The Australian

Inject sense into psychiatric care:

The appointment of Pat McGorry as Australian of the Year casts a light on the woeful state of the nation's mental health service reforms

- **Alan Rosen**
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THE decision to name Pat McGorry Australian of the Year is timely. He's a pioneer in early intervention for young people with psychiatric disorders, a clinical innovator and a researcher of international renown.

He's also a tireless advocate for desperately needed mental health services for all Australians: services that should be accessible, effective, welcoming and more community-based.

Hopefully, in his new role McGorry, a keen surfer, will help us catch the anticipated wave of national health reform to develop urgently needed and better funded and organised services.

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Why is the mental health community so desperate for an invitation from the federal government to the health reform dance? Because the Department of Health and Ageing has let us down dismally with the latest versions of the National Mental Health Service Policy, Plan and Standards.

The government has allowed federal and state health bureaucracies to weaken and substantially downgrade all three tools, even though it's obvious to the mental health community that they're overdue for upgrading.

To seasoned consumer advocates and family networks struggling with mental illnesses, it appears Australian mental health services will continue to fail their litmus-test question: Will services really be any different in five years? Australian national mental health reform, the envy of the world in the early 1990s, has stalled, allowing the development of a policy vacuum and a fragmented approach by state and federal bureaucracies.

The national policy and plan contains few specific objectives or goals, no targets, few timelines, no commitment of resources and no strategies for consistently rolling out road-tested services. It's a Clayton's plan, a list of suggestions committing no one to anything.

Just wait for the implementation action plan, we're told. Well, last time around the action plan came out near the end of the five-year national plan cycle, and achieved little. Even many senior public mental health directors believe the new national policy and plan will demand no change of practice from service providers.

Stakeholder consultation held during the formulation of these documents was, at best, gestural and erratic. It was often ignored.

Unlike New Zealand and Canada, we have no arm's-length national mental health authority empowered to consult stakeholders and the research literature continuously, to set the agenda. Such a body could hold states and territories accountable for achieving and sustaining evidence-based services, according to a broadly agreed national blueprint.

The final report of the National Health and Hospitals Reform Commission, with its patchy approach, is also in danger of disappointing mental health stakeholders. It usefully recommends consistent provision of early intervention and rapid-response outreach teams. But it ignores other equally cost-effective interventions and evidence-based service delivery systems that are just as crucial to improving mental health outcomes.

These include assertive community (home-based mobile) treatment teams for individuals with delayed recovery and persistent conditions; personalised, ongoing, community-based, recovery-oriented key workers for all with a severe condition; multiple family group interventions; 24-hour staffed community residential respite facilities, and so on.

There's consensus that we need a shift in the centre of gravity of mental health services from being hospital-centred with occasional community outreach, to community-centred services with in-reach into hospitals as required.

Community mental health facilities should be located in shopping hubs. Hospitals shouldn't be allowed to pull them into less convenient hospital campuses, so sites can be sold to fund hospital rebuilding. The NHHRC report appears indifferent to this.

The commonwealth murmurs interest in primary health agencies as budget holders for all community health services, although its GP super-clinic program isn't fully operational and the divisions of general practice haven't been properly tested in this role.

Medical domination could eclipse the psycho-social aspects of community mental health services. so primary care budget-holding should exclude mental health services.

Mental health services would, however, welcome collocation at primary health and community health one-stop-shops with certain provisos, including retention of discrete mental health teams. Only since we've had such teams focusing on particular functions or phases of care have mental health services been able to show substantial improvements in outcomes.

So, who should run mental health services? Not state and territory governments.

With the exception of Victoria and the ACT, they've forfeited any custodial right by allowing community care to shrivel. They've retreated to fortress-hospital psychiatry, leading to blocked access.

Not private health funds and facilities, as proposed by the NHHRC.

They have no track record in commissioning the entire range of acute and recovery services required, except for cherry-picking the most profitable.

Instead, as in New Zealand and Britain, commonwealth-funded regional mental health commissioning authorities could do it, but only if operating independently of all providers. Australia's mental health services are so fragmented, unco-ordinated and under-servicing that they're ripe for takeover for rebuilding or further stripping. The ideal model must integrate all local public, private and non-government sector providers. It must be independent from providers and political or bureaucratic meddling, and protected from personal or private exploitation.

That's a tall order, but achievable if the political will is there.

Will the lord and lady of the dance invite us to the gig? If so, will they just swirl by or offer us a hand?

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