

36. A young person can usually access headspace after a relatively short time or no wait at all. Whilst headspace is equipped to deal with mild to moderate problems, once a young person develops a more complex problem and perhaps suicidal risk or significant disturbance or aggression, then headspace needs back up specialised assistance from, for example, Orygen or other specialist mental health, services which as noted are in very short supply.

The Orygen model

37. Orygen is a specialised youth mental health clinical service and an integrated research and educational program. One element forms part of the public mental health system in Melbourne and sees young people aged 15 to 25, with a focus on early intervention and youth-specific approaches. Other elements form the National Centre of Excellence in Youth Mental Health – Australia's translational mental health research platform in youth mental health.

38. The sort of assistance it can provide to young people complements headspace and includes the service of Orygen's Youth Access Team, which is a mobile team, staffed by mental health clinicians and psychiatrists who are skilled in managing mental health crises in the community. This team is seriously under-resourced for the task it is expected to perform.

39. Orygen services the north west of metropolitan Melbourne (approximately a quarter of Melbourne) and is only partially developed and resourced. This model does not exist at even this level in other parts of the city. The youth focus is present in part in other parts but it is not well-resourced. It is an embryonic reform that has stalled in recent times and even gone backwards in the last 4-5 years.

40. A young adult who is threatening or perpetrating violence, would most likely end up in the Emergency Department brought in by police, if a mental health issue were suspected. However if mental ill-health is present, this is often not identified and violent situations typically result in a purely criminal justice response, rather than a health response.

41. We were seeing a lot of offending behaviour and violence being perpetrated by young men with mental illness accessing our service at Orygen, which prompted us to set up a forensic clinic. This worked extremely well but was subsequently defunded by the Victorian Health Department for reasons which were unclear.

42. A mixed forensic and mental health response is usually what is required for such young people and I have engaged with police, Magistrates and other stakeholders about the need for a model of this kind. However, there is yet to be any funding made available to progress this thinking and implement such a response.

43. We have advocated previously for a youth version of the Adult forensic mental health service known as Forensicare. This is urgently needed in Victoria and could be a joint venture of Orygen and Melbourne Juvenile Justice Centre.

Trauma informed care

44. Despite some of the failings I have outlined above, psychosocial risk factors are given high consideration by workers within youth mental health system and child and adolescent health system too. Trauma, for example, is seen as a key risk factor and it can be a very potent cause even for the more traditional mental illness like schizophrenia which have been seen by some as more biological and genetic in causation. Aetiology is multifactorial.

45. Trauma is not just child abuse or family violence, but bullying, for example, is very powerful in causing mental ill-health. It can be a potent cause of young people suiciding as can child sexual abuse.

46. In relation to family violence, of the young people we see, I suspect that about one third would have been exposed to multiple disruptions of attachment or difficult circumstances relating to blended families. There is often a lot of conflict and violence around the separation of parents. The children in out of home care are an especially high risk group as victims and perhaps later as perpetrators..

47. In addition, many of the young people we see have lived in homes where there has been violence, and not just violence against the mother but also against the young people too, which has severely damaging effects on their mental health.

Collaboration between sectors

48. My impression is that the family violence and mental health sectors are presently siloed. We are trying to break down these silos e.g. with the headspace model, being a one-stop-shop but it is early days. The specialist systems are another story. Health and social services staff spend much wasted time communicating with each other in meetings and not enough time actually working directly with the young people and families they are supposed to be serving. The balance is wrong.

49. There is yet to be an effective integration of drug and alcohol and mental health services and I envisage that would be an equal challenge in relation to the family violence sector. There is an urgent need to have all sorts of organisations working out in the community coming together.

Recommendations for reform

50. There are several layers to what I consider could be done better, including:

    (a) The top priority for Victoria in terms of reducing the risks of family violence from a mental health perspective is to urgently redesign and invest in progressive growth and rebuilding of the State public community mental health system, especially assertive mobile community treatment teams and systems of multidisciplinary care, with specialist psychiatric leadership. These investments must be protected from exposure to the financial pressures of the acute public hospital system. Fortunately the recently elected Andrews government appears to have accepted this diagnosis of the depleted state of mental health care in making a clearcut election commitment to reform and rebuild the State mental health system.

    (b) While non-one wants to see the walls of the old asylum system rebuilt, there is an obvious need to build walls around the governance and finances of the public mental health system within the wider Victorian hospital system. Unless this occurs judgement on the mainstreaming of mental health within general acute health will be that it was a progressive idea which has been very poorly implemented with no objective review in nearly 20 years.

    (c) Investment in mobile outreach and home/community treatment teams and having this as the first response to acute mental health crises, not the police or ambulance and not having the Emergency Department as the eye of the needle through which to access mental health in a crisis. The Emergency Department can be the worst place for someone in a distressed or angry state to be since they can be treated punitively or as a nuisance, undeserving of appropriate and expert care. If aggression surfaces they are likely to be consigned by a swarm of security guards, shackling or sedation with little safety net or expert engagement.

    (d) Investing in early intervention by expanding collaborative models and building on expertise. headspace gives us the opportunity to engage young adults, but in my view we are only half way there if we do not have the specialist and comprehensive expertise deployed behind this, in order to service the needs of young people with more complex emerging mental disorders.

51. The current approach/system is putting all of the ambulances at the bottom of the cliff, so to speak.

52. The Bouverie Centre: Victoria's Family Institute is a good example of an approach that looks at the broader family situation. It combines clinical family therapy, academic teaching, qualitative and quantitative research, workforce development and community education in one integrated service. It is an island of expertise in an ocean of unmet need.

53. Their work focuses on the fundamental role of the family and alternative social networks in the healing process and the power of relationships to foster social, emotional and mental wellbeing. It is complementary to other individual approaches.

54. Whilst public awareness is growing in relation to the systematic issues, it has not yet demanded change. Only 40 to 50 per cent of the public can get even basic primary mental health care. When it comes to specialist mental health care, it is even less. The welcoming expert care found in cancer is out of reach for the great majority of Australians with mental ill health at present. Tackling this unmet need for mental health and substance use care would contribute greatly to reducing the risks of family violence.

Patrick Dennistoun McGorry

Dated: ___ July 2015

20/7/15.