EARLY
Intervention

Prof Patrick McGorry AO

ROOTS&

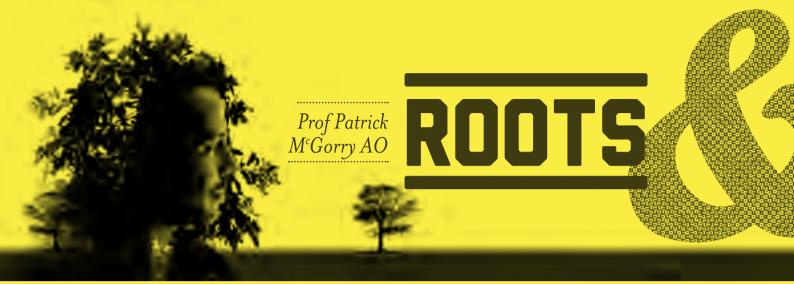In the first decade of this century, Australians have recognised that mental ill-health poses one of the greatest threats to our health and wellbeing across the lifespan, as well as to the social and economic health of the nation.

Australians now understand that mental health is everyone's business, and want a better deal for those living with mental illness, whether it be a family member, friend or colleague. Greater awareness has been fostered, especially by beyondblue and SANE, revealing substantial unmet need, and a shameful gap in access and quality of care between physical and mental healthcare. This results in so much unnecessary suffering and wasted potential.

The World Economic Forum recently calculated this waste worldwide, highlighting the enormous cost to world economies. This is because mental disorders are the chronic diseases of the young, with maximum impact across the main productive decades of life. Despite loads of rhetoric, endless process, and some genuine but modest funding initiatives, Australians still have to tolerate a mental healthcare system that is nowhere near the true scale of the problem, and is consequently fragmented, beleaguered and cannot, despite the dedicated efforts of countless clinicians, produce the required results.

Dr Thomas Insel, the Director of the National Institute of Mental Health in Washington DC, has pointed out that unlike in cancer and cardiovascular disease, where there have been substantial improvements in outcomes in recent decades, people experiencing mental ill-health have not benefited from improvements in premature mortality and disability. What is needed is not only more research, but an immediate, genuine and sustained root-and-branch reform process that is transformational, not incremental, and which gives a lot more weight to prevention and early intervention. Crucially, this reform must deliver equal access to quality care for mental and physical health conditions.

Today, most of the 19th century asylum model has been swept away through a process of mainstreaming of the mental healthcare of people with severe mental illness. This, like the asylum model itself, was well-intentioned but has been poorly designed, funded, executed and maintained. From the 1970s, beds were created within acute hospitals and a minimalist community mental health system was established as a base camp for ongoing care. State governments never really got beyond this base camp and have actually retreated down the mountain.

The post-asylum system was not built to scale, and has buckled under the strain of rising demand and population growth. Mental healthcare has retreated from its embryonic community base, with risk management now overshadowing care and the magnetic pull of the Emergency Department taking over. The ambulances are all at the bottom of the cliff. The system has largely abandoned acute care in the community to the ambulance system, the police and the emergency departments, in that order. The poorly-targeted investment in non-governmental organisation-based programs has fragmented care further, with poor coordination and widespread confusion the rule. Rather than dealing with the fundamental problem here, we are apparently to have more coordinators.

Even the grossly inadequate budgets that are allocated to mental health within the public health system have not been ring-fenced, and in the cash-strapped environment of acute hospitals, community mental health resources, block-funded each year independent of activity and services throughput, are a soft target for the insatiable needs of other health areas that are perceived to be more pressing. Things are likely to worsen unless community mental healthcare is included in activity-based funding. Heartened by the lessons of the former National Disability Insurance Scheme (now DisabilityCare Australia), our best hope is for a dramatically stronger federal government stake in the leadership, design, funding and governance of community mental healthcare, which should be linked conceptually and operationally to primary care, with the states retaining responsibility for hospital care. It would allow them to concentrate on fixing a serious problem. Inpatient care is in a parlous state Australia-wide with very negative experiences for staff and patients alike. It is in urgent need of root-and-branch redesign, with a serious review of work practices and an expansion of alternatives also needed.

