SENATE SÉNAT
CANADA

REPORT 2

Mental Health Policies and Programs in Selected Countries

Interim Report of
The Standing Senate Committee On Social Affairs, Science And Technology

The Honourable Michael J.L.Kirby, *Chair*
The Honourable Wilbert Joseph Keon, *Deputy Chair*

November 2004

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The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on
Mental Health, Mental Illness and Addiction

Report 2

MENTAL HEALTH POLICIES AND PROGRAMS IN SELECTED COUNTRIES

Chair
The Honourable Michael J.L. Kirby

Deputy Chair
The Honourable Wilbert Joseph Keon

November 2004

ORDER OF REFERENCE

Extract from the *Journals of the Senate* for Thursday, October 7, 2004:

The Honourable Senator Kirby moved, seconded by the Honourable Losier-Cool:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on issues arising from, and developments since, the tabling of its final report on the state of the health care system in Canada in October 2002. In particular, the Committee shall be authorized to examine issues concerning mental health and mental illness.

That the papers and evidence received and taken by the Committee on the study of mental health and mental illness in Canada in the Thirty-seventh Parliament be referred to the Committee; and

That the Committee submit its final report no later than December 16, 2005 and that the Committee retain all powers necessary to publicize the findings of the Committee until March 31, 2006.

The question being put on the motion, it was adopted.

Paul C. Bélisle

Clerk of the Senate

SENATORS

The following Senators have participated in the study on the state of the health care system of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee
The Honourable Wilbert Joseph Keon, Deputy Chair of the Committee

The Honourable Senators:

Catherine S. Callbeck
Ethel M. Cochrane
Joan Cook
Jane Mary Cordy
Joyce Fairbairn, P.C.
Aurélien Gill
Janis G. Johnson
Marjory LeBreton
Viola Léger
Yves Morin
Lucie Pépin
Brenda Robertson (retired)
Douglas Roche (retired)
Eileen Rossiter (retired)
Marilyn Trenholme Counsell

Ex-officio members of the Committee:

The Honourable Senators: Jack Austin P.C. or (William Rompkey) and Noël A. Kinsella or (Terrance Stratton)

Other Senators who have participated from time to time on this study:
The Honourable Senators Di Nino, Forrestall, Kinsella, Lynch-Staunton, Milne and Murray.

MENTAL HEALTH,
MENTAL POLICIES AND PROGRAMS
IN SELECTED COUNTRIES

INTRODUCTION: INTERNATIONAL COMPARISONS

This document is the second in a series of four reports by the Standing Senate Committee on Social Affairs, Science and Technology as part of its study on mental health, mental illness and addiction. The first report, entitled *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada*, presents an overview of mental illness and addiction policies and services in Canada. This second report draws some lessons for mental health reform in Canada from descriptions of the mental health policies and programs in four selected countries. Together, the first and second reports provide background material that was used in the preparation of *Mental Health, Mental Illness and Addiction: Issues and Options in Canada*, the Committee's third report. The third report outlines the major issues facing the provision of mental health services and addiction treatment in Canada and presents potential policy options to address some of these issues. In the fourth and last report, which will be released in November 2005, the Committee will detail its recommendations for reform.

In the course of its two-year study of the acute care sector in Canada, the Committee recognized the importance in the health policy field of looking beyond the borders of one's own country. In fact, it devoted an entire volume of its six-volume study of Medicare to examining the experience of a variety of countries in order to glean lessons that could be applied in the Canadian context. Given Canada's relative backwardness in developing a national strategy to foster mental health and treat mental illness, it was evident to the Committee that international comparisons could provide a valuable reference point and a source of policy inspiration for the Committee's current investigation.

Due to each country's unique circumstances, there are important limits to the comparability of experience from one country to another. The complexity of health care systems, both in terms of funding arrangements and service delivery mechanisms, as well as their inextricable connections to the history, politics and culture of each nation, mean that it is never possible simply to transpose measures from one jurisdiction to another. The common nature of many of the issues confronting health care policy makers and practitioners throughout the industrialized world means, however, that there is much that can be gained from careful study of both the successes and failures elsewhere in the world.

Moreover, a comparative framework can be extremely useful in highlighting common dilemmas and challenges. It can help suggest questions for further study, point to issues that need to be discussed and offer policy options for action. In this spirit, this volume of the Committee's report is structured around four country studies (Australia, New Zealand, England and the United States), followed by a chapter that synthesizes some of the key lessons for Canada.

Each of the country studies covers the same basic topics, although the specific details that are examined necessarily vary according to the particular experience of each country and depending on the documentation that was available. The Committee was greatly assisted by the testimony by videoconference of leading experts and policy makers from each of the countries it examined, and wishes to thank them for their help. In conducting this comparison, the Committee did not have the resources to do extensive field research and therefore relied on material that was readily available on the Internet or from the collections of the Library of Parliament.

With regard to substance abuse and addiction, testimony that was heard is referred to wherever possible. However, the Committee recognizes that it would require considerably more research into the policies and programs of each country before it could undertake a meaningful international comparison on this subject.

As best we could tell, there is no existing international comparison of mental health policy and practice available that takes into account the most recent developments in the countries that are studied as the Committee does in the chapters that follow. This part of the Committee's report may therefore also be of help to policy makers elsewhere who are examining the state of their mental health system. The Committee was guided in its choice of countries by recommendations from experts and practitioners, as well as by the need to select countries whose health care systems were broadly comparable to Canada's. The fact that two of the countries have federal systems (Australia and the United States) while two do not (New Zealand and the United Kingdom) provides an additional element of comparison.

CHAPTER 1: MENTAL HEALTH CARE IN AUSTRALIA[1]

1.1 HISTORY AND OVERVIEW

1.1.1 General Health Care Provision in Australia

Like Canada, Australia has a federal system of government and health care is a shared responsibility between the national (or Commonwealth) government and sub-national governments (six States and two Territories). However, in Australia the Commonwealth government has a stronger role in health care than is the case in Canada. In particular, States and Territories in Australia are more dependent on the Commonwealth government for health care funding than are provincial governments in Canada. As in Canada, local governments (municipalities) in Australia play a relatively small role in health care.

The Commonwealth government is responsible for public policy making at the national level in the fields of public health, research and national health information management. It operates "Medicare", the national, publicly-funded health care insurance plan and regulates the private health care insurance industry. It also finances and regulates residential aged care (nursing homes) and, jointly with States and Territories, it funds and administers some community-based care and home care. Commonwealth funding for health care is derived from general taxation plus a dedicated health care levy of 1.5% on taxable income.

The State and Territory governments have primary responsibility for the management and delivery of publicly insured health services within their jurisdiction. They deliver public acute and psychiatric hospital services and a wide range of community and public health services including school health, dental care, maternal and child health. State and Territory governments are also responsible for the regulation of health care providers as well as for the licensing and approval of private hospitals. Health care funding by States and Territories is derived mostly from grants from the Commonwealth government, as well as from general taxation and user charges.

Medicare in Australia provides universal coverage to all citizens. Public health care insurance is broader in Australia than in Canada as it covers physicians, hospitals, prescription drugs and some community-based care and home care. In contrast to Canada, however, user

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[1] Unless otherwise indicated, the information in this chapter is drawn from the following: Commonwealth Department of Health and Ageing (2002) National Mental Health Report 2002: Seventh Report. Changes in Australia's Mental Health Services under the First Two Years of the Second National Mental Health Plan 1998-2000; Australian Health Ministers, National Mental Health Plan 2003–2008; Thornicroft, G. and V. Betts 2002, International Mid-Term Review of the Second National Mental Health Plan for Australia; Whiteford, Harvey, Ian Thompson and Dermot Casey, "The Australian Mental Health System," International Journal of Law and Psychiatry, Vol. 23, No. 3-4, 2000; Whiteford, Harvey, Bill Buckingham and Ronald Manderscheid, "Australia's National Mental Health Strategy," British Journal of Psychiatry (2002) 180; Groom, Grace, Ian Hickie and Tracey Davenport 'Out of Hospital, Out of Mind!' April 2003; SANE Mental Health Report 2002-03, SANE Australia; The Mental Health Council of Australia, Promoting the mental health of all Australians, a 2001 Federal Election Submission.

charges may be required for publicly insured health services and extra-billing by doctors above the scheduled fee is permitted. More specifically, Australian Medicare is made of three main components:

- The Medical Benefits Scheme (MBS) ensures access to physician services (outside of hospitals). The MBS lists a wide range of physician services and stipulates the fee applicable to each item (the "scheduled fee"), but only reimburses 85% of the doctors' scheduled fee. However, physicians are permitted to charge above the "scheduled fee."
- The Australian Health Care Arrangements (AHCAs) provide the basis for funding by the Commonwealth government to the States and Territories for hospital services. Funding by the Commonwealth government takes the form of annual block grants whose amounts are negotiated in five-year agreements with the States and Territories, who in return agree not to allow user charges for public hospital services.
- The Pharmaceutical Benefits Scheme (PBS), which is based on a national drug formulary, subsidises access to drugs prescribed outside of public hospital, with consumers making a co-payment on each prescription, subject to annual thresholds, which once reached lead to further reductions in the amount each individual pays.

As in Canada, some 70% of health care spending is financed by the public sector (46% by the Commonwealth government and 24% by State and Territory governments) and 30% by the private sector. The Commonwealth government is empowered under the constitution to collect income taxes and finances a greater proportion of Australian health care than does the federal government in Canada. It is the primary public insurer of prescription drugs and physician services and funds some 50% of hospital expenditures.

The states, and to a minor extent local governments, are responsible for the bulk of outlays. About 25% of State and Territory government budgets are allocated to health care and about 69% of those funds go to public hospitals. State government funding for health care comes from two main sources: first, Commonwealth general revenue and specific purpose grants, and second, the state general revenue base. The Commonwealth funds the states through block grants for health, which increasingly are tied to certain conditions, and through untied GST (Goods and Services Tax) payments.

In contrast to Canada, private health care insurance in Australia both complements and competes with Medicare. Private insurers may cover the same benefits as under the public plan and Australians can supplement their Medicare benefits through private health care insurance, but they cannot opt out of the publicly-funded system since they continue to pay their taxes. Private health insurance in Australia is fully community rated, meaning that there is no premium discrimination against people by virtue of age, sex, state of health or potential health risk.

On the delivery side, there are a small number of private for-profit hospitals built and managed by private firms providing public hospital services under arrangements with State/Territory governments. However, most acute care beds and emergency outpatient clinics are in public hospitals. Private hospitals tend to provide less complex non-emergency care, such as simple elective surgery.

As Mr. Dermot Casey, Assistant Secretary, Health and Priorities and Suicide Prevention, for the Department of Health and Ageing, Government of Australia, told the Committee during his testimony by videoconference:

> *We think the private sector is an integral part of our health care system. The government's policy is such that people have choices in terms of where they receive their health care. […] We are trying to encourage all states and territories to have private facilities available because the government's policy is one system, multiple choice.*

1.1.2 The National Mental Health Strategy

The mental health of the Australian community has been a priority of Australian Commonwealth, State and Territory governments since 1992. Australia has benefited from a consistent political bipartisan approach to mental health reform during this time that has enabled it to set international benchmarks with regard to the design and implementation of national goals with respect to mental health and mental illness.

The National Mental Health Policy was adopted by all Australian states, territories and the Federal government in April 1992. The Policy, implemented through a series of 5-year National Mental Health Plans, became known as the National Mental Health Strategy.

This Strategy represented the first attempt to coordinate nationally the development of public mental health services. As in other Western nations, rapid reduction in psychiatric beds within Australia's public mental health system began during the mid 1960s. As elsewhere, the move to 'deinstitutionalization' in Australia was driven by a combination of new drug treatments, clinical practice developments and the emergence of the human rights movement that advocated the abolition of systems that isolated people with disabilities from the mainstream community.

Estimates suggest that Australia reached a peak of approximately 30,000 psychiatric beds in the early 1960s, a time when the population was about half of its current size.[2] During this period the isolation and custody of people with mental illnesses dominated the treatment culture and many beds were located in rural asylums, far from families and social networks. Overcrowding in these facilities was widespread, with wards built to cater for 25 people often housing up to 100 patients. However, the reduction in size of hospitals that began in the 1960s occurred in a policy environment that did not provide safeguards to ensure that alternative community services were developed to replace the functions of the shrinking institutions.

The National Mental Health Strategy was conceived in part to respond to this legacy created by extensive bed reductions and attempted to set a coherent direction that would guide future reform. The Strategy was agreed to by all Australian Health Ministers in 1992 and

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[2] As of July 2004, the population of Australia was estimated to be 19,913,000.

established a collaborative framework between all levels of government to pursue 12 agreed priority areas over a five-year period under the First National Mental Health Plan (1993–1998), including the following:

- Expanding the proportion of acute psychiatric inpatient care provided in general hospitals rather than separate psychiatric hospitals;
- Including integrated mental health services within the mainstream organizational arrangements for general health services;
- Ensuring that each State, Territory and area/region had a plan for the mix of services available to its population;
- Reducing the size of, or closing, existing psychiatric hospitals and at the same time providing sufficient alternative acute hospital, accommodation and community based services;
- Increasing the number and range of community based supported accommodation services and ensuring an adequate range of services to meet consumer needs.

Another impetus for the introduction of the National Mental Health Plan was pressure exerted on the Commonwealth Government by the State and Territories, as Mr. Casey explained to the Committee:

> *It was interesting that the drive for change in Australia really came from the states and territories lobbying the federal government to take a role and become involved in mental health care. […] The argument was put that the federal government is incurring large levels of expenses but has no control upstream in terms of improving our response to mental health. That was in the late 1980s and early 1990s.*

The first plan was followed by The Second National Mental Health Plan, endorsed by all Australian Health Ministers in July 1998. It provided a second five-year (1998–2003) framework for activity at the national and State and Territory levels, building upon the achievements of the National Mental Health Policy and the First National Mental Health Plan. The essence of the Second Plan was to consolidate existing reforms and extend into additional areas of reform with a strong emphasis on population health issues and interventions.

Three additional priority themes emerged from the Second Plan:

- promotion and prevention;
- partnerships in service reform and delivery; and
- quality and effectiveness.

A third plan has recently been adopted. Its provisions will be outlined in the penultimate section of this chapter.

1.1.2.1 Assessment of the National Mental Health Strategy

An assessment conducted by international experts mid-way through the second plan concluded that the National Mental Health Strategy and its First and Second National Mental Health Plans reflected "exemplary mental health policy leadership that have produced significant achievements in mental health at all levels throughout Australia." Among the chief accomplishments highlighted by the international consultants were "the integration of mental health assessments and interventions in mainstream health delivery and the authentic inclusion of consumers and carers in mental health policy development at every level."

According to the international review, Australia, in many ways, "leads the world in mental health promotion, mental illness prevention, early intervention initiatives, and stigma reduction," setting "a standard for other nations in what can and should be done as a national policy initiative" and demonstrating how federal and state governments can agree through policy documents to address difficult social and health concerns. The international review suggested that "no other nation on earth has taken the time to focus its intellectual and political capital to develop such an extensive, measurable plan" and that "the Australian National Mental Health Strategy and the First and Second National Mental Health Plans are international exemplars for mental health policy," having captured the attention and imagination of the world.

Nonetheless, according to the Mental Health Council of Australia, the leading non-governmental advocacy group in mental health in Australia, in 1997 only 38% of people suffering from a mental disorder accessed mental health services. The Council notes that, despite the positive developments associated with the Mental Health Strategy, there remains widespread dissatisfaction with many aspects of mental health services in Australia.

1.2 COSTS AND FUNDING OF MENTAL HEALTH SERVICES

In 1999-2000, total spending on mental health services[3] by third party funders (Commonwealth and State/Territory governments as well as private insurers) was A$2.6 billion,[4] which represented approximately 6.6% of total gross recurrent expenditure on health services. Of this amount, the States/Territories spent A$1.6 billion or 60.8% of the

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[3] Estimates of spending given here are drawn from the *National Mental Health Report (2002)* and only cover the provision of 'specialized mental health services'. This excludes a wide range of services needed by people affected by mental illness, such as general hospital and medical services, housing, income security, employment and training and general community support programs. The report notes that international comparisons of Australia's mental health spending as a share of total health expenditure are not reliable because different approaches are used in counting mental health expenditure. For example, some countries include amounts that are specifically excluded in Australian estimates such as drug and alcohol services, intellectual disability services, dementia care or housing and income security payments for mental health consumers.

[4] As of 9 August 2004, the Australian dollar was worth just over 94 cents Canadian.

total, the Commonwealth government A$884M or 34.5% of the total, and private health funds A$120M, or 4.7% of the total.

Total recurrent spending on mental health services by the major funding authorities has increased by 44% over the course of the National Mental Health Strategy (1993-2000) when measured in constant 2000 prices. Total expenditure on health services increased by 42% over the same period, meaning that mental health has increased its position in terms of relative spending, but not significantly.

While the percentage of total health spending devoted to mental health services and related activity has remained relatively stable over the course of the National Mental Health Strategy, significant growth in Commonwealth outlays increased its share of total national spending on mental health from 27% in 1992-93 to 35% in 1999-2000. The main driver of this increase, accounting for 68% of increased Commonwealth spending, was growth in the costs of psychiatric drugs provided through the Pharmaceutical Benefits Scheme (PBS). Expenditure on psychiatric drugs has increased by 402% since 1992-93, nearly four times the rate of growth in overall PBS expenditure (105%) over the period.

The Australian Institute of Health and Welfare estimates that mental disorders accounted for approximately 30% of the non-fatal disease burden in 1996 and for 27% of years lost to disability. Lost productivity arising from mental health disorders is estimated to cost A$5 billion per year. People with mental disorders in Australia have five times the average number of workdays lost per year compared to those with physical disorders, and they account for an estimated 70 million work and school days lost each year.