Signs of transformational reform

However, there has been more positive evidence of transformational reform from the federal side, though its future is in the balance. The advent of much stronger support for the role of primary care and allied health in mental healthcare and for a wide variety of psychosocial programs was a major contribution of the Howard government. The establishment of headspace, Australia's National Youth Mental Health Foundation, in 2006 was a major innovation that built on these reforms.

BRANCHES
Reform

The Gillard government, through the leadership of the former Minister for Mental Health and Ageing, Mark Butler and with the personal support of the Prime Minister, has continued and added to these reforms, producing a significant initial package of investment and reform in 2011, which did cover the full lifespan. This was claimed to be a first step in a 10-year program of further growth and investment in mental healthcare, though competition from other policy initiatives has distracted from this commitment. This risks following the old familiar pattern for mental health reform: a surge in advocacy and community concern, followed by a loss of interest and momentum. The National Mental Health Commission, of which much is expected, has yet to hold government accountable for implementation of its reforms. Instead of a true report card on the performance of the system, their first contribution is yet another plan, which many see as having narrowed the agenda again (see Frank Quinlan's article). It remains unclear whether this mechanism on its own will really help.

In Canada and New Zealand, the impact of mental health commissions has been relatively modest and they do not appear to have stood the test of time. Many in Australia believe the Commission needs to become a true commission, to be strengthened and made more independent of government, so its report cards are unconstrained.

This independent voice needs to be backed by a large-scale grassroots voice for hundreds of thousands of people with mental ill-health, powered by internet-based platforms and community activism.

Furthermore, in contrast to other fields, notably disability and cancer, mental health advocacy lacks maturity and unity, and we have been unwilling to prioritise and offer government a range and sequence of achievable reforms that we as a sector will back with solidarity. We simply cannot afford to waste money on new, poorly conceived programs which, while stakeholder-friendly, are untested and not informed by evidence. There are several examples of this. This is especially so when assertive community treatment, employment programs, Housing First programs and early intervention for young people are all ready to go national. We must go with the best buys and the transformational investments. While we have had an overdose of plans, talkfests and roadmaps, all with little sustained impact, what we really need is a high level national inquiry with real teeth, perhaps via the Productivity Commission this time.

The partnership between the Early Psychosis Prevention and Intervention Centre and headspace, which has bipartisan support, represents an emblematic transformational reform in the provision of mental healthcare not only in Australia, but worldwide. There is intense interest in this Australian innovation in Europe and North America, where youth mental health is increasingly seen as a major priority. In addition to completing this reform agenda, we also need similar federally funded and led initiatives in housing, employment and primary care-based community mental healthcare for children, older adults and the elderly.

My personal view, fuelled by the harsh day-to-day experiences of so many ordinary Australians, is that while we have solutions at hand we need to mature as a sector, fight a lot harder for those impacted by mental ill-health and not merely for our own organisational goals, and in the current financial environment ensure that we invest wisely in transformational evidence-based programs that will be successful and represent the best buys in mental healthcare. While Australia leads the world in the development of innovative responses, we still have a long way to go to reach our ultimate goal of equality in care and providing the right care and supports for not only some of the most vulnerable people in our community and their families but for every one of the four million Australians with mental ill-health, who deserve a vastly better deal than they have now.

> WHAT IS NEEDED IS NOT ONLY MORE RESEARCH, BUT AN IMMEDIATE, GENUINE AND SUSTAINED ROOT-AND-BRANCH REFORM PROCESS THAT IS TRANSFORMATIONAL, NOT INCREMENTAL, AND WHICH GIVES A LOT MORE WEIGHT TO PREVENTION AND EARLY INTERVENTION. CRUCIALLY, THIS REFORM MUST DELIVER EQUAL ACCESS TO QUALITY CARE FOR MENTAL AND PHYSICAL HEALTH CONDITIONS.

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