From the inception of the original National Mental Health Policy, an issue of concern was to ensure that savings that resulted from the planned downsizing of stand alone psychiatric hospitals would be redirected back to new service development. All levels of government made a commitment to some form of budget protection so that such savings plus the benefits of additional funds provided under the National Mental Health Strategy would not be negated by a concurrent reduction in State and Territory funding. Specifically, the agreement between governments to protect mental health resources had two components:

- a commitment to maintaining the level of expenditure on mental health services; and
- a commitment to reinvest any resources released from closure or rationalisation of services back into mental health programs.

In this regard, Mr. Casey told the Committee that efforts to protect mental health spending had been successful, to the point that they were no longer needed:

> *In fact, one of fears of the federal government 10 years ago was that if we were to give money for mental health, then the states and territories would simply take it and spend it somewhere else. We had an agreement with them that they would maintain their level of funding if the federal government added to the pie. We actually tracked the dollars and the states and territories had to report to a system of monitoring expenditure.*

> *We do not need that system now, 10 years later, because governments, realizing how important this is at a jurisdictional level, would not use the money for something else because it has become such a political issue in the communities.*

The impact of the changes brought about during the period following the adoption of the Mental Health Strategy was to reduce Australia's reliance on institutional care, to strengthen community care alternatives and begin to address the inadequacies of mental health service systems that had been identified in numerous inquiries over the preceding decade. Over the first five years of the Strategy:

- spending on community services grew by 87% in real terms;
- resources released from institutional downsizing were re-invested in alternative services and provided approximately half of the additional funds used to expand community services.

From 1998-2000 expenditure on separate psychiatric hospitals were reduced by a further 13% so that by 1999-2000, stand alone hospitals accounted for only 23% of total service expenditure (compared to 49% in 1992-93). Moreover, spending on community based services increased by an additional 16% during this period, taking the total increase in expenditure on these services, since the commencement of the Strategy, to 117%. Approximately three quarters of the growth since the commencement of the Strategy has been directed to ambulatory care services,[5] so that by 1999-2000, 49% of total spending on mental health services was directed to community based services compared with 29% at the beginning of the Strategy.

The Seventh *National Mental Health Report* (2002) issued by the Commonwealth Department of Health and Ageing drew the following conclusions from its analysis of mental health spending trends since the commencement of the Strategy:

- The commitments made by all governments to protect mental health resources during a period of rapid change have been met. Total annual government expenditure on mental health has increased by 46% in real terms since 1992-93. Average annual growth in mental health expenditure has continued to increase under the Second National Mental Health Plan.
- Australia now spends $778 million more of public funds on mental health services – or $33 more per person per year – than it did at the commencement of the Strategy. Much of this increase has gone to expanding community services.
- Growth in mental health spending has simply mirrored overall health expenditure trends. Although significant in real terms, the implication is that mental health has maintained its 'share' of the total health dollar but not significantly increased its position.

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[5] Ambulatory care refers to all mental health services dedicated to the assessment, treatment, rehabilitation or care of non admitted inpatients.

- Commonwealth grants to States and Territories under the National Mental Health Strategy represent only 3% of annual State and Territory mental health spending but have acted as a stimulus in generating funding for new services and guiding the overall reform process. The collaborative foundation of the Strategy appears to have been successful in preventing the cost shifting that is the concern of many Commonwealth-State partnership initiatives.

Concerns have nonetheless been expressed by some that despite the success of the National Mental Health Strategy in increasing and redirecting expenditures on mental health services in Australia, there are still too few resources being devoted to the sector. For example, some mental health advocates claim that at 6.6% of total health spending, the level of spending on mental health in Australia remains below that of comparable countries, including New Zealand, the United Kingdom and Canada.

1.3 SERVICE DELIVERY AND ORGANIZATION

Services for people with mental illness in Australia are provided through a range of programs. In the public sector, the typical specialized mental health service delivery model involves services being provided for a defined catchment population, with the service integrated across hospital and community settings. Inpatient services are provided in general hospitals and in separate psychiatric hospitals. Community-based services comprise a range of service types, including clinic-based, mobile follow-up and treatment, and mobile crisis response services. Case management is often used to coordinate services provided in different settings. Housing, disability support, employment, and income security services are funded under other government programs. State and Territory governments continue to play the largest role in specialized mental health service delivery, as they are primarily responsible, either directly or indirectly, for the delivery and management of most services.

Substantial change in both the level and mix of inpatient services have occurred since the implementation of the National Mental Health Strategy. At the commencement of the Strategy in 1992:

- 73% of specialist psychiatric beds were located in stand alone institutions;
- only 29% of mental health resources were directed toward community based care;
- stand alone hospitals consumed half of the total mental health spending by States and Territories;
- and less than 2% of resources were allocated to non government programs aimed at supporting people in the community.

By June 2000, the total number of psychiatric beds available in the public sector had been reduced by 25% (1,991 bed reduction). When the Strategy began, only 55% of acute psychiatric beds were located in general hospitals. This had increased to 73% by the close of the First National Mental Health Plan in 1998. By June 2000, fully 80% of acute psychiatric beds were located in general hospitals as a result of the ongoing reduction in stand alone acute services and a 13% increase (330 beds) in general hospital acute services. Over the life of the Strategy, the number of acute psychiatric beds located in general hospitals has increased by 51% or 990 beds.

The National Mental Health Strategy does not stipulate an optimum level or mix of inpatient services. Instead, the Strategy recognizes the different histories and circumstances of each jurisdiction and the need for plans to be based on an analysis of local population needs. The final balance of services may therefore differ substantially between the States and Territories. Early National Mental Health Reports noted a convergence between the States and Territories for an acute psychiatric bed provision level of around 20 beds per 100,000 population. Similar consensus on provision of non acute beds has not yet emerged.

1.3.1 Accommodation in the Community, Ambulatory Care and NGOs

The monitoring of community accommodation under the National Strategy has focused mainly on the extent to which each State and Territory has developed alternative community residential services staffed on a 24-hour basis. Units of this type, known variously as ‘community care units’, or ‘psychiatric hostels’, were proposed to replace the functions traditionally performed by long stay asylum beds located in psychiatric hospitals. By June 2000, a total of 1,382 24-hour staffed beds were available, a 68% increase above the June 1993 level.

At the national aggregate level, however, the growth in 24-hour staffed residential services (558 beds) is equivalent to only about a quarter of the reduction in long stay beds in psychiatric hospitals (2,285 beds). Development of community residential services has thus been patchy, with substantial variation between jurisdictions, and no consensus has emerged between the States and Territories on planning benchmarks for provision of specialized community residential services. Lack of development of such services by most jurisdictions has been identified as a significant issue in relation to the commitment by all States and Territories to develop a full range of community services to replace the historical functions of the stand alone psychiatric hospitals. In this regard, Mr. Casey told the Committee:

> *Yes, we have had some major reforms in relation to the service system. However, what we have not been able to do very well yet is to provide the employment responses, the housing responses and the social care models that ensure people who are living with a mental illness — and I think that is the term we use now, it is not something that will be cured, necessarily — are able to do so with the maximum social interaction and social participation that in itself will help to keep them stable and will help towards recovery. Medical treatment alone will not be an adequate response for people with mental health problems.*

Ambulatory care services refer to all mental health services dedicated to the assessment, treatment, rehabilitation or care of non admitted inpatients. The category comprises outpatient clinics (hospital and clinic based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care of people affected by mental illness or psychiatric disability who live in the community. By

1999-2000, the size of the clinical workforce engaged in the delivery of ambulatory mental health care was 90% greater than the pre-Strategy baseline year, equivalent to approximately 3,000 additional workers.

The National Mental Health Strategy also envisaged that a key role would be played by not-for-profit non government organizations (NGOs) in providing support services to consumers and carers whose lives are affected by mental illness. A wide range of services is provided by the sector including home-based outreach to support people living in their own homes, residential rehabilitation units, recreational programs, self help and mutual support groups, carer respite services and system-wide advocacy.

The first National Mental Health Report described funding to non government organizations as limited, and the services needed to support the carers of people with mental disorders as poorly developed at the beginning of the Strategy. Moderate improvement in the funding base occurred over the 1993-98 period with the sector increasing its share of annual mental health expenditure from 2% to 5%. By 1999-2000 this figure had increased to 5.4%.

The role played by non government organizations varies across the jurisdictions, reflecting differences in the way in which services are organized and delivered. Increasingly, in some jurisdictions, services provided by NGO's substitute for those formerly provided by 'government sector' or clinical services. For example, the State of Victoria has expanded its not-for-profit non government sector as a key provider of psychosocial rehabilitation programs, many of which were previously confined to clinical services, as well as funding new types of psychiatric disability support services. National consensus on desirable service models for developing the sector has not emerged under the National Mental Health Strategy.

1.3.2 Human Resources

Australia's current mental health workforce predominantly consists of general practitioners, psychiatrists, mental health nurses, occupational therapists, psychologists, social workers and others. The clinical workforce employed in public sector mental health services is estimated to have increased by 15% over the course of the Strategy, equivalent to approximately 2,100 additional staff. Fifty percent of the growth occurred under the Second National Mental Health Plan.

Accompanying the growth in numbers have been changes in both the settings in which people are employed and the staffing mix. A greater proportion of clinical staff is now working outside of hospitals and providing treatment in a range of community settings. Similarly, clinical workers in 1999-2000 accounted for a higher percentage of the total workforce (79%) than at the beginning of the Strategy (estimated 70%). This change has occurred as services are mainstreamed and moved to a community based focus. Since the commencement of the Strategy:

- Total staffing in inpatient services have decreased by 14% and accounted for 53% of the total staff in 1999-2000 compared with 71% in 1992-93;

- Combined staffing in ambulatory care and residential services has grown by 87% and accounted for 47% of the service delivery workforce in 1999-2000 compared with 29% in 1992-93;
- Medical staff have increased by 27% and made up 11% of the clinical workforce in 1999-2000;
- Allied Health staff – Psychologists, Social Workers and Occupational Therapists and other categories of therapists – have increased by 55%, accounting for 21% of the total in 1999-2000; and
- Nursing staff numbers have increased by 7% and represented 65% of the total 1999-2000 clinical workforce.

At the same time, workforce shortages have been reported by all jurisdictions and are particularly critical in nursing, affecting both the quantity and quality of care. Reports indicate that retention rates are decreasing across all disciplines of the mental health workforce, and the number of new graduates may not be sufficient to meet the burden of mental illness.

Moreover, inequities continue between the States and Territories in the availability of mental health professionals employed in the public sector. In particular, jurisdictions with significant rural areas to service have experienced difficulty in recruiting sufficient numbers of skilled staff. There are few standards to guide States and Territories in planning their workforce requirements and many challenges remain. For example:

- In terms of the nursing workforce, the overall nursing complement appears to be too limited to fill even current posts. The future is even more daunting as nursing is an ageing work force without sufficient new recruits, while the current strategy of the States and Territories appears to be to poach from each other's limited personnel pools.
- The medical psychiatric workforce is poorly distributed and largely sited in the metropolitan areas (86.1% of psychiatrists were located in capital cities, 5.4% in major urban areas, 4.9% in large rural centres, and 3.5% in other rural and remote locations).
- Psychologists are, by international standards, relatively few within State and Territory mental health services, and too often work as generic case managers. Psychologists' expertise is often unnecessarily diluted by their work as case managers at a time when increasing evidence supports the effectiveness of cognitive behavioural interventions for depression, anxiety-related and psychotic disorders.

Mr. Casey indicated to the Committee that the Australian government had introduced measures designed to facilitate the delivery of care to people living with mental illness by primary care physicians. In particular, he described a program introduced by the federal government three years ago that rewards general practitioners financially for spending more time with people with mental health problems. He explained that this program,

> *…gives [general practitioners] access to referral to psychologists as an essential part of the mental health treatment team, and it also improves their education and training and provides them with emergency consultation services so that they do not feel they are left to deal with the problem alone if they engage with their patients' mental health problems. We have been told that if you are a GP and someone comes into your consulting room and you think they have a mental health problem, you keep quiet, because if you open the dialogue, you will still be there 20 or 30 minutes later, and of course, fee for service is the treatment model. We have encouraged them by saying that if it will take 20 minutes, we will pay them extra for taking the time. Currently, about 15 per cent of our GP workforce has enrolled in this program. We have about 3,500 GPs who are now enrolled in this program and recognize themselves as people who can offer slightly more and better mental health care. That is a new program.*

1.3.3 Private Sector Mental Health Services

Strengthening the complementary roles of public and private sector mental health services emerged as a priority under the Second National Mental Health Plan. A range of mental health care services are provided by the private sector including services provided by psychiatrists in private practice funded through the Commonwealth Medicare Benefits Schedule, and hospital and community-based services provided by private hospitals, for which private health insurance funds pay benefits.

Private sector services also include limited services provided in general hospital settings and services provided by general practitioners and by other allied health professionals. Private psychiatric hospitals provide services predominantly by way of inpatient care. This reflects both the history of mental health services in Australia and the predominant way in which health insurance funds pay benefits for mental health care.

The private sector thus plays a key role in overall service delivery. By 1999-2000, the sector:

- provided 21% of total psychiatric beds (rising from 14% in 1992-93 as a result of a growth in the number of private beds combined with the reduction in the number available in the public sector);
- employed an estimated 12% of the national mental health workforce; and
- treated an estimated 50-60% of all people seen by the specialist mental health sector.

In this regard, Mr. Casey explained to the Committee that:

> *Our private sector is very complicated, but it does treat a pretty large proportion of the population, and the overall private sector, psychiatrists, GPs, and the private hospital providers, have all become part of the National Mental Health Strategy. It is not just a public sector strategy.*

There has been substantial growth in the private psychiatric hospital sector over the course of the National Mental Health Strategy. The number of hospital providers has increased by 36%, total inpatient bed capacity has grown by 28% and revenue by 48% between 1992-93 and 1999-2000. Alongside these changes the sector has shifted its overall pattern of care to one of providing a significantly greater proportion of services to its consumers on a same day care basis. Same day admissions have increased from 39% of total admissions in 1992-93 to 69% in 1999-2000. Estimated total revenue in 1999-2000 for private sector psychiatric units was $168.2 million, an increase in constant price terms of 48% since 1992-93.

Although 1.47% of Australians see a private psychiatrist at least once a year, access is uneven due to the concentration of providers in the capital cities, particularly Melbourne, Adelaide and Sydney. Little change in the distribution of services has occurred since the commencement of the National Mental Health Strategy.

1.3.4 Mental Health Service Provision to Indigenous Peoples

Ms. Jenny Hefford, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing, Government of Australia, told the Committee that Indigenous people have lower health ratings than non-indigenous Australians, and that their average life expectancy is some 20 years lower than for a non-indigenous Australian. She indicated that:

> *Indigenous people fare far worse in our system in terms of all substance use. Prevalence rates for smoking, for example, are far higher among indigenous Australians than among non-indigenous Australians. Substance abuse issues, particularly with alcohol and petrol sniffing, are extreme in some indigenous communities.*

Several reports have noted that the current delivery of mental health services for Indigenous people is not sufficiently tailored to the cultural specificities of these communities. The following have been identified among the reasons for this lack of cultural appropriateness:

- health professionals' lack of knowledge and understanding of Indigenous perspectives and cultures;
- an insufficient appreciation of the different ways in which Indigenous peoples conceptualize and define illness and health;
- a limited understanding of the nature and scope of mental health needs within Indigenous communities;
- a lack of consultation by Governments and medical professionals with Indigenous Australians;
- a lack of education and training for service providers.

Mr. Casey told the Committee that attitudes were evolving and that there was growing recognition that "Indigenous people have a lot to offer us in understanding the relationship between how you experience your world from your psychological and your social perspective, and what implications that has for how you physically can live your life in terms of a sense of wellness."

1.4 ADDICTIONS AND SUBSTANCE ABUSE

Ms. Hefford told the Committee that "addiction/substance abuse issues are dealt with within our public health area and regarded as public health issues," rather than as mental health issues exclusively. She explained that the Australian approach relied on three pillars: (1) supply reduction, which involves using border controls as well as working to close down clandestine drug laboratories in order to remove the product from the streets; (2) demand reduction, which employs school-based drug education and government-run campaigns; and (3) harm reduction, which encompasses treatment services and diversion programs for young people, designed to keep them out of the criminal justice system.

She further indicated that the acute health care sector, and in particular the hospital sector, has only a very limited role. It provides detox programs and deals with situations such as overdose deaths, where things have gone badly wrong. The primary care sector, for its part, is largely focused on managing opiate dependency. General practitioners prescribe methadone and pharmacists administer methadone-type programs, for the 30,000 Australians currently in methadone programs.

Ms Hefford noted that "as many as 60 per cent or 70 per cent of clients of drug and alcohol treatment services have an underlying or undiagnosed mental health disorder." She concluded that despite still not reaching as many people as they would like, that much had improved in recent years. One of the things she pointed to in particular was the more collaborative approach that now prevailed across sectors and through various levels of government. She told the Committee:

> *We now have a strategy into which the federal government has put $1 billion over the last five or six years, and it involves health, law enforcement, education and customs at a federal, state and local level. We think that we are actually getting better at working through the issues because we have this cross-disciplinary, cross-sector approach. That means, for example, that we have been able to introduce early diversion programs for young people who are identified by the police as in possession of cannabis or small amounts of other drugs, and who are given the opportunity to choose not to have a sentence of any kind recorded but to go into assessment and treatment. Some of those things have been very successful. We have had between 30,000 and 40,000 young people diverted out of the judicial system and into treatment through that sort of process.*

1.5 PROMOTION AND PREVENTION

In general, a variety of mental health promotion and illness prevention initiatives have been pursued in Australia in the course of, and parallel to, the implementation of the National Mental Health Strategy.

Mr. Casey explained to the Committee that the adoption of a broader "whole population approach" to mental health issues led to carrying out large-scale mental health literacy campaigns throughout the community. In particular, in the mid-1990s a major television, cinema and newspaper advertising campaign was undertaken with the sole objective of making people aware there were mental health problems. This was followed by more focused initiatives, including a mental health promotion program for high schools, nearly 70 per cent of whom are now running the program.

As well, a separate, not-for-profit, private company funded by government, was established in October 2000 with the objective of promoting a better understanding of depression. Called "*beyondblue*", it works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression, to bring together their expertise around depression. In the annual report for 2002-2003 the Chairman of *beyondblue*, the Hon. Jeff Kennett wrote:

> *In 2000, when* beyondblue *started out, few people were willing to speak in public about depression and their experiences, media coverage was often negative, barriers in insurance and employment were considerable and there was no national voice or advocacy service for those whose lives were affected. Australian general practitioners were not rewarded directly for providing better services and no systems for improving access to non-drug treatments were available. While we still have many challenges in front of us, in 2003 we can report that major advances in all these areas have now been achieved.*

Another initiative that was undertaken was the National Media Strategy, where the government worked directly with the media to promote more positive messages about mental health and suicide prevention. The media strategy operates in journalism schools and universities, where journalists are taught how they should approach these issues when reporting them to the community so as not to stigmatize people living with mental illnesses.

Mr. Casey indicated that these various initiatives had helped improve "mental health literacy in the Australian population by about 10 percentage points since 1996." He also told the Committee that:

> *our hospital contact data and our health service contact data show that there is a greater proportion of the population seeking care than was the case when we did our epidemiology study. We would conclude from that that they are now at least more prepared to seek treatment — and of course there are many effective treatments.*

1.5.1 Suicide Prevention

Australia also has in place a framework for prevention of suicide and self-harm. Called *Living Is For Everyone* (LIFE), it is concerned with suicide in all age groups, with a particular focus on young people and young adults, for whom the loss of life years and potential is so great.

The LIFE Framework has four broad goals:

- Reduce deaths by suicide across all age groups in the Australian population, and reduce suicidal thinking, suicidal behaviour, and the injury and self-harm that result.
- Enhance resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reduce the prevalence of risk factors for suicide.
- Increase support available to individuals, families and communities affected by suicide or suicidal behaviours.
- To provide a whole of community approach to suicide prevention and to extend and enhance public understanding of suicide and its causes.

1.6 PROSPECTS FOR FUTURE REFORM

As noted earlier, a new National Mental Health Plan that builds on the work of the two previous plans has been adopted for the period 2003–2008. It acknowledges the complexity of the reform process and notes that while the first ten years of reform have seen an impressive start in terms of policy, there is still much to be achieved in terms of implementation. This conclusion echoes the concerns of advocacy groups who feared that the Mental Health Strategy was in the process of "losing momentum and faltering."[6]

The goal of the National Mental Health Plan 2003–2008 is to consolidate the achievements of the First and Second Plans, address the gaps identified in both, and take the National Mental Health Strategy forward with restated and new directions. The Plan explicitly adopts a population health framework that recognizes that health and illness result from the complex interplay of biological, psychological, social, environmental and economic factors at all levels – individual, family, community, national and global.

A number of key principles that underpin the reform process are enumerated in the plan, including:

- All people in need of mental health care should have access to timely and effective services, irrespective of where they live
- The rights of consumers, and their families and carers, must shape reform
- A recovery orientation should drive service delivery
- Investment in the workforce is essential

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[6] SANE Mental Health Report, 2002-03, p. 2.

- Mental health reforms must occur in concert with other developments in the broader health sector
- Mental health reforms require a whole-of-government approach

The new Plan is guided by four priority themes. Outcomes and key directions for achieving these outcomes are identified, although the new Plan does not seek to specify projects to be funded within the new reform agenda. These themes are:

- Promoting mental health and preventing mental health problems and mental illness
- Increasing service responsiveness
- Strengthening quality
- Fostering research, innovation and sustainability

The following are amongst the outcomes that the plan seeks to achieve:

- Increase the extent to which mental health promotion is incorporated into policy and planning, at Commonwealth, State/Territory and local levels
- Increased extent to which mental health services adopt a recovery orientation
- National agreement on the broad levels and mix of services necessary to align current and future supply of and demand for mental health care across the lifespan
- Improved access to acute care, early intervention services, and to a range of community-based care alternatives
- Enhanced care pathways across the spectrum of care
- Reduced service system gaps and increased integration between private and public mental health services
- Improved coordination between the mental health sector and other areas of health
- Increased levels of full and meaningful consumer, family and carer participation in policy and in service planning, delivery and evaluation at all levels with evidence of improvement in quality
- Monitoring of the performance of mental health services regarding emotional and social wellbeing issues, through the collection and sharing of information and data
- Improved supply and distribution of the mental health workforce

1.7 COMMITTEE COMMENTARY

It is clear to the Committee that Canada has a great deal to learn from Australia in the field of mental health and mental illness. In particular, the consistent commitment for over a decade by both the Commonwealth and State Governments in Australia to planning and monitoring progress through regular reporting has set international benchmarks that Canada is a long way from attaining. As well, the Committee was impressed by the explicit adoption of a population health framework for overall planning.

As a federal state, Australia has also demonstrated the importance of close cooperation between the various levels of government and of the benefits that can be derived by all communities when this collaboration is sustained. In addition, the Committee noted the importance attached by Australian authorities to adapting national targets and goals to regional and local conditions, and to ensuring that the implementation of agreed upon objectives respected the circumstances of various communities across the country. Moreover, the Committee was impressed by the efforts to include consumers and carers in mental health policy development.

The Committee also wishes to highlight two funding related issues. First, the Committee was struck by the success of efforts to 'ring fence' mental health funding as the Commonwealth government increased its proportion of mental health funding and as delivery of services became increasingly community based. According to the witnesses, the essential nature of adequate funding for mental health services has now been sufficiently demonstrated, and the commitment of all levels of government to sustain this funding become sufficiently secure, that it is no longer necessary to retain the formal agreements that were initially established to protect mental health funding.

Second, the Committee was pleased to see the success of the program recently introduced to improve the ability of general practitioners to participate in the treatment of people with mental health disorders. Enhanced training, and in particular adequate financial compensation for the actual time spent with patients presenting symptoms of mental health difficulties, as well as easier referring to mental health specialists, seem to the Committee to be measures that could enable the effective integration of mental health into primary care delivery.

Finally, the Committee took note of the many innovative approaches pioneered in Australia in raising public awareness about mental health issues, in particular the *beyondblue* campaign centred around depression, and believes that a closer study of a number of them is warranted in order to establish whether they could be adapted to the Canadian context.

CHAPTER 2:
MENTAL HEALTH CARE IN NEW ZEALAND[7]

2.1 HISTORY AND OVERVIEW

New Zealand is a small country of two islands in the Southern Pacific Ocean with a population of 4 million in 2004. At least 800 years before the first European settlers, New Zealand was first populated by Maori, of Eastern Polynesian ancestry. The main ethnic groups today include people of European descent, mostly from the United Kingdom and Ireland (75%), Maori (15%), Pacific Island people (6%) and Asian (4%).

The country became a colony of Great Britain with the signing of the Treaty of Waitangi in 1840 between Great Britain and the majority of Maori Tribes. This is one of New Zealand's founding constitutional documents and sets out a partnership with the Maori, acknowledging their need for self-determination, outlining the responsibilities of governments, as well as protecting Maori rights. A resurgence of Maori identity over the last 20 years has made this treaty a major focus of policy-making.

New Zealand has a parliamentary system of government and is an independent state within the British Commonwealth. The government system is unitary, that is, only one House of Representatives with executive authority vested in a Cabinet structure led by a Prime Minister.

The New Zealand health care system is funded mainly through general taxation, supplemented by out-of-pocket payments and private health insurance. In 1999/2000, 75% of health sector finance came from taxation, 15.7% from consumer out-of-pocket payments, and 6.3% from private insurance (although there is almost no coverage for mental illness by private insurers). The public share of health care funding decreased over the last two decades from 88% of the total in 1979/1980 to around 77% in 1994/1995, but has since increased slightly to reach 78% in 2000.

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[7] Unless otherwise indicated, the information in this chapter is drawn from the following: Wilson, Janice, "Mental Health Services in New Zealand," *International Journal of Law and Psychiatry*, Vol. 23, No. 3-4, 2000; French, Sian, Andrew Old and Judith Healy *HiT Summary: New Zealand*, European Observatory on Health Care Systems, 2002; Conference Board of Canada, "New Zealand," in *Challenging Health Care System Sustainability: Understanding Health System Performance of Leading Countries*, June 2004; Powell, Gayla, "New Zealand's National Mental Health Strategy: Report on Progress 2000-2001," August 2002; Ministry of Health, New Zealand, *Looking Forward: Strategic Directions for Mental Health Services*, June 1994; Ministry of Health, *New Zealand, Moving Forward: The National Mental Health Plan for More and Better Services*, July 1997; New Zealand Information Service, *Mental Health Data, 1994*, Ministry of Health, New Zealand, 1998; Mental Health Commission, *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*, December, 1998; Ministry of Health, New Zealand, *National Plan 2001-2003 – Project to Counter Stigma and Discrimination Associated with Mental Illness*, June, 2001; Mental Health Commission, *Briefing to the Incoming Minister of Health*, August, 2002; Ministry of Health, New Zealand, *Building on Strengths: A New Approach to Promoting Mental Health in New Zealand/Aotearoa*, December, 2002; Mental Health Commission, *Report on Progress 2001-2002: Towards Implementing the Blueprint for Mental Health Services in New Zealand*, April, 2003; Ministry of Health, New Zealand, *Like Minds, Like Mine – National Plan 2003-2005*, September, 2003.

Patients receive free state hospital outpatient and inpatient services although they must meet some or all of the costs of primary health care and make co-payments for pharmaceuticals (with concession cards available for low-income patients and those with chronic illnesses). New investment and reform of the primary health care system undertaken in 2004 has begun to decrease the level of individual out-of-pocket payments that are required.

The government retains overall responsibility for the health system but delivery is shared between the public, voluntary and for-profit sectors. Independent medical practitioners and specialists provide most ambulatory medical services, public hospitals provide most secondary and tertiary medical care, while the small private hospital sector specializes mainly in elective surgery and long-term care.

New Zealand governments in the 1990s went further than most countries in introducing market model practices into the health sector, including competition and a purchaser/provider split.[8] However, at the end of the decade, the Labour/Alliance government decided that the "internal market" had not delivered significant improvements in effectiveness and efficiency. In 2000, the government returned responsibility to district boards for funding and partly providing health services. It created 21 District Health Boards (DHBs) covering geographically defined populations, which both deliver services themselves and fund other providers to do so. These autonomous authorities are allocated their own resources in a three-year funding package, based on historical provider contracts. They are responsible to the Minister of Health for the health of their district populations, for setting their strategic direction, for appointing their chief executive, and for their own performance. Each board covers at least one large public sector hospital.

New Zealand health services generally are regarded as adequate in supply and of good quality. Although in 2004 the majority of DHBs are meeting their targets, there is a perception that hospitals are under-funded, causing long waits for elective surgery. Since 2001, primary health care is being reorganized with the introduction of Primary Health Organizations. These will be local non-profit organizations funded at least in part using a system of 'capitation,' that is based on the number of patients who are enrolled with each organization. The intention is to reduce the burden of out-of-pocket payments upon patients. To date, full funding, or 'universal coverage,' of primary care services has only been available to targeted groups on the basis of income or chronic illness. Dr. Janice Wilson, Deputy Director General, Mental Health Directorate, at the New Zealand Ministry of Health, told the Committee that the goal of the new primary health care strategy was to "progressively over the next five to 10 years build up that universal payment until it covers about 80 per cent of the population."

2.1.1 Mental Health Strategy

The National Mental Health Strategy was launched by the Government in June 1994 with the publication of *Looking Forward: Strategic Directions for the Mental Health Service.* The Strategy was developed further in a second document released in July 1997, the National Mental

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[8] This term refers to the fact that, in the 1990s, several countries in which the same institutions were responsible for both funding and delivering health care services moved to separate these functions with the aim of increasing efficiency and stimulating competition.

Health Plan, *Moving Forward: The National Mental Health Plan for More and Better Services*. Overall, the Strategy articulated two key goals:

1. To decrease the prevalence of mental illness and mental health problems within the community;
2. To increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community.

Dr. Wilson indicated that "the main thrust of the policy at that time was to get a framework around what is called deinstitutionalization." She told the Committee that policy was also partly driven by best practices internationally that pointed to the need to "take a more whole-of-government approach, linking with other sectors such as housing, employment, labour and so on" in order to make mental health services more community-based and integrated with other health services.

In 1996, a Mental Health Commission was established to ensure that the national mental health strategy was implemented. It consists of three Commissioners and its functions are:

- To monitor and report to Government on the performance of the Ministry of Health and the 21 District Health Boards in the implementation of Government's national mental health strategy;
- To work with the sector to promote better understanding by the public of mental health, and to reduce discrimination and prejudice against those with mental illness;
- To work to strengthen the mental health workforce.

The Commission released the *Blueprint for Mental Health Services in New Zealand* in 1998. The Blueprint provided a practical basis for Strategy implementation and has been accepted as government policy. Its objective is to give health boards and providers a clear view of the steps they can take to improve quality, and to provide consumers and families an understanding of what they should expect from a well functioning system. It is animated by a strong focus on recovery for those living with mental illness.

The national strategy now encompasses seven strategic directions, that are summarized briefly below:

> *Strategic Direction 1: Implementing community-based and comprehensive mental health services.* The objective is to offer services that would cover health promotion and mental illness prevention, assessment and early intervention, treatment, rehabilitation, and continuing care.
>
> *Strategic Direction 2: Encouraging Maori involvement in planning, developing and delivering mental health services.* This strategic direction is aimed at improving the mental health of Maori, so that it is at least as good as that of New Zealanders as a whole. The use of mental health services by Maori is considerably higher than by the rest of the population.

Strategic Direction 3: Improving the quality of care. The goal is to overcome some of the obvious gaps in services that were inherited from the past. It is hoped that service standards, quality assurance programmes and performance indicators to monitor effectiveness and efficiency will make sure that the national objectives are being achieved.

Strategic Direction 4: Balancing personal rights with protection of the public. This strategic direction aims to more clearly strike a balance between the mental health consumer's right to live in the community and the public's right for protection.

Strategic Direction 5: Developing a national alcohol and drugs policy. The intent behind this strategic direction is to better integrate existing alcohol and drug services, to use the mix of residential and outpatient treatment options more efficiently, and to provide more systematic care for people who have both an addiction and some form of mental disorder.

Strategic Direction 6: Developing the Mental Health Services Infrastructure. This strategic direction was added in 1997. It covers the "infrastructure" necessary for delivering more and better services – elements such as workforce development, data collection and analysis, and co-ordination between services. These elements had originally been seen as part of *Strategic Direction 3* but subsequently become recognized as important enough and complex enough to warrant a separate strategic direction of their own.

Strategic Direction 7: Strengthening Promotion and Prevention. This too was another strategic direction that was added to the Strategy in 1997 in order to place more emphasis on making progress towards achieving the goal of decreasing the prevalence of mental illness and mental health problems.

The elaboration of the mental health strategy in New Zealand was based on epidemiological evidence that indicated that one in five of the adult population has a diagnosable mental health problem at any one time. Of these, it is believed that about 3% of adults - and about 5% of children and young people under 20 years - have severe mental health disorders. A further 5% of adults have moderate to severe disorders, and 12% have mild to moderate disorders or problems.

The intention of the national strategy was to ensure that there are enough of the right kinds of mental health services to meet the needs of those adults and young people who have severe mental health disorders. The resource guidelines that are contained in the Blueprint provide estimates of the beds and community staff needed per 100,000 population, assuming that 3% of the population need such services. These guidelines were developed primarily for calculating national funding and service development requirements but are also used at a regional level.

The model of service provision that is employed in the *Blueprint* emphasises community service delivery, but also allows for acute inpatient services as well as rehabilitation and long-term hospital care. The guidelines also take into account development of services provided by consumers. The table below shows the national targets that were established by the *Blueprint* in 1998. These are adjusted as the population levels increase.

RESOURCE TARGETS, 1998			
Resource		National target	National current
Inpatient	Beds or 'care packages'[9]	1,535	1,424
Residential	Beds or 'care packages'	3,243	2,576
Community mental health	FTEs[10]	3,822	1,923
Community support	FTEs	1,284	388
Advisory services and initiatives (consumer and family)	FTEs	246	63
Access to newer anti-psychotic medication	People	8,500	3,547
Detoxification	Beds or 'care packages'	113	96
Residential alcohol and drug	Beds or 'care packages'	378	376
Community alcohol and drug FTEs	FTEs	614	262
Methadone treatments	Places	5,666	3,030
Mental illness prevention FTEs	FTEs	378	0

2.2 COSTS AND FUNDING OF MENTAL HEALTH SERVICES

Dr. David Chaplow, Director of Mental Health and Chief Adviser, Government of New Zealand, told the Committee that "having a costed plan with analysis of the gap between what existed and what we needed was a very powerful advocacy tool" in negotiations with the treasury in order to secure additional funding for mental health. Since the adoption of the mental health strategy, funding for mental health has indeed increased. Between

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[9] The 'Blueprint' indicates that while the most common measure for these services resources is 'beds', "a shift to the provision of 'care packages' is needed" (p. 41) but does not specify how these are to be defined with regard to each service.

[10] Or "Full-Time Equivalent" position.

1993/1994 and 2001/2002, public funding for mental health services in New Zealand increased from $270 million to $725 million per annum. This represents an increase of approximately 127% after adjusting for inflation, and Dr. Wilson indicated that "we have had a commitment from the current government to continue the funding stream at this rate until at least 2007 because we have not yet completed all of the reform agenda."

Nonetheless, in general, the Mental Health Commission has noted that the starting point for recent increases in funding levels was a poorly resourced base. In its view, acceptable levels of service delivery in mental health have still not been met and there is still some way to go towards meeting the goals set by the Blueprint. According to Dr. Wilson,

> *They set targets and we have implemented about 75 per cent [to 2004]. Some parts of the country are closer to 60 per cent and some are almost fully implemented at close to 100. We have regional variation, depending on population growth and other factors.*

The Table below presents estimates made by the Commission in its 2002 Briefing to the incoming Minister of Health.

PERCENTAGE OF BLUEPRINT FUNDING TARGETS MET AS OF 2002

Service Area	**Approximate level of funding at July 2002 to *Blueprint* guidelines**
Hospital Inpatient	89%
Community Clinical	69%
Community Non-Clinical	44–59%
Community Drug & Alcohol	74%
Methadone Services	65%
Child & Youth Community	63%

Consistent with the trend to more community-based services, 69% of mental health services funding (excluding pharmaceuticals and public health services) in 2001/2002 was for community services. This is up from 67% in the previous year and includes 57.4% of the District Health Board provider funding and almost all NGO funding. The proportion of mental health funding that is spent on services provided by non-government organisations (NGOs) has remained relatively stable over the last three years.

Despite the increases in funding, the Mental Health Commission continues to express concerns both over the level of funding and the commitment on the part of DHBs to actually spend the money that has been allocated to mental health. An additional and recurring concern has been that the impact of increased funding on levels of services has been constrained by workforce shortages. This has meant that even where funding has been made available, many positions have gone unfilled.

The Commission has therefore reiterated its recommendations that:

- A sustainable funding path be identified for mental health services development, consistent with the directions of the national mental health strategy, implementation of the Blueprint, and the capacity of the sector to develop.
- Funding for mental health services targeted to the 3% of the population most severely affected by mental illness be protected by a clear and robust ring-fence.

2.3 SERVICE DELIVERY AND ORGANIZATION

The overriding goal of New Zealand's *Blueprint* for mental health is to ensure that 3% of the population has access to mental health services. For the whole of New Zealand, reported access to mental health services was approximately 1.7% of the population in 2001/2002. This was up slightly from 1.6% the previous year. However, during this time, data was not being collected from all NGOs, which means that the figures may under-represent the number of people being seen by services.

As elsewhere, the move away from dedicated psychiatric institutions has been occurring in New Zealand over the past quarter century. Although there is some variation around the country, most of the mental health services are community based and include services provided by mobile 24-hour crisis services, and in general hospital acute wards. By 2000, all acute psychiatric wards (with one exception) had been integrated into general hospitals and just about all of the 10 dedicated psychiatric institutions had closed completely, with a few retaining only forensic or other specialized services.

Despite this reorganization, Dr. Chaplow pointed out that,

> *…at no time have we diminished the total number of beds... We have spread those places in a variety of configurations, so that some are still configured in hospital units and some are in community placements.*

Thus, there are some hospital-based rehabilitation wards and a growing range of supported accommodation and vocational training options, as well as day programs and drop-in centers, often consumer-run. Most adults receiving mental health services have a clinical case manager and/or a community support worker.

The most recent *Report on Progress* issued by the Mental Health Commission highlights the following statistics for the year 2001-2002:

- The number of people admitted to inpatient services in New Zealand is small compared with the total receiving mental health services. During the six months to 30 June 2002, 0.14% of the total population (5,546 people) received inpatient hospital care, compared with 1.7% receiving care of any kind from mental health services (63,271).

- During 2001/2002 there was no progress in the development of more general non-residential, adult community clinical services. The number of funded clinical staff positions in these services was 85% of the *Blueprint* guidelines compared to 87% in June 2001.
- Non-clinical community based services include home-based support, employment and education support, day activities and living skills, peer support and family support services. These services are provided primarily by support workers, nurse aides and cultural support workers working for NGOs in a therapeutic/support role. Resource levels in community non-clinical support services, have increased from 59% the previous year to 65% of the *Blueprint* guidelines.
- For the country as a whole, all general adult community residential beds slipped from 93% of the *Blueprint* guidelines in 2000/2001 to 83% in 2001/2002. Much of this reduction is due to a large NGO changing from providing residential services to providing community care in service users' homes, and thus does not reflect a reduction in capacity.

In New Zealand, as elsewhere, general practitioners are a first port of call for accessing mental health services. However, there are many in the community (particularly among the Maori and Pacific people communities), who do not use general practitioner services, and thus do not have access to the pathways into mental health care early enough.

The impact of user charges for primary health services on access to mental health services is also an issue. It has been recognized that these charges can be a barrier to the use of primary health services and therefore can encourage people with mild or moderate illness to try to access specialized mental health services (which may not have the same user charges) when they could be treated more appropriately by their primary medical services. Indeed there is even the concern that user charges may stop people going to any service at all. As noted earlier, efforts are underway to reorganize primary care delivery on a capitation model that could help reduce the impact of user charges.

2.3.1 Services to Maori

Ms. Arawhetu Peretini, Manager of Maori Mental Health, Government of New Zealand, explained to the Committee that:

> *The majority of [the Maori population] live in urban settings. They have no reservations. They tend to be fairly integrated into mainstream society. The majority exist probably in one city in particular in the northern part of the island, which is mostly urban. There has been, over the last 10 years, a call for many Maori to return to their tribal lands, or which about 90 per cent are rural based. However, the call has not occurred for many because most work in the urban settings.*

A leading expert, Professor Mason Durie, has suggested that "mental health problems are now the number one health concern for Maori." He notes as well that, "psychiatric admissions, alcohol and drug disorders, suicides and attempted suicides are increasing at a time when other health problems such as heart disease are decreasing."[11] Maori have many needs which are not being met by mental health services. Although accurate and up-to-date information on the prevalence of mental illness for Maori is not available, it is known that there are disproportionate numbers of Maori in crisis, acute inpatient, and forensic services. As Ms. Peretini noted,

> *Some of the problems have resulted from the fact that a lot of indigenous Maori within this country tend to appear at services at acute stages of mental illness.*

In addition, Maori have substantially higher rates of re-admission than non-Maori; these rates have risen steadily in recent years and are continuing to rise. Maori are also greatly over-represented in alcohol and drug services; alcohol and drug abuse and psychosis are the main reasons for Maori being admitted to a psychiatric ward or hospital.

Between 1 January and 30 June 2002, approximately 10,500 Maori were reported as being seen by mental health services, that is 1.9% of all Maori. Maori access mainstream mental health services as well as services specifically targeted to their needs. While acknowledging that there "are still gaps in a knowledge base about things such as admission and re-admission rates," Ms. Peretini told the Committee that:

> *We do know that some of the 21 services — because we did a survey three years ago now — are actually responsive to the needs of the Maori, by just incorporating a cultural assessment component as part of the clinical assessment. There were very few at that stage. Of nine district health boards, only seven had even considered policies around meeting the needs of indigenous people being admitted to the mainstream services. Of those seven, only three had cultural assessment tools that were well developed enough to be useful.*

Since 1998 there has been a significant increase in Maori providers and availability of services specifically for Maori. There have also been a number of initiatives to increase the number of skilled Maori in the mental health workforce. Ms Peretini elaborated on this point:

> *Two years ago, the Ministry of Health, as part of our workforce development strategy, commissioned the development and establishment of a Maori-focused workforce development organization. Almost a year ago, that organization undertook a series of surveys on our workforce. Rather than going into the detail, I will say is that we do not have a large*

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[11] Quoted in the *Blueprint*, p. 56.

> *workforce. We currently have probably about five psychiatrists in training.*
>
> *… there have been educational quotas for certain themes in this country. They have existed for at least the past 20 years. We also have had some key leaders in Maori health who have become psychiatrists.*

The Maori Mental Health National Strategic Framework, was released in April 2002 after extensive consultation. The framework has the following five-year goals:

- to provide comprehensive clinical, cultural and support services to at least 3% of Maori, focused on those who have the greatest mental health needs
- to ensure that active participation by Maori in the planning and delivery of mental health services reflects Maori models of health and Maori measures of mental health outcomes
- to ensure that 50% of Maori adults seeking wellness will have a choice of mainstream or specialized Maori community mental health service
- to increase the number of Maori mental health workers, including clinicians, by 50% over 1998 levels

Dr. Chaplow indicated that New Zealand was "in an interim stage," during which "indigenous psychiatrists will have to be augmented or supplemented by others." However, he also affirmed that "one of the significant advances is that now Maori people own their services and own the challenge."

Dr. Wilson explained the importance of this development:

> *One of the key things about mental illness is that it affects the way that you think about yourself — your spiritual and cultural beliefs. People relate much better to people of their own culture. If you are the person with the illness, the relationship you have with your care provider — your doctor or nurse — is probably the most crucial thing to getting well and gaining recovery. If that person is able to understand your cultural belief system, then the chances of a successful outcome are better.*

2.3.2 Human Resources

Numerous commissions and reports have called attention to workforce development as an important part of resolving the existing problems that affect mental health service delivery in New Zealand. It is generally recognized that the current mental health workforce, although having increased significantly due to the national strategy development, still falls short of what is required by mental health consumers. For example, New Zealand has a shortage of psychiatrists when compared with other similar western countries. Dr. Chaplow told the committee that "in terms of world health statistics, such as the suggestion that there should be one psychiatrist for 10,000 people per population, we only have one psychiatrist per 15,000 people here." But he insisted that:

> *The issue is how you utilize psychiatrists as part of the team. Also, psychiatrists tend to cluster near universities or schools. That is what happens. You often have an imbalance between urban and rural access to good psychiatry.*

Dr. Wilson further noted that human resource shortages were widespread:

> *In respect of the workforce overall, of course we are short throughout the system. It is not just psychiatrists. We have shortages of nurses, psychologists and all the other professionals. That is why we have a major workforce initiative that includes looking at how we recruit as well as retain.*

Reports from 2000/2001 also suggested that unfilled community positions for which funding was available were at about 6 or 7% of the total. Another challenge is in the recruitment and retention of the workforce outside the main centres, where the implications of the need to provide 24 hour coverage, along with the lack of peer support, and professional isolation create difficult working conditions.

The National Mental Health Workforce Development Coordinating Committee was established early in 1998 to co-ordinate workforce development throughout the sector and develop and implement a definitive framework on which to build the national regulation of mental health workforce development, and the allocation of resources for it. The Committee is led by providers and represents key stakeholders in the sector. However, there is still no comprehensive mental health workforce development plan.

Dr. Wilson also recounted that in recent years new types of mental health workers have been trained.

> *We have a new workforce, called community mental health support workers, that has been training over the last five years probably. They work predominantly in the NGO sector but they also work in the public mainstream sector. They are trained to support patients or consumers with mental illness, either in their homes or in formal residential settings in the community, or to help them work through the system. They would be the person who would go with them to the income support agency, to the employment agency, to help them battle the societal barriers.*

These community mental health workers receive formal qualifications set under the National Qualifications Framework. There are now about 2,000 new workers who have been granted a certificate in community mental health support work.

2.4 PROMOTION AND PREVENTION

In December 2002, following a two year period of consultation with over 200 individuals and organizations, the Ministry of Health issued the document *Building on Strengths* that outlines a national approach for mental health promotion for a five year period. *Building on Strengths* seeks to promote the mental wellbeing of New Zealanders and to reduce inequalities in mental wellbeing by improving the social, economic, cultural, political and physical environments in the country.

New Zealand's mental health promotion strategy recognises the need for co-operation between health and other sectors, including local government, other government departments and Maori, Pacific and other community groups and calls for the health sector to take a leadership and co-ordination role around mental health promotion.

Building on Strengths aims to achieve three things:

1. To enable individuals and communities to take action on their own behalf.
2. To outline planned priority actions for the Ministry of Health for mental health promotion.
3. To provide guidance to health sector providers and other sectors on what they can do to contribute to positive mental health and wellbeing for New Zealanders.

The strategy outlined in *Building on Strengths* has three specific goals:

- To reduce inequalities relating to mental health experienced by some groups.
- To create environments that are supportive of positive mental health.
- To improve individual and community resiliency skills.

To achieve these goals, five priority actions are detailed. They are to:

1. Reorient health services to reduce inequalities between socioeconomic groups.
2. Strengthen community action in mental health promotion activity.
3. Create safe and supportive environments within actions that create cohesive cities, communities, workplaces, schools, homes.
4. Develop personal skills by emphasising mental health protective factors such as resiliency, social support and life skill development.
5. Build healthy public policy through improved research and evaluation to identify and address mental health promotion needs.

The Ministry of Health currently spends several million dollars each year on mental health promotion, and *Building on Strengths* has been developed to provide a national framework for the continued allocation of these funds. It is not anticipated that any additional funding will be allocated to the campaign.

2.4.1 Project to Counter Stigma and Discrimination Associated with Mental Illness

A project to counter the stigma and discrimination associated with mental illness, called "Like Minds, Like Mine" was established as a five-year project in 1996, and was subsequently funded as an ongoing undertaking by government. Since its inception, activities sponsored by "Like Minds, Like Mine" have developed public awareness about aspects of mental illness, with an emphasis on the stigma faced by people with experience of mental illness. As a result, the project can now point to significant and quantifiable changes in attitudes among most sectors of the population.

Dr. Wilson helped the Committee understand the basis for this progress:

> *First, it is quite important to understand at the very beginning of this initiative or program, a significant amount of base research was undertaken. There was research done on attitudes in the community and on how people might respond to such an awareness raising. That went alongside our community development approach.*
>
> *Then [the] first national campaign was run and the research that followed indicated a surprising change in attitudes. There seemed to be increased understanding the common mental disorders such depression, anxiety disorders, alcohol addiction and so on.*

The most recent plan (for 2003-2005) therefore began a shift in emphasis towards reducing discrimination, now that it was felt that good progress had been made on the groundwork of awareness raising. The project plan has incorporated a specific human rights model which it has allied to a social model of disability, on the grounds that such a model has strong relevance to the discrimination faced by people with experience of mental illness.

The overall aims of the project are to:

- Enable all people with experience of mental illness to gain equality and respect and to enjoy the same rights as others.
- Change public and private sector policy to value and include all people with experience of mental illness.
- Create greater understanding, acceptance and support for all people with experience of mental illness.

Its more specific objectives include:

- Engaging the leadership and participation of individuals and groups of people with experience of mental illness.

- Advocating for non-discriminatory policies and practices within organizations that are responsible for housing, education, employment, income and access to goods and services, and within organizations that are responsible for mental health services.
- Using mass media, community education and other means to improve the social inclusion of people with experience of mental illness.
- Developing specific approaches by Maori, in recognition of their status under the Treaty of Waitangi, to address the discrimination faced by Maori with experience of mental illness.

Dr. Wilson indicated that the first iteration of the campaign had been "based on famous New Zealanders who were willing to talk publicly about their problems with depression and anxiety disorders," but that "the current campaign has moved away from the famous people to ordinary people who have also suffered significant illnesses such as manic-depressive or bipolar disorder, schizophrenia and so on. It focuses on them, their families and lives."

2.5 PROSPECTS FOR FUTURE REFORM

Dr. Wilson informed the Committee that work was currently underway on a second national mental health plan and that a draft would soon be taken to cabinet before engaging in wide consultations with the community. She hoped that this plan would be finalized and accepted by government before the end of 2004.

As well, in April 2004, the Mental Health Commission published an issues paper in order to gather feedback on how best to maintain and consolidate progress already made in providing mental health care in New Zealand and ensure that the *Blueprint* is able to keep up with changes and provide a relevant platform for the future. Ways forward may include:

- better application of the *Blueprint;*
- modifications to the *Blueprint* that make it easier to apply;
- substantive amendment of the *Blueprint;* or
- changes to funding, planning, contracting and service delivery practices.

The *Blueprint* was developed in 1997 and 1998, and so is now more than five years old. The issues paper notes that over that period there has been substantial change in the health sector and New Zealand society. The following are some of the factors it listed as requiring attention in updating the *Blueprint*:

- Structural changes – four regional health authorities and then the Health Funding Authority have been replaced by 21 DHBs, including three with populations of less than 50,000, and only four with populations over 400,000.
- Regional planning processes have emerged, using multiple stakeholder networks that have been superimposed on the statutory district health board structure.

- Emphasis on competition in the health sector has been replaced by expectations of coordination and collaboration and provider capability development.
- Expectations of the public, politicians, consumers, families, and clinicians regarding mental health service provision have increased.
- A new non-clinical workforce has emerged, primarily in NGOs, with nationally agreed minimum standards of training.
- There have been changes in clinical practice, including adoption of the recovery model and the National Mental Health Sector Standard, and widespread use of new generation antipsychotic medication.

The discussion and debate will guide the Commission in its next task of writing a companion or guidance note to support the *Blueprint* and look at how to adapt its implementation to changing circumstances.

2.6 COMMITTEE COMMENTARY

The Committee was greatly impressed by the progress New Zealand has achieved since the launch of its mental health strategy in 1994. New Zealand's experience offers further strong evidence of the crucial importance of sustained planning in the mental health field. In particular, the Committee took note of the fact that the existence of a detailed and carefully costed plan with very specific targets had contributed to the ability of the mental health community to secure a significant increase in government funding.

In addition, the focus during the process of deinstitutionalization in New Zealand on the development of comprehensive community-based services has allowed the reallocation of resources to take place so that there was no decline in the number of beds available to those in need. The Committee was also struck by the important role that an independent body, the Mental Health Commission has played in this process, and by the willingness of the government to adopt the recommendations made by the Commission.

Perhaps the aspect of New Zealand's efforts over the past decade that most impressed the Committee was the consistent attention to the needs of the indigenous Maori population. Making participation by Maori themselves a cornerstone of the strategic orientation would seem to have yielded important gains in terms of allowing this community to begin to take ownership of these programs and to infuse them with a much greater cultural sensitivity to their own needs. Moreover, the emerging success of efforts devoted to the training of Maori mental health professionals offers the Committee much encouragement that it is possible to grapple with these difficult issues.

Another dimension of initiatives to train needed personnel that seemed worthwhile to the Committee were the programs introduced to provide formal qualifications to community mental health workers in New Zealand. The Committee also notes that efforts in New Zealand to further improve access to primary care services and to reduce demand on secondary care services has involved taking measures to diminish the impact of user fees on the behaviour of those in need of health care services. Experience in New Zealand thus provides additional evidence that user fees do act as a deterrent to seeking care.

In addition, the Committee will be interested to see if it is possible to draw on the experience of the smaller District Health Boards in New Zealand in order to find ways of improving the delivery of mental health services to Canadians living in rural and remote areas.

Finally, the Committee was impressed by the evolution of the efforts made in New Zealand to combat stigma and discrimination against people living with mental illness, and in particular the long-term funding commitment that was made by the government in this regard. As well, the Committee believes that the New Zealand experience points to the importance of building evaluation and data collection into the design of anti-stigma campaigns so that it is possible to learn from each experience and to adjust the focus as necessary.

CHAPTER 3:
MENTAL HEALTH CARE IN ENGLAND[12]

3.1 HISTORY AND OVERVIEW

The United Kingdom has the same Parliamentary system as Canada, but until the creation of devolved Parliaments in Scotland and Wales in recent years it had been a unitary state comprising Great Britain (England, Scotland and Wales) and Northern Ireland. The public health care system – the National Health Service (NHS) – is similar throughout the United Kingdom but managed by each jurisdiction separately. In this chapter we discuss mental health care in England, almost exclusively. We will refer to the United Kingdom when describing common features. The NHS was established in 1948, and within each jurisdiction remains amongst the more centrally managed and financed health care systems in the world.[13] Government is not only involved in the financing of health services but is also heavily involved in the management and delivery of services.

As in Canada, all people normally resident in the United Kingdom are eligible for health care insurance coverage under the NHS. The NHS does not specify an explicit list of services to be covered. However, the NHS is more comprehensive than Canadian Medicare as it covers physicians, hospitals, prescription drugs, dental care and optical services. There are no user charges for physician services in the United Kingdom and hospital and specialist services are also provided free-of-charge. User charges do apply to prescription drugs, dental and optical services. Unlike Canada, the United Kingdom also allows people to purchase private health care insurance covering the same benefits as the NHS, but supplied by providers working outside of the NHS.

In the United Kingdom, a larger proportion of health care spending is financed by the public sector (82%) than in Canada (70%). The NHS is financed mainly through central government general taxation together with an element of national insurance contributions made by employers and employees. User charges account for less than 3% of total NHS financing.

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[12] Unless otherwise indicated the information in this chapter is drawn from the following: Department of Health, *National Service Framework for Mental Health*, 1999; Select Committee on Health, *Fourth Report: Provision of NHS Mental Health Services*, 2000; McCulloch, Andrew, Matt Muijen and Heather Harper, "New Developments in Mental Health Policy in the United Kingdom" *International Journal of Law and Psychiatry*, Vol. 23, No. 3-4, 2000; The Sainsbury Centre for Mental Health, "Mental Health Policy: the challenges facing the new Government," July 2001; Department of Health, *The Journey to Recovery – The Government's Vision for Mental Health Care*, Nov. 2001; National Institute for Mental Health in England, *Cases for Change – Policy Context*, 2002; Department of Health, *National Suicide Prevention Strategy for England*, Sept. 2002; Levenson, Ros, Angela Greatley and Janice Robinson, *London's State of Mind*, King's Fund Mental Health Inquiry, 2003; The Sainsbury Centre for Mental Health, *Money for Mental Health: A review of public spending on mental health care*, 2003; Commission for Health Improvement, *What CHI has found in mental health trusts (sector report)*, 2003; Social Exclusion Unit, *Mental Health and Social Exclusion*, Office of the Deputy Prime Minister, 2004.

[13] Paul Wallace, writing in *The Economist* (July 17, 2004), notes that with 1.4 million employees, the NHS is the world's third largest employer, surpassed only by China's Red Army and the Indian Railways.

Many significant reforms of the management and provision of health services in the United Kingdom were undertaken during the 1990s. These reforms initially created an 'internal market,' meaning that certain market-oriented principles were introduced into the publicly-funded health care system. A "purchaser-provider split" altered the relationships between the regional health authorities and the hospitals, while the establishment of "GP Fundholding" modified the organization and shape of general family practices. The Labour government of Tony Blair, first elected in 1997, was critical of the internal market; it has since modified a number of significant features of the system, but has not sought to return it to its original form.[14]

Ms. Anne Richardson, Head of the Mental Health Policy Branch, Department of Health, Government of the United Kingdom explained to the Committee that since 2001, the National Health Service has had three tiers, with the Department of Health at the apex. She indicated that "the Department of Health develops policy as well as the systems and structures needed to deliver services. However, it does not actually implement that change directly." There are 28 Strategic Health Authorities (SHAs) that are responsible for managing the performance of local services. They vary in size from 20 to 30 staff per location and are in turn responsible for as many as 30 Primary Care Trusts (PCTs), which comprise the third tier.

PCTs are now at the centre of the NHS and will get 75% of the NHS budget. They are responsible for managing health services at the local level. Most PCTs cover populations of between 50,000–250,000 people, with the average size PCT serving around 100,000 people. There are now 302 PCTs across England. They do not all have the same level of experience and their expertise also varies.

PCTs directly provide primary care and community health services and commission[15] services from hospital trusts and other secondary and tertiary care providers. PCTs may also commission other primary care services, such as physiotherapy, alternative therapies, and counselling. As we shall see, PCTs are also involved in the commissioning of mental health services. In particular, as Ms. Richardson told the Committee, PCTs "have the job of looking at national standards and targets, balancing those against the needs of their local population and interpreting national standards for their local population."

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[14] In fact, some analysts contend that the Labour Government is now engaged in a process of reintroducing the "internal market." Thus, Paul Wallace writes that this return to the "internal market" follows "a major policy shift after the 2001 election." (*Ibid.*)

[15] Even in the United Kingdom there is still some confusion concerning the exact meaning of the term 'commissioning' and its relationship to the more familiar 'purchasing.' The two terms, both conceptually and in fact, tend to be used loosely. This is one common definition: *Commissioning* is the strategic activity of assessing needs, resources and current services, and developing a strategy to make best use of available resources to meet identified needs. Commissioning involves the determination of priorities, the purchasing of appropriate services and their evaluation. *Purchasing* is the operational activity set within the context of commissioning, of applying resources to buy services in order to meet needs, either at a macro/population level or at a micro/individual level.

3.1.1 Mental Health

Until the 1950s, the main form of provision for mentally ill people was the old Victorian asylum. As elsewhere, with the arrival of new medication and the idea that mentally ill people had a right to live in mainstream society, this began to change from the 1960s onwards. The old asylum hospitals began to close and more modern psychiatric units were provided in local general hospitals. Thus, hospital beds have been drastically reduced from 129,000 in 1968 to 91,000 in 1978, 63,000 in 1988/89 and 36,000 in 1998/99.

How best to manage the process of deinstitutionalization and its many ramifications continues to be at the centre of policy deliberations. In the initial years of this policy, it appears that policy makers under-estimated the level of continuous support which would be required by a relatively small group of severely disabled people who would previously have lived in the old asylums. Insufficient provision was made in the community to support these people. In particular, there was an absence of intensive health and social support and supported housing. This contributed to the idea in some circles that the policy itself – 'community care' – was wrong, despite international evidence showing that adequate community care leads to better outcomes for the vast majority of people living with mentally illness.

In recent years, mental health policy has been overhauled in a major attempt to create a working system of care which can support people with all types and severity of mental health problems. A series of policy initiatives by the new Labour Government towards the end of the 1990s have attempted to consolidate community based services around an appropriate balance between care and control, support and public safety.

The policy has been promulgated in the following publications produced by Government:

- A 1998 white paper, *Modernising mental health services: safe, sound and supportive*, set out to identify and fill the gaps in service provision. It articulated a vision of creating safe, sound and supportive mental health services, through a variety of measures including the introduction of more intensive community support services such as 'assertive outreach teams' to address the problems of people living in the community with complex needs;
- This was followed by the *National Service Framework (NSF) for Mental Health* which set detailed standards and targets for mental health services for adults with mental health problems aged between 18 and 65 years of age (see below);
- The *NHS Plan,* issued in 2000, extended the agenda described by the national service framework by detailing new services, including assertive outreach, crisis resolution (sometimes called home treatment) and early intervention in psychosis services. The plan introduced graduate primary care mental health workers, gateway workers and carer support workers and endorsed structural changes such as the creation of care trusts. It also considered the mental health workforce requirements and issues relating to recruitment and retention, leadership and training. The NHS Plan included £300 million of new revenue for mental health services.

The National Service Framework for Mental Health (NSF-MH) is a 10-year programme. This is how Ms. Richardson described the purpose of its seven standards to the Committee:

> - Standard one is concerned with mental health promotion — that is all the action that is needed to help us take action against the stigma that there is surrounding mental ill health and the risks, to reduce risks of people developing mental ill health.
> - Standards two and three were about mental health in primary care, which addressed the action that was needed to improve access to services by people with so-called common mental disorders.
> - Standards four and five were about people with severe mental ill health — the relatively small proportion of the total group of people with mental health problems — who nonetheless carry the biggest risk in relation to death by suicide and other causes, and who also carry the highest levels of morbidity. I am thinking of people with a diagnosis of schizophrenia or bipolar disorder or very severe depression.
> - Standard six concerned the action that was needed to improve services and supports for caregivers.
> - Standard seven focused on all that we needed to do across the spectrum of mental health and social care services to reduce the risk of death by suicide.

We set out in the box below the seven standards in more detail.

NSF-MH STANDARDS

1. *Health and social services should:*
    - promote mental health for all, working with individuals and communities
    - combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

2. *Any service user who contacts their primary health care team with a common mental health problem should:*
    - have their mental health needs identified and assessed
    - be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

3. *Any individual with a common mental health problem should:*
    - be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care
    - be able to use *NHS Direct*, as it develops, for first-level advice and referral on to specialist helplines or to local services.

4. *All mental health service users on the Care Programme Approach (CPA) should:*
    - receive care which optimises engagement, prevents or anticipates crisis, and reduces risk
    - have a copy of a written care plan which
        - — includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators

    - advises the GP how they should respond if the service user needs additional help
    - is regularly reviewed by the care co-ordinator
    - be able to access services 24 hours a day, 365 days a year.

5. *Each service user who is assessed as requiring a period of care away from their home should have:*
   - timely access to an appropriate hospital bed or alternative bed or place, which is
     - in the least restrictive environment consistent with the need to protect them and the public
     - as close to home as possible
   - a copy of a written after care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

6. *All individuals who provide regular and substantial care for a person on CPA should:*
   - have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
   - have their own written care plan, which is given to them and implemented in discussion with them.

7. *Local health and social care communities should prevent suicides by:*
   - promoting mental health for all, working with individuals and communities (standard one)
   - delivering high quality primary mental health care (standard two)
   - ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an Emergency department (standard three)
   - ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (standard four)
   - providing safe hospital accommodation for individuals who need it (standard five)
   - enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (standard six)
     and in addition:
   - supporting local prison staff in preventing suicides among prisoners
   - ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk
   - developing local systems for suicide audit to learn lessons and take any necessary action.

The NSF-MH was the first comprehensive statement that set out what was expected of health and social services in England. A new body, the National Institute for Mental Health in England (NIMHE), was set up to oversee the implementation of the service framework. As Ms. Richardson explained, NIMHE

> *has a series of eight regional development centres spread across England. Their job is to specifically help local services improve their closeness to targets. They set out models of best practice, visit local services and employ champions to raise the profile of the new service model and of the needs of people with mental illness. There are about 26 programs of*

> *work led through the National Institute for Mental Health, all of which have central funding. These programs are designed to support reform.*

Ms. Richardson gave the following example of one of these programs:

> *We have a Black and minority ethnic mental health program, currently funded to the tune of £2.5 million over the period to 2006. That will employ new community development staff and pump-prime about 80 community development projects, which will help us to [improve service to] users with mental health problems who come from Black and minority ethnic groups...*

NIMHE is organized in 8 regional offices, and each office is linked directly with local communities, trusts, NGOs and service users. This allows NIMHE to organize its contribution to implementing the NSF-MH and its technical assistance programs around a community integration approach.

Moreover, the NSF-MH directed each area to create a local implementation team (LIT) comprising representatives from service users, carers, local authority departments, Primary Care Groups, NHS Trusts and Health Authorities with a mandate to develop a local implementation plan. Initially, 126 LITs were established, and some have worked better than others. Ms. Richardson told the Committee that,

> *The LITs have been absolutely essential to such changes as we have been able to secure. I do not want to create a falsely positive picture because we have an enormously long way to go. We are nearly five years into this program and we have made significant change but there is a long way to go. The LITs have been essential for that and it is terribly important in thinking about the whole of the reform program to get that infrastructure right, from the beginning.*

In addition, the Government has since issued a detailed *Policy Implementation Guide* in support of the NSF-MH (2001), and published proposals for reforming the Mental Health Act (2002).

Despite many positive responses to the NSF-MH, some have been concerned that the resources provided were inadequate for the tasks ahead, while others have felt that the NSF-MH did not acknowledge the current debate about the medical versus social models of mental health. These critics saw the way that the NSF-MH referred to mental health problems as 'mental illness' as reflecting a failure to see users and survivors as people who have strengths as well as problems. Despite the various criticisms, for most commentators the NSF-MH has nonetheless given cause for optimism about the future of mental health services in the UK.

3.2 COSTS AND FUNDING OF MENTAL HEALTH SERVICES

A report issued in June 2004 by the Mental Health and Social Exclusion Unit under the Office of the Deputy Prime Minister provides the following figures on costs associated with mental illness in England:

- The overall costs of mental health problems in England are estimated to be £77.4 billion annually. The impact on quality of life, including premature mortality, accounted for well over half that figure.
- Output losses associated with missed employment opportunities were estimated at over £23 billion per year.
- The economic costs of suicide are estimated to be in the region of £5.3 billion.

In terms of spending, the Secretary of State for Health told the Parliamentary Select Committee on Health in 2000 that mental health services accounted for around 12% of the total hospital and community health services budget. Ms. Richardson indicated to the Committee that in 2001-02 this figure had risen to 13%. At the same time, she insisted that it was important to recognize that

> *Hospital and community health service expenditure is only a portion of the money that is spent on mental health. We also have social care spending, which goes down a separate route to local government for social services, education services and the like.*

In this regard, an estimate made by the Sainsbury Centre for Mental Health[16] (2003) suggested that about 80 per cent of total spending on mental health services is funded by the NHS. Of the remainder, 15 per cent comes from the social services budgets of local authorities, 3 per cent is covered by the Mental Health Grant (a ring-fenced grant for mental health services made available to local authorities by central government) and the balance comes from other sources, including user charges.

The Sainsbury Centre also estimated that around 75 per cent of total expenditure on mental health services corresponds to the direct costs of service provision (mainly staff costs), while the remaining 25 per cent is accounted for by indirect costs, overheads and capital charges.

As noted earlier, the NHS Plan envisaged increasing funding for mental health in order to pay for an expansion of services. In its report on mental health spending, the Sainsbury Centre calculated that cash spending on adult mental health services (NHS and local authority combined) increased by 7.1 per cent in 2002/03, and is planned to rise by 6.3 per cent in 2003/04. In both years, however, their analysis indicates that growth in expenditure on mental health services is significantly slower than the growth in overall spending on health and social care. This means that, adjusting for the effects of pay and price rises,

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[16] The Sainsbury Centre for Mental Health (SCMH) is a charity that works to improve the quality of life for people with severe mental health problems. It carries out research, development and training work to influence policy and practice in health and social care. The SCMH is affiliated to the Institute of Psychiatry at King's College, London. Its work is highly respected world-wide.

expenditure on mental health services will increase at less than half the rate of total spending on the NHS and social services over the two years 2002/03 and 2003/04.

The Sainsbury Centre thus concluded that despite its status as a priority service, the share allocated to mental health in NHS and social service budgets is falling. It notes that the rise in spending is also well below the average rate of increase of 11.5% per annum that is required to implement the National Service Framework for Mental Health in line with the Government's timetable. According to them, if the timetable is to be met, annual cash expenditure on mental health services would need to increase at nearly double the rate recorded in 2002/03 and 2003/04.

While they observe that there are local differences in spending patterns, the Sainsbury Centre concludes that these should not be allowed to obscure the "single most important finding" of their study, which is that at the national level current expenditure trends imply a widening gap between promise and performance in the delivery of better mental health services. In their view, decision makers are faced with a clear choice: either scale back the reform agenda or ensure that mental health gets more resources.

However, in her testimony to the Committee Ms. Richardson stated:

> *I think I have to challenge robustly the perception that there has not been an increase in resources for mental health in association with the national service framework. As I think I said earlier, the NHS plan set out how an additional £330 million over and above baseline would be invested in the NHS in order to fast-forward the national service framework by 2003-04.*

She also pointed out that:

> *Our evidence supports the fact that that money did go into mental health services. We know that up to April last year an additional £262 million was spent on mental health over and above the baseline figure for 2001.*

At the local level, however, there are additional challenges posed by the new ways in which funds are now directed to local needs. As noted earlier, locally run Primary Care Trusts (PCTs) now receive NHS funding directly from central government rather than through Health Authorities. PCTs are responsible for allocating these funds between different health services, including services for mental health, and also for setting local priorities for the future development of services. PCTs are the major source of funding for mental health care and in theory can redirect resources between services and providers according to local priorities.

A recent study was conducted by the King's Fund on mental health services in London (2003). It noted that although responsibility for commissioning most mental health services has now passed from health authorities to PCTs, "most PCTs appear to have been unable to devote as much time to mental health commissioning as might be expected from the *size* of their budgets, or as required, given the state of development of mental health services." The

Sainsbury Centre surveyed the Local Implementation Teams (LITs) that are responsible for putting the mental health reforms into practice. Overall, their analysis suggested that 58 per cent of LITs think that funding in 2003/04 is unlikely, on balance or otherwise, to be sufficient to maintain baseline services and deliver the Government's reform programme, while 42 per cent took a more optimistic view. Evidence from Local Delivery Plans, covering the three years to 2005/06, also indicates that there is likely to be under-performance against national targets and policy objectives.

More generally, mental health budgets are being squeezed as a result of a number of pressures. The most important of these are staff shortages (leading to high levels of spending on costly forms of temporary staffing), the rapid growth of prescribing costs and the requirement to pay off inherited debts. For example, the Sainsbury Centre gave an illustration of an extreme budget overrun: a trust in the south of England reported overspending £145,000 on advertising for staff and £1,672,000 on medical locums.

A report prepared for the Mental Health Providers Forum (MHPF) in 2002 estimates that expenditure on and by the voluntary sector in providing mental health services corresponds to about 10 per cent of public expenditure on mental health. The combined income of MHPF members in 2001/02 was £320 million, much of which was received from the NHS and local authorities for mental health services provided on a contractual basis. Residential care was the largest area of contracted activity with 69 per cent of total spending, followed by community services (23 per cent). The balance of expenditure went on a range of services including information, advocacy, research, campaigning, training and support for caregivers.

3.3 SERVICE DELIVERY AND ORGANIZATION

The modernization of mental health services in the UK is taking place within the context of significant organizational change. Within the public sector, the main organizational change of recent years has been the emergence of specialist mental health trusts, many of which are still in the process of being developed as a number of different agencies are amalgamated to create a single provider responsible for the broad spectrum of mental health services within each locality. Some of these providers have been set up as health and social care trusts, with unified budgets combining health and social service funding as well as common staffing and premises.

The development of these specialist mental health trusts is a new phenomenon, the majority having come into existence in April 2002. They replace an array of services that had previously been provided and managed by acute trusts, community trusts and some specialist mental health trusts. Mental health trusts vary across a range of dimensions, including: the size of their overall budgets, numbers of staff employed, numbers of inpatient beds, numbers of sites for delivering services and the range of geographical areas covered.

They also vary in terms of the range of client groups served. Many cater to people with learning difficulties. Most provide services for older people and for children and adolescents as well as for adults of working age. Increasingly, trusts may also provide "home treatment" or "crisis services", which aim to care for individuals experiencing acute mental distress to enable them to remain in the community, usually at home, instead of becoming hospital inpatients. The NHS trusts providing general mental health services often also have access to a locked ward, or intensive care ward, where patients who need a higher level of physical security, or greater staff input than is possible on acute wards, can be cared for.

Both the Royal College of Nursing and the Royal College of Psychiatrists argued in their testimony to a Select Parliamentary Committee in 2000 that good quality community care is only possible if patients also have access to good quality in-patient care. The Select Committee received evidence from a variety of witnesses that indicated that much in-patient care was still of low quality. The Select Committee referred to a study by the Sainsbury Centre which suggested that the pressures on acute beds were so great that the environment was positively "untherapeutic", that services lacked clear goals, and links with community services were poor. The Mental Health Foundation similarly suggested to the Committee that the "real weakness" in the mental health service at present was to be found in acute wards.

A substantial proportion of mental health services are also provided in primary care settings. The Report on Mental Health and Social Exclusion indicated that "approximately nine out of ten adults with mental health problems, and one quarter with severe mental health problems receive all their support from primary care," and that "around 30 per cent of GP consultations concern mental health problems, usually depression, eating disorders and anxiety disorders."

At the same time, Ms. Richardson indicated that "it is fair to say that we have not had a formal strategy for the integration of primary and secondary care." However, she did inform the Committee about a particular initiative designed to improve the delivery of services at the primary care level. The NHS plan of 2000 set a target to develop 1,000 new graduate primary care mental health workers by December 2004, in order to help GPs manage and treat people of all ages with common mental health problems. In Ms. Richardson's terms, "the graduate worker is a new breed of worker." She described the program as follows:

> *…we had a group of able [university] graduates in our system who wanted to work in the NHS who could be trained, so the evidence suggested, to deliver brief, effective evidence-based treatments in primary care for people with common disorders… we set up 12 new programs of education and training across England to provide them with one year of post-graduate certificate level training offered on a day-release basis.*
>
> *Our graduate workers, thus far, tend to have qualifications in social sciences or psychology and are not nurses. That additional one year of post-graduate training qualifies them to deliver the kind of self-help, the information dissemination, and some of the brief effective cognitive behavioural treatments for people with common disorders.*

The NHS Plan also contained a number of other specific targets, including the creation of an additional 50 assertive outreach teams. According to Ms. Richardson, this goal has been met. She told the Committee that an assertive outreach team

> *…is a small multidisciplinary team consisting of anywhere between 9 to 15 staff. Their aim is to focus particularly on the estimated 1,500 people who are in the mental health service system with a severe mental illness and who are at particular risk of falling out of contact with services or of disengaging with their key workers.*
>
> *The assertive outreach team would start its work after a period of admission. Let us say, typically, a service user would have an admission to a psychiatric hospital, have a period of treatment and get a care plan. The assertive outreach team would follow up, as the name suggests, quite assertively. They would visit the person at home; if the person missed an appointment, they would chase it up. They might see the service user, the patient, in the place of his or her choosing. We know assertive outreach teams that work in the local launderette, and they will be trying to help ensure that the service user sticks with the care plan and does not fall out of contact.*

In addition to the major service providing agencies, there is usually a range of independent providers in most localities. Quite often these are voluntary sector agencies that are part of national bodies. The private sector can also be part of the local scene, most notably as providers of secure and special needs accommodation. As well, there are private landlords who have specialized in providing accommodation for people with mental health needs in certain areas.

3.3.1 Human Resources

There remain many serious problems across the UK with the recruitment and retention of mental health staff. Significant staffing shortages, primarily of psychiatrists and inpatient nurses, continue to have a major impact on clinical leadership and the quality of care. As noted earlier, problems recruiting and retaining staff lead to a high use of temp and agency staff. However, local experience varies, depending on working conditions, recruitment strategies and the attraction of particular organisations and localities.

In 2000, the Secretary of State for Health testified to a Parliamentary Committee that there were shortages of nurses, psychiatrists "and other specialist staff," but he also noted that the picture varied at both local and regional level and that the figure for nursing vacancies in mental health nursing (2.1%) was actually below the general nursing figure (2.6%). The Royal College of Psychiatrists estimated in its testimony to the Committee that there is "an average of something like 15 per cent consultant psychiatric vacancy across the country."

A study conducted by the Commission for Health Improvement (CHI) in 2003 indicated that many permanent staff are working excessive hours. At the same time, CHI was impressed by the commitment and dedication of clinical, non clinical and care staff to providing high quality care to service users across the sector, despite the fact that many staff work under considerable pressure in difficult environments.

3.3.2 Services to Minorities

The Report on Mental Health and Social Exclusion indicated that in the UK:

- People from ethnic minority groups are six times more likely to be detained under the Mental Health Act than white people;
- Rates of diagnosed psychotic disorders are estimated twice as high among African Caribbean people than white people, although they are three to five times more likely to be diagnosed and admitted to hospital for schizophrenia;
- South Asian women born in India and East Africa have a 40 per cent higher suicide rate than those born in England and Wales.

Statistical evidence presented to the Select Committee on Health in 2000 by the British Psychological Society also pointed to the tendency of ethnic minority patients to access services later, when they are more severely ill and more likely to be detained. Other evidence given to the Select Committee indicated that the services offered to visible minorities are often "inappropriate or insensitive." Some minority groups are also under-represented in services. It was pointed out to the Select Committee that women from South Asian communities, for example, make below-average use of formal mental health services and have an above-average suicide rate.

The reasons put forward by witnesses to the Select Committee as to why ethnic minority use of mental health services is significantly different from that of white patients fell into two broad categories: the inappropriateness of services and a failure by service providers to understand the needs of ethnic minority patients. The Select Committee expressed concern that despite the fact that these problems have been recognized for some years, change remains slow in coming.

3.4 PROMOTION AND PREVENTION

3.4.1 Countering Stigma and Discrimination

As noted above, the National Service Framework for Mental Health (Standard One) aims to ensure that health and social services promote mental health and reduce discrimination and social exclusion. Ms Richardson told the Committee that the Government began

> *in March 2001 by launching a national campaign called 'Mindout for Mental Health.' That campaign was aimed at tackling the stigma and discrimination faced by people with mental health problems. It was designed to support their social inclusion.*

This campaign lasted for three years and concluded in March 2004. One of the positive features of the 'Mindout' campaign that was identified in the report on Mental Health and Social Exclusion was its use of an 'Ambassador Bureau,' composed of more than 40 people with experience of mental health problems who were trained to speak to the media and employers about their experiences. Evaluation found that ambassadors were perceived to make the campaign 'human and personal', and that hearing first-hand about mental health problems challenged misconceptions.

Another anti-stigma effort, the five-year 'Changing Minds' campaign organized by he Royal College of Psychiatrists' ended in late 2003. Ongoing campaigning work is also being pursued by number of voluntary organizations. Within governmental structures, the National Institute for Mental Health in England (NIMHE) has lead responsibility for tackling stigma and discrimination around mental health problems.

While there has thus been considerable effort to tackle stigma in England, the report on Mental Health and Social Exclusion notes that "this has not always been well co-ordinated, and has focused on education and awareness rather than achieving behavioural change." The report concluded that "two key lessons from the 'Mindout' campaign were the need for longer-term funding strategies and robust evaluation." It further cited a literature review of international work that had been commissioned by NIMHE that found that average spending on mental health awareness in England is lower and more short-term than in countries with more successful programmes (see table below). Thus while the report identified stigma and discrimination as being "the greatest barriers to social inclusion for people with mental health problems," it also concluded that "despite a number of campaigns, there has been no significant change in attitudes."

INTERNATIONAL SPENDING ON MENTAL HEALTH CAMPAIGNS PER HEAD OF THE GENERAL POPULATION*	
Mindout for mental health	1.44 pence
See Me, Scotland**	13 pence
Like Minds, Like Mine, New Zealand	$NZ1 (approx 36 pence)

* Figures are an approximation of overall spending divided by population, with annual spending averaged over the campaign. Each British pound is made up of 100 pence and is worth approximately CA$2.43.
** See box at next page.

The new strategy outlined in the report to combat stigma and discrimination is therefore based on the recognition that dealing with mental health problems requires more than a medical solution. In particular, the report argues that a positive response on the part of society to accommodate people's individual needs and to promote mental well-being is needed. To accomplish this, it sets out a 27-point action plan to bring together the work of government departments and other organizations in a concerted effort to challenge attitudes, enable people to fulfill their aspirations, and improve opportunities and outcomes for this excluded group.

SEE ME CAMPAIGN, SCOTLAND

See Me is an anti-stigma campaign run by an alliance of five Scottish mental health organisations and supported by the Scottish Executive. The campaign is a major part of the National Programme for Improving Mental Health and Well-being. It was launched in October 2002, and has almost £3 million of funding over four years (to 2005-06). It has been developed through extensive consultation with people with experience of mental health issues. The campaign works on a national level, underpinned by local activities. It uses multimedia advertising, supported by people with mental health problems trained to speak to the media. *See Me* includes a 'stigma stopwatch' that encourages people to respond to discriminating attitudes and language in the media. Recognition of the campaign has been maintained at 28 per cent.

The plan includes a programme to challenge negative attitudes and promote awareness of people's rights. This new anti-stigma programme is backed by a £1.1 million investment from the Department of Health and additional funding has been made available through other government departments. It will be led by NIMHE and, according to the Report, the programme will:

- be based on international evidence of what works, and learn from previous mental health and health promotion campaigns;
- target key audiences, in particular employers, young people and the media;
- deliver consistent, tested messages under a single brand;
- promote the positive contribution that people with mental health problems can make to society;
- have sustained funding to plan ahead;
- address issues of ethnicity and gender;
- provide a framework and materials to support local campaign work, targeting in particular issues facing deprived neighbourhoods;
- be clearly evaluated by a regular survey.

3.4.2 Suicide Prevention

There has been a National Suicide Prevention Strategy for England in place since 2002. It was developed to implement the target of reducing the death rate from suicide and undetermined injury by at least a fifth by the year 2010 that had been set out by the Government in a 1999 White Paper, *Saving Lives: Our Healthier Nation*.

The plan is seen as an on-going, co-ordinated set of activities that strives to be to be comprehensive, evidence-based, specific and subject to evaluation. It will be delivered as one of the core programmes of the National Institute for Mental Health in England (NIMHE). The plan sets six goals, each of which further embrace a number of more specific objectives. These goals, followed by the objectives, are listed in the box below.

Ms Richardson told the Committee that the strategy would appear to be bearing fruit:

> *The first report of progress with the strategy was published last year. There are encouraging signs that the rate of death by suicide is falling. The data for the last two years show the lowest rate yet. The three-year average for 2000-2002 was the lowest rate yet compared with the baseline that we set in 1995. Currently the rate is 8.9 deaths per 100,000 population. That compares moderately favourably with the European rate, which I think was 8.8 at last count.*

NATIONAL SUICIDE PREVENTION STRATEGY FOR ENGLAND

GOAL 1 To reduce risk in key high risk groups.

- Reduce the number of suicides by people who are currently or have recently been in contact with mental health services.
- Reduce the number of suicides in the year following deliberate self-harm.
- Reduce the number of suicides by young men.
- Reduce the number of suicides by prisoners.
- Reduce the number of suicides by high risk occupational groups.

GOAL 2 To promote mental well-being in the wider population.

- Promote the mental health of socially excluded and deprived groups.
- Promote mental health among people from black and ethnic minority groups, including Asian women.
- Promote the mental health of people who misuse drugs and/or alcohol.
- Promote the mental health of victims and survivors of abuse, including child sexual abuse.
- Promote mental health among children and young people (aged under 18 years).
- Promote mental health among women during and after pregnancy.
- Promote mental health among older people.
- Promote the mental health of those bereaved by suicide.

GOAL 3 To reduce the availability and lethality of suicide methods.

- Reduce the number of suicides as a result of hanging and strangulation.
- Reduce the number of suicides as a result of self-poisoning.
- Reduce the number of suicides as a result of motor vehicle exhaust gas.
- Reduce the number of suicides on the railways.
- Reduce the number of suicides as a result of jumping from high places.
- Reduce the number of suicides using firearms.

GOAL 4 To improve the reporting of suicidal behaviour in the media.

- Promote the responsible representation of suicidal behaviour in the media.

GOAL 5 To promote research on suicide and suicide prevention.

- Improve research evidence on suicide prevention.
- Disseminate existing evidence on suicide prevention.

GOAL 6 To improve monitoring of progress towards the *Saving Lives: Our Healthier Nation* target for reducing suicide.

- Monitor suicide statistics relevant to the goals and objectives in the strategy.
- Evaluate the national suicide prevention strategy.

3.5 PROSPECTS FOR FUTURE REFORM

Mental health services are now almost half way into the ambitious 10 year programme outlined in the National Service Framework (NSF), and much progress has been made. However, concerns remain about whether the goals that it set out will be fully met. For example, in 2000, the Commons Select Committee on Health described the system as a "patchwork quilt", with enormous variations in both standards of service and methods of service delivery around the country. In 2003, the Commission for Health improvement concluded that the historical legacy of the neglect of mental health services had still not been overcome.

Both the direction of reform and the concrete implementation of changes to the organization and delivery of services remain the subject of debate. Concerns have been expressed in recent reports over the priority accorded to mental health within the overall health system and over the implementation of the commissioning process for mental health services. More emphasis is seen as being given to the acute sector, particularly to reducing waiting times and extending patient choice, leaving the NSF and NHS Plan targets for mental health relatively low on the list of priorities.

Challenges also remain in the devolution of the commissioning of mental health services to local trusts so that the full benefits of this shift can be reaped. In particular, the dilution of expertise across a large number of commissioners has been identified as a potential source of problems. In spite of the positive developments associated with commissioning, there are commentators who have argued that the effectiveness of commissioning has a long way to go; and in the mental health field, commissioning seems particularly patchy and under-developed.

In its recent report, the Sainsbury Centre painted a picture of a system that is under a range of pressures which — taken together — in their eyes raise questions about the deliverability of the Government's reform agenda. They noted that it remains the case that the finances of many mental health providers are in a precarious state. At the same time, witnesses indicated to the Committee that the Government was committed to mental health reform and to making the necessary resources available.

3.6 COMMITTEE COMMENTARY

The Committee was very impressed by the scale of the planning that has taken place in England since the introduction of the National Service Framework for Mental Health in 1999, in particular the 10-year planning horizon and the detailed standards for service delivery that it sets out.

The Committee was also struck by the importance of the Local Implementation Teams that were established in order to translate and adapt the framework to local conditions, as well as by the emergence of mental health trusts that are designed to create a single local provider of mental health services. In the same vein, the Committee was impressed by the creation of a separate implementation arm, the National Institute for Mental Health in England, whose tasks include assisting in training, disseminating expertise and propagating best practices.

In general, the Committee noted the enormous challenge that confronts government in funding and organizing reform in the mental health sector. The Committee was further impressed by the careful attention paid to the assessment of the implementation of mental health reform both by governmental agencies and by non-governmental organizations in England.

It would also seem possible to conclude from recent experience in England that human resource shortages have the potential to engender serious short term financial consequences throughout the system, as well as to pose a threat to the realization of reform plans. In this regard, the training of graduate mental health workers to assist in the delivery of services at the primary care level struck the Committee as an important initiative.

Finally, the Committee was impressed by the ongoing commitment to fight stigma and discrimination that confront people living with mental health disorders, and, in particular by the scope of the initiatives announced in the report on Mental Health and Social Exclusion in June 2004. The UK experience also shows, however, that changing attitudes is no simple matter, and that adequate resources as well as perseverance are required. The Committee noted as well that there are recent indications that mental health promotion and suicide prevention have contributed to declining suicide rates in England.

CHAPTER 4:
MENTAL HEALTH CARE IN THE UNITED STATES[17]

4.1 HISTORY AND OVERVIEW

The American health care system is unique in the extent to which it relies on the private sector both to provide health care coverage and deliver health services. Private sources account for 55% of health care financing, made up of private health care insurance (33%), out-of-pocket payments made by individuals under both public and private plans (17%), and other sources (5%). The majority of Americans receive their private insurance coverage through employer-sponsored plans.

The federal government contributes approximately 33% of total health care spending, with state and local governments paying the remaining 12%. The national government of the United States is responsible for administering and operating Medicare, which provides health care insurance for the elderly. Jointly with the states, it finances Medicaid for the poor and the State Children's Health Insurance Program (SCHIP) for children. Overall, public health care insurance covers about 24% of the population in the United States.

Medicare is a federal health care insurance plan for people 65 years of age and over, some people with disabilities under 65, and people with end-stage renal disease. Medicaid is a joint federal and state means-tested health care insurance plan available to people with low income. The federal government pays from half to over 75% of the cost incurred by individual states in providing coverage for the poor, depending on the wealth of individual states. It also establishes national guidelines for Medicaid eligibility and services. However, each state administers its own program and sets the rate of payment for services. All states are held to minimum requirements for eligibility and for required services but, with federal agreement, they may expand eligibility or services provided. Medicaid programs therefore vary from state to state.

4.1.1 Mental Health

In the words of a recent report by the President's New Freedom Commission on Mental Health, the current mental health care system in the United States "is a patchwork relic," that

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[17] Unless otherwise indicated, the information in this document is drawn from the following sources: *Mental Health: A Report of the Surgeon General* (1999), in particular Chapter 6, "Organizing and Financing Mental Health Services"; U.S. Department of Health and Human Services, *National Strategy for Suicide Prevention: Goals and Objectives for Action* (2001); The President's New Freedom Commission on Mental Health *Final Report* (July, 2003) and *Interim Report* (October, 2002); Tanner, Jane "Mental Illness Medication Debate," *The CQ Researcher*, Feb. 6, 2004, pp. 109-118; Cunningham, Robert "The Mental Health Commission Tackles Fragmented Services: An Interview With Michael Hogan," *Health Affairs*, Web Exclusive, Sept. 9, 2003; Barry, Colleen L., and Jon R. Gabel, Richard G. Frank, Samantha Hawkins, Heidi H. Whitmore, and Jeremy D. Pickreign **"**Design Of Mental Health Benefits: Still Unequal After All These Years," *Health Affairs*, Vol. 22, No. 5, Sept.-Oct. 2003, pp. 127-37; Hogan, Michael F. "The President's New Freedom Commission: Recommendations to Transform Mental Health Care in America," *Psychiatric Services*, Vol. 54, No. 11, Nov. 2003, pp. 1467-1474; Mechanic, David and Scott Bilder, "Treatment Of People With Mental Illness: A Decade-Long Perspective," *Health Affairs*, Vol. 23, Number 4, July/August 2004.

is in need of "dramatic reform" because it "does *not* adequately serve millions of people who need care." Analysts agree that the American mental health services system defies easy description. In fact, the Report of the Commission insists that "the reality is that the mental health system looks more like a maze than a coordinated system of care."

Mental disorders and mental health problems in the United States are treated by a variety of caregivers who work in diverse, relatively independent, and loosely coordinated facilities and services—both public and private—that researchers refer to, collectively, as the de facto mental health service system. These programs exist at every level of government and throughout the private sector and have varying missions, settings, and financing.

About 15 percent of all adults and 21 percent of U.S. children and adolescents use services in the de facto system each year. The system is usually described as having four major components or sectors:

- The specialty mental health sector consisting of mental health professionals such as psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers who are trained specifically to treat people with mental disorders.
- The general medical/primary care sector consisting of health care professionals such as family physicians, general internists, paediatricians, and nurse practitioners in office-based practice, clinics, acute medical/surgical hospitals, and nursing homes.
- The human services sector consists of social services, school-based counselling services, residential rehabilitation services, vocational rehabilitation, criminal justice/prison-based services, and religious professional counsellors.
- The voluntary support network sector, which consists of self-help groups, such as 12-step programs and peer counsellors, is a rapidly growing component of the mental and addictive disorder treatment system.

The de facto mental health service system is also divided into public and private sectors. The term "public sector" in this context refers both to services directly operated by government agencies (e.g., state and county mental hospitals) and to services financed with government resources (e.g., Medicaid, and Medicare). Publicly financed services may be provided by private organizations. The term "private sector" refers both to services directly operated by private agencies and to services financed with private resources (e.g., employer-provided insurance).

Most Americans (84 percent) have some sort of insurance coverage—primarily private insurance obtained through the workplace. However, its adequacy for mental health care is extremely variable across types of plans and sponsors. The public sector serves those individuals with no health insurance, those who have insurance but no mental health coverage, and those who exhaust limited mental health benefits in their health insurance.

Each sector of the de facto mental health service system has different patterns and types of care and different patterns of funding. According to the President's Commission, the causes of the fragmentation of the existing system are not a lack of commitment and skill on the part of those who deliver care, but rather stem from underlying structural, financing, and organizational problems, whose roots go back to the 1950s when the move away from care in institutions to care in communities began.

De-institutionalization was motivated by reformers' desire to bring services to people in their communities, but its unintended consequence was that responsibility became scattered across levels of government and across multiple agencies. The shift began under President Dwight D. Eisenhower, but it got a big push when President John F. Kennedy signed the Community Mental Health Centers Construction Act in 1963. It set up a funding stream for local programs, with a goal of cutting state mental hospital populations by half.

This goal was far exceeded: only 40,000 hospital beds exist today for the mentally ill, compared with some 550,000 in 1955. However, goals for developing community mental health centers did not fare as well. Only about half the intended centers were initiated and federal funding covered only the seven-year start-up period. In 1981, the mental health centers program was replaced with a block grant for mental health.

But communities did not embrace the psychiatric patients who were thrust into their neighborhoods, and most of the money saved by closing state hospitals was not put back into community programs. "Jails and prisons have become the new institutions for many with severe mental disorders, with many others left to fend for themselves as homeless street people," Darrel A. Regier, director of research at the American Psychiatric Association, told the federal mental health commission.

At the same time, Mr. William Emmet, the co-ordinator for the U.S. Campaign for Mental Health Reform, told the Committee that:

> *In many ways, deinstitutionalization was a great success. There were many people who did not belong in the institutions, and they did leave and start living productive lives — or at least far better lives than they had in the institutions. The problem over time has been that people who formerly would have gone to institutions have not been able necessarily to get the services they need.*

And Michael Hogan, the Chair of the President's Commission on Mental Health, added in his testimony before the Committee:

> *None of us in the field would argue for a minute that we ought to go back. The system of institutions failed to touch most people. Those whom it did touch were confined very expensively and they did not get better. They received "three hots, a cot and health care," but they were never able to get a life. We cannot go back to that situation but we have not yet solved the problem of creating a care system that is well organized and robust enough to do a good job.*

Two years after President Kennedy's speech, Medicare and Medicaid were created. Over the years, states increasingly used Medicaid to pay for mental health care. This has led to Medicaid becoming the nation's largest purchaser of mental health care. Critics say that states moved mental health care into Medicaid simply because the federal government picks up half the tab in a matching contribution, and pays up to 75 percent in poorer states.

The introduction of Medicaid also contributed to the decline of state-run psychiatric hospitals in three ways. First, Medicaid did not reimburse most care provided in these settings. Second, it did pay for acute care in psychiatric units of general hospitals, which became a preferred location for short term treatment. Finally, Medicaid paid for care in nursing homes and much of the decline in the use of state psychiatric hospitals is attributable to the transfer of elderly patients from state hospitals to nursing homes.

Within the framework of the American health care system, mental health care is unique because there are state- and county-administered care systems specifically for a category of illness. The Federal government now pays for most services for people with a serious mental illness, while responsibility for providing them rests with states and localities. However, most Federal resources are in mainstream programs (e.g., Medicaid, Medicare, Vocational Rehabilitation, housing) that are not always tailored to the specific requirements of mental health care and are usually administered by different state agencies. This often leaves consumers and families struggling to find appropriate services.

Moreover, because the provision of mental health care services has now been devolved to fifty states and hundreds of counties and local communities, there is considerable variability in the availability of these services. As Mr. Hogan put it in an interview, "if you've seen one state, you've seen one state."

Major changes have also occurred recently in the private sector, especially with the advent in the 1990s of managed care as the predominant way of organizing private insurance coverage.

4.2 COSTS AND FUNDING OF MENTAL HEALTH SERVICES

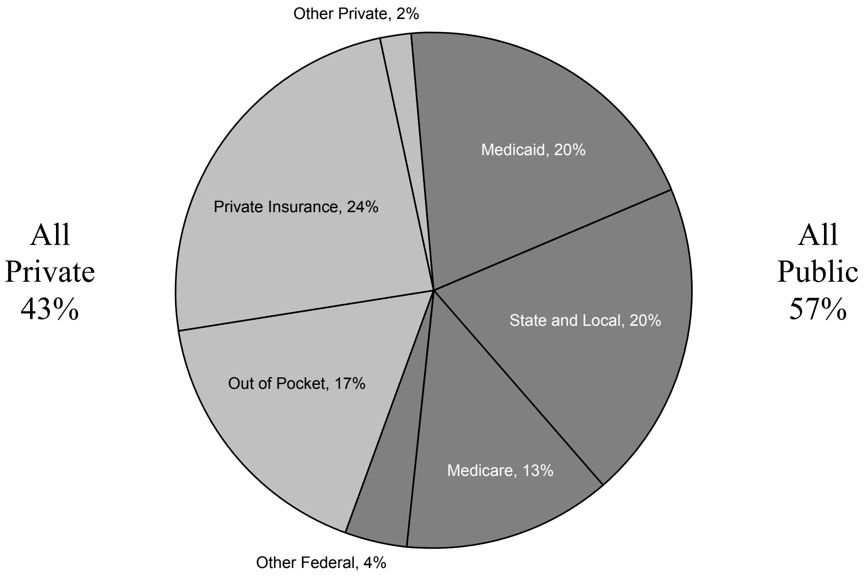
4.2.1 The Costs of Mental Illness in the United States

There are both direct and indirect costs of mental illness to the economy. The *indirect costs* of all mental illness imposed a nearly $79 billion loss on the U.S. economy in 1990. Most of that amount ($63 billion) reflects the loss of productivity because of illness. But indirect costs also include almost $12 billion in mortality costs (lost productivity due to premature death), and almost $4 billion in productivity losses for incarcerated individuals and for the time of individuals providing family care.

In 1996, the United States spent more than $99 billion for the *direct* treatment of mental disorders, as well as substance abuse, and Alzheimer's disease and other dementias. Of this, $69 billion was spent in 1996 for diagnosis and treatment of mental illness alone, representing 7% of total health care spending that year. More than 70% of direct mental health spending was for the services of specialty providers, with most of the remainder for general medical services providers.

In 1997, all public sources accounted for 57% of mental health spending, with all private sources covering the remaining 43% (Figure 1). Between 1986 and 1996, mental health expenditures grew at an average annual growth rate of more than 7 percent, compared with overall rate for health care of more than 8 percent. According to the U.S. Surgeon General, this difference may stem from the greater reliance of mental health services on managed care cost-containment methods during this period. Among the fastest-rising expenses for mental health services were outpatient prescription drugs, which account for about 9 percent of total mental health direct costs.

DISTRIBUTION OF PUBLIC AND PRIVATE MENTAL HEALTH EXPENDITURES, 1997



4.2.2 Publicly Funded Mental Health Insurance

During the past two decades there have been important shifts in who pays for mental health care in the United States. The role of individual states in the direct funding of mental health care has been reduced, whereas Medicaid funding of mental health care has grown in relative importance. This is in part due to substantial funding offered to the states by the Federal government. However, Mr. Emmet noted that, "as a medical entitlement program [Medicaid] covers only certain approved services… and it requires matching contributions from the states that are increasingly difficult for the states to make in these tight budgetary times." One consequence of this shift is that Medicaid is now the largest payer of mental health services in the country and it has therefore become very influential in shaping the delivery of mental health care. Private insurance coverage has played a somewhat more limited role in mental health financing in recent years.

Some Federal funding is directed specifically to mental health programs. One such program, the Community Mental Health Services Block Grant, funded by the U.S. Department of Health and Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA), provides funding to the States and territories. It totaled approximately $433 million in 2002, but this amounted to less than 3% of the revenues of the State agencies involved.

In fact, larger Federal programs that are not focused on mental health care play a much more substantial role in the financing of mental health services. For example, through Medicare and Medicaid programs alone, HHS spends nearly $24 billion each year on beneficiaries' mental health care (a figure which does not include the state share of Medicaid). Moreover, the largest Federal program that supports people with mental illnesses is not a health services program but rather income support programs run by the Social Security Administration — Supplemental Security Income (SSI) and Social Security Disability Income (SSDI).

Escalating costs, especially for prescription drugs, have placed significant pressure on both individuals and states. In 2002, 25 states spent more money for Medicaid services than they had budgeted, and 28 expected to fall short when 2003 figures were tallied, according to the National Association of State Budget Officers. The federal government stepped in with a one-time infusion of extra cash for state Medicaid programs — a total of $10 billion paid out last year and this year. Between 1990 and 2000, Medicaid prescription costs rose fourfold — from $5.1 billion to $20.9 billion, according to the federal Center for Medicare and Medicaid Services.

4.2.3 Private Mental Health Insurance

As noted above, most Americans (84 percent) have some sort of insurance coverage— primarily private insurance obtained through the workplace. However, its adequacy for mental health care is extremely variable across types of plans and sponsors.

4.2.3.1 Basic Elements Of Private Mental Health Insurance Coverage

Historically, mental health coverage has been more limited than coverage for other medical services. Health plans have tended to require higher co-payments and to set more stringent limits on inpatient hospital days and outpatient visits for mental health treatment. Plans have also limited mental health coverage through the use of annual and lifetime dollar limits. Many have seen these restrictions as a reflection of the stigmatization of mental illness which remains a serious barrier to the provision of adequate care.

In recent years, legislation regulating insurance and fundamental changes in the delivery of mental health services have altered the environment in which mental health coverage is bought and sold. Parity legislation that has been introduced in the Congress and many state legislatures aims to eliminate the difference in insurance coverage for mental health care and other medical conditions. However, to date efforts to attain parity have had an uneven fate, with Congress, for example, not yet having passed such legislation.

Likewise, managed care has transformed the delivery of mental health care services over the past decade. Employers and health plans now frequently contract out administration of their mental health benefits to specialty managed behavioural health care organizations (MBHOs). These carve-outs use specialized expertise to manage utilization and to direct care to treatment in provider networks. Mental health is said to be the only sector of health care where managed care has successfully controlled costs.

A recent survey suggests that 98 percent of workers in the United States with employer-sponsored health insurance had coverage for mental health care in 2002. Ninety-six percent of covered workers had inpatient mental health coverage, while 98 percent had outpatient mental health coverage. From 1991 to 2002, the proportion of workers with some form of health insurance who were offered mental health benefits actually increased.

But although most workers with general health insurance were offered some coverage for mental health services in 2002, firms continued to place special limits on mental health benefits. As already noted, federal and state parity laws have been enacted in recent years in an effort to curb these insurance limitations. However, gaps in these federal and state parity laws have meant that differences in coverage between mental health and general medical benefits persist. Data indicates that 74 percent of covered workers were subject to an annual outpatient visit limit, and 64 percent were subject to an annual inpatient day limit. Although health plans have historically attempted to control costs by requiring that enrollees pay more at the point of service for mental health care compared with other medical services, a recent survey indicated that in 2002 only 22 percent of covered workers had higher cost sharing for mental health benefits

4.2.3.2 Organization Of Private Mental Health Coverage

Managed care has greatly altered the organization and delivery of mental health services. As noted earlier, firms increasingly opt to carve out the administration of mental health benefits to specialty companies. These organizations use specialized expertise to establish networks of providers, negotiate volume-related discount contracts, identify evidence-based treatment protocols, and develop other incentive programs to manage utilization and costs.

Health maintenance organizations were the first form of managed care. They initiated the practice of negotiating contracts to provide all medical services on a prepaid, per capita basis. Today, there exist a number of different types of managed care, such as Preferred Provider Organizations (PPOs — managed care plans that contract with networks of providers to supply services) and Point-of-Service plans (POS — managed care plans that combine features of capitated and fee-for-service insurance). As recently as 1988, insurance based on fee-for-service was the predominant method of financing health care, but managed care arrangements (HMO, PPO, or POS plans), now cover the majority of Americans.

In carve-out Managed Behavioral Health Care, segments of insurance risk—defined by service or disease—are isolated from overall insurance risk and covered in a separate contract between the payer (insurer or employer) and the carve-out vendor. Data suggest that about a third of people with employer sponsored health insurance were offered mental health care through carve-outs. Managed care has shown that it is able to reduce the cost of mental health services, but research is just beginning on whether managed care cost-reduction techniques affect access and quality.

There is concern that restrictive cost-containment strategies and various incentives to providers and facilities to reduce specialty referrals, hospital admissions, or length or amount of treatment may ultimately contribute to lowered access and quality of care. Mental health advocates have worried that strict benefit limitations expose people with serious mental illnesses to catastrophic expenses. Prior authorization constitutes an additional organizational feature of managed behavioral health care. While it can encourage the use of evidence-based protocols by practitioners, prior authorization has also been used to control utilization. Prior authorization rules require physicians to obtain approval from a health plan or a carve-out prior to prescribing treatment. In 2002, half of all covered workers were required to obtain authorization prior to using outpatient specialty mental health services.

Despite the rise of managed care and behavioral health carve-outs, employees still carry a greater out-of-pocket cost burden for the use of mental health services in comparison with other illnesses. The one mental health benefit consistently on a par with general medical insurance is coverage for prescription drugs (although this may be because psychiatric medicines constitute one component of a package of Medicaid benefits and are not 'carved out'). Outpatient psychotropic drugs now constitute the fastest-growing cost in mental health care. According to a recent study, prescription drug use grew from 22 percent of total mental health care spending in 1992 to 48 percent in 1999 among people with employer-based health insurance.

In summary, continued benefit limits combined with powerful managed care techniques to control utilization have contributed to reduced growth in mental health spending compared with health spending overall; however, they also could signal access problems. In this vein, Mr. Hogan remarked that,

> … *managed care, funded adequately and done well, seems to be the best approach. The trouble is, often it is not funded adequately in the States and, if it is done poorly, it becomes a disaster.*

4.3 SERVICE DELIVERY AND ORGANIZATION

As noted earlier, the recent report by the President's Commission on Mental Health concluded that the mental health service delivery system in the United States needs dramatic reform. While many consumers do receive effective treatments and services, many others do not, as they confront a system in which available services are fragmented, driven by complex financing rules and regulations, and restricted by bureaucratic boundaries. As Mr. Hogan told the Committee:

> *There is this paradox of how there are many more services now than there were a decade ago, and the people who are lucky enough to use them do well. However, the fact that there are all these services has made things much more complicated at the community level, so families do not know where to turn when a problem is emerging. That is the challenge of fragmentation.*

The report by the President's Commission suggested that many of these problems are due to the "layering on" of multiple, well-intentioned programs without overall direction, coordination, or consistency. Given this situation, consumers can often feel overwhelmed and bewildered when they must access and integrate mental health care, support services, and disability benefits across multiple, disconnected programs that span Federal, State, and local agencies, as well as the private sector. Recent reports concur that the system's failings lead to unnecessary and costly disability, homelessness, school failure, and incarceration. Mr. Hogan described the situation in the following terms:

> *The result has been this patchwork quilt where we have all these different federal agencies that have some responsibility for mental health care. They tend to work through the corresponding agency at the state level…The entities at the state level and then at the local level that are responsible for care are different bureaucracies and different systems, creating the situation where the person with mental illness and the family has to navigate what has become a terribly complicated system; and they must do this, by and large, when they are at their worst.*

While many people are given good care and manage to recover, the reality, according to the Interim Report of the President's New Freedom Commission, is that about one out of every two people in the United States who needs mental health treatment does not receive it.[18] Moreover, the individual who succeeds in accessing care may find that many treatments and services are simply unavailable, especially in rural areas. Also, the quality of care may be inadequate. A diagnosis may sometimes be missed, the dose of medication may be insufficient, or the length of treatment too short. For ethnic and racial minorities, the rate of treatment is even lower than that for the general population, and the quality of care is poorer.

At the same time, a recent article pointed out that there are areas where access to services in the United States is improving, in particular with regard to people suffering from serious mental illnesses (SMI). The authors, David Mechanic and Scott Bilder, write that:

> *The good news—contrary to frequent assertions in the mental health community as noted at the outset—is that access to care for people with SMI has improved, and there is evidence of progress even in the more proximate period between 1997 and 2001. People with SMI were more likely to receive mental health specialty services in 2001 than in 1997, but those with [other mental illnesses] and no mental illness each showed declines. Since the latter two populations are much larger than the population with SMI, these decreases in the aggregate may contribute to the perception that services are less available.*

They also note that:

> *Similarly, numbers of mental health providers have risen dramatically. Although the supply of traditional providers such as psychiatrists and psychiatric nurses has increased only modestly, there have been larger increases in psychology and social work and very large increases in counseling and psychosocial rehabilitation. Patient care full-time-*

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[18] *Interim Report*, p. 3.

> *equivalent (FTE) staff in mental health organizations increased from 347,000 in 1986 to 532,000 in 1998.*

4.3.1 General/Primary Care

The general medical/primary care sector consists of health care professionals such as family physicians, general internists, paediatricians, and nurse practitioners in office-based practice, clinics, acute medical/surgical hospitals, and nursing homes. More than 6 percent of the adult U.S. population use the general medical sector for mental health care, with an average of about 4 visits per year. The general medical sector has long been identified as the initial point of contact for many adults with mental disorders, and about half of the care for common mental disorders is delivered in general medical settings. Primary care providers actually prescribe the majority of psychotropic drugs for both children and adults.

While primary care providers appear positioned to play a fundamental role in addressing mental illnesses, recent reports have pointed to ongoing challenges in the areas of identification, treatment, and referral. Despite their prevalence, mental disorders often go undiagnosed, untreated, or under-treated in primary care. Although the number identified is increasing, primary care providers' rates of recognition of mental health problems are still low, and referrals from primary care to specialty mental health treatment are often never completed.

4.3.2 Specialty Care

The specialty mental health sector consists of mental health professionals such as psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers who are trained specifically to treat people with mental disorders. The great bulk of specialty treatment is now provided in outpatient settings such as private office-based practices or in private or public clinics. Most acute hospital care is now provided in special psychiatric units of general hospitals or beds scattered throughout general hospitals. Private psychiatric hospitals and residential treatment centres for children and adolescents provide additional intensive care in the private sector. Public sector facilities include state/county mental hospitals and multi-service mental health facilities, which often coordinate a wide range of outpatient, intensive case management, partial hospitalization, and inpatient services. Altogether, slightly less than 6 percent of the adult population and about 8 percent of children and adolescents (ages 9 to 17) use specialty mental health services in a year.

4.3.3 Human Services

The human services sector consists of social services, school-based counselling services, residential rehabilitation services, vocational rehabilitation, criminal justice/prison-based services, and religious professional counsellors. In the early 1980s, about 3 percent of U.S. adults used mental health services from this sector.

4.3.3.1 Employment

People with mental illnesses have one of the lowest rates of employment of any group with disabilities in the United States — only about 1 in 3 is employed. High unemployment occurs despite surveys that show the majority of adults with serious mental illnesses want to work, and that many could work with help. Unfortunately, according to recent reports, most people with serious mental illnesses do not receive any vocational rehabilitation services at all.

Many consumers with serious mental illnesses continue to rely on Federal assistance payments in order to have health care coverage, even when they have a strong desire to be employed. They face a financial disincentive to achieve full employment because they would lose Federal benefits if they become employed. Since most jobs open to these individuals have no mental health care coverage (according to a large, eight-State study, only 8% of people with mental illnesses who succeeded in returning to full time jobs had mental health coverage), they must choose between employment and coverage. Consequently, they depend on a combination of disability income and Medicaid (or Medicare), all the while preferring work and independence. In fact, they are the largest cohort — 35 percent — of those receiving federal income-assistance checks through the Social Security program for the disabled, called Supplemental Security Income (SSI). In this regard, Mr. Hogan told the Committee that:

> *The biggest single expenditure attributable to mental illness in this country is disability payments for people who have become disabled by mental illness. We send them a cheque every month. It is not adequate enough to live on. Essentially we make a deal with them that they have to stay disabled in order to get that cheque, which is a terrible situation. If we were to provide better care to them and help them get a job — it might not be a full-time, 40-hour job — everybody would be much better off.*

4.3.3.2 Housing

The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses. Today, millions of people in the United States with serious mental illnesses lack housing that meets their needs. The shortage of affordable housing and accompanying support services causes people with serious mental illnesses to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing. People with serious mental illnesses also represent a large percentage of those who are repeatedly homeless or who are homeless for long periods of time.

Of the more than two million adults in the U.S. who have at least one episode of homelessness in a given year, 46% report having had a mental health problem within the previous year. A recent study shows that people who rely solely on SSI benefits — as many people with serious mental illnesses do — have incomes equal to only 18% of the median income in the United States and cannot afford decent housing in any of the 2,703 housing market areas defined by the U.S. Department of Housing and Urban Development (HUD).

Federal public housing policies can make it difficult for people with poor tenant histories, substance use disorder problems, and criminal records — all problems common to many people with serious mental illnesses — to qualify for housing assistance or public housing units.

4.3.3.3 Services For Incarcerated People

About 7% of all incarcerated people in the United States have a current serious mental illness; the proportion with a less serious form of mental illness is substantially higher. People with serious mental illnesses in the U.S. who come into contact with the criminal justice system are often:

- Poor
- Uninsured
- Disproportionately members of minority groups
- Homeless
- Living with co-occurring substance abuse and mental disorders.

They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems.

When they are put in jail, people with mental illnesses frequently do not receive appropriate mental health services. Many lose their eligibility for income supports and health insurance benefits that they need to re-enter and re-integrate into the community after they are discharged.

4.3.3.4 Access To Services In Rural Areas

In rural and other geographically remote areas of the United States, many people with mental illnesses have inadequate access to care, limited availability of skilled care providers, lower family incomes, and greater social stigma for seeking mental health treatment than their urban counterparts. As a result, rural residents with mental health needs in the U.S.:

- Enter care later in the course of their disease than their urban peers
- Enter care with more serious, persistent, and disabling symptoms
- Require more expensive and intensive treatment response.

Compounding the problems of availability and access is the fact that rural Americans have lower family incomes and are less likely to have private health insurance benefits for mental health care than their urban counterparts. Moreover, while most big cities with medical schools have plenty of psychiatrists, smaller cities often do not have enough, and rural areas typically have none.

4.3.3.5 Services To Minorities

Recent reports indicate that the mental health system in the United States has not kept pace with the diverse needs of racial and ethnic minorities, often under-serving or inappropriately serving them. For instance, African Americans are more likely to be over-diagnosed for schizophrenia and under-diagnosed for depression. In general, reports indicate that the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems. In this regard, Mr. Emmet told the Committee:

> *In the United States, we are finding that specific communities — that is to say African Americans or the Latino- Hispanic population — really do not avail the public mental health system in great numbers. We know that there is a great deal of stigma involved. We do know, however, that they work through the churches and different community organizations to try to address their problems.*

As a result, American Indians, Alaska Natives, African Americans, Asian Americans, Pacific Islanders, and Hispanic Americans tend to bear a disproportionately high burden of disability from mental disorders. This higher burden does not arise from a greater prevalence or severity of illnesses in these populations. Rather, according to recent reports, it stems from receiving less care and poorer quality of care.

4.3.3.6 Services For Children

Almost 21 percent of children and adolescents (ages 9 to 17) in the United States had some evidence of distress or impairment associated with a specific diagnosis and also had at least a minimal level of impairment on a global assessment measure. Almost half of this group (almost 10 percent of the child/adolescent population) had some treatment in one or more sectors of the de facto mental health service system, and the remainder (more than 11 percent of the population) received no treatment in any sector of the health care system. This translates to a majority of children and adolescents with mental disorders in the U.S. not receiving any care. However, Mechanic and Bilder point to data that indicate that "children's mental health problems are receiving more attention than in earlier periods." In particular, they cite

> *Analyses by Sherry Glied and Alison Evans Cuellar of the 1987 and 1998 National Medical Expenditure Survey [that] noted a 60 percent increase in children with a treated disorder.*

Nonetheless, the General Accounting Office (GAO) recently issued a report that illustrates one serious consequence of the state of mental health services for children and adolescents in the U.S. Thousands of parents have felt themselves obliged to place their children into the child welfare or juvenile justice systems each year so that they may obtain the mental health services they need. Parents who have exhausted their savings and health insurance face the wrenching decision of surrendering their parental rights and tearing apart their families to secure mental health treatment for their troubled children. The GAO report estimates that, in 2001, parents were forced to place more than 12,700 children in the child welfare or juvenile justice systems as the last resort for those children to receive needed mental health care treatment. According to the President's Mental Health Commission, these numbers are actually likely an undercount because 32 states, including the five largest, were unable to provide data on the number of children affected.

According to the GAO report, several factors contribute to the practice of "trading custody for services," including:

- Limitations of both public and private health insurance
- Inadequate supply of mental health services
- Limited availability of services through mental health agencies and schools
- Difficulties meeting eligibility rules for services.

A lack of access to mental health treatment is thus leading thousands of parents to surrender custody of their children with severe psychiatric disorders to child-welfare agencies and juvenile detention solely to get treatment.

4.4 PROMOTION AND PREVENTION

There are many initiatives underway in the United States with regard to mental health promotion and the prevention of mental illness, substance abuse and addiction. For example, the Committee was told that the National Association of State Mental Health Program Directors is currently in the process of approving a position statement calling for the development of policies and practices for the:

- Promotion of positive mental health,
- Earliest possible identification and intervention in mental health problems,
- Reduction of the incidence of mental illness and suicide,
- Prevention of disability due to mental illness and co-occurring conditions, and
- Prevention of conditions commonly associated with mental illness, including medical illness, substance abuse, and trauma.

To further illustrate the concrete efforts being undertaken in this area, we concentrate below on the National Strategy for Suicide Prevention.

4.4.1 National Strategy for Suicide Prevention

The National Strategy for Suicide Prevention (National Strategy or NSSP) evolved out of a series of initiatives by both governmental and non-governmental actors in the late 90s. In early 2000, the Secretary of Health and Human Services officially established the National Strategy Federal Steering Group to facilitate its initiation.

The overall aims of the strategy are to:

- Prevent premature deaths due to suicide across the life span
- Reduce the rates of other suicidal behaviors
- Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends
- Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities.

The document, *Goals and Objectives for Action* was released in 2001 in order to articulate of a set of goals and objectives and to provide a roadmap for action. It presents the 11 goals and 68 objectives for this component of the National Strategy. A set of activities will be developed for each objective in the next phase of the NSSP.

The goals of the Strategy refer to broad and high-level statements of general purpose that are meant to guide planning around an issue, and that focus on the end result of the work. The objectives of the Strategy narrow the goal by specifying the who, what, when and where associated with obtaining the goal. Finally, activities specify how these objectives will be reached.

The Goals of the Strategy are to:

- Promote awareness that suicide is a public health problem that is preventable
- Develop broad-based support for suicide prevention
- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
- Develop and implement community-based suicide prevention programs
- Promote efforts to reduce access to lethal means and methods of self-harm
- Implement training for recognition of at-risk behavior and delivery of effective treatment
- Develop and promote effective clinical and professional practices
- Improve access to and community linkages with mental health and substance abuse services
- Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media
- Promote and support research on suicide and suicide prevention
- Improve and expand surveillance systems

The National Strategy is designed to serve as a model that can be adopted or modified by States, communities, and tribes as they develop their own suicide prevention plan. In this sense, the National Strategy is seen as articulating a framework for national efforts, while also seeking to assist local groups in making suicide prevention into a higher priority for action.

A significant next step that is envisaged as part of the National Strategy is to develop an operating structure or coordinating body that could become the national focus for prevention activities and provide a mechanism for engaging public will. The document *Goals and Objectives for Action* envisions this body as a public/private partnership, that could shepherd the development of an action agenda, although it acknowledges that, to expedite progress, the development of a coordinating body and an action agenda might have to proceed in tandem.

4.5 PROSPECTS FOR FUTURE REFORM

The President's New Freedom Commission on Mental Health, the first presidential mental health commission in 25 years, published its final report in July, 2003. The Commission was created by the White House in February 2001 as part of a broad cross-disability action plan, the New Freedom Initiative, that encompassed ten proposals designed to "tear down the barriers that face Americans with disabilities today."

Because Presidential attention to mental health is rare, the Commission set itself the goal of galvanizing change at all levels—not just in the federal government. Drawing on the experience of past commissions, the New Freedom Commission concluded that its objective should be to foster progress by staged, incremental, changes in major federal programs such as Medicaid, Medicare, and Social Security, rather than by seeking "big-bang" reform measures or increased support for specific mental health programs. Mr. Hogan explained the strategy behind the report to the Committee in these terms:

> *The logic of what our group proposed was to try to sidestep the notion of reform or reorganization. We had a sense that reform had gotten us into this mess, and we had to have a different language or concept. We ended up being galvanized around this notion of transformation. We do not know exactly what it means, but we think that this transformation means that actions are necessary at many levels. It is not just a federal problem such that the wisdom will flow out of the national capital and local people will adapt. We need local action as well and we need small and large actions, not just large and unachievable actions. For example, creating a situation wherein individual patients and families are more empowered in their own treatment sounds like a small change but, in the long run, it may be more potent or revolutionary than larger changes. We propose the idea of national vision for mental health care and the establishment of national goals, which we hope would serve to motivate and organize people…*

In addition to its interim (October, 2002) and final reports, the Commission also developed a series of detailed reports on components of mental health care that will be published later as working papers, in the hope that this will help create an agenda that could serve the field well in future years.

The interim report identified five major barriers to care:

- Fragmentation and gaps in care for children,
- Fragmentation and gaps in care for adults with serious mental illnesses,
- High unemployment and disability for people with serious mental illnesses,
- Lack of care for older adults with mental illnesses, and
- Lack of national priority for mental health and suicide prevention.

However, the aspect of the interim report that seemed to attract the most attention was the Commission's statement that, "the system is in shambles." This language was criticized by some as too strong, but the Commission stuck by its indictment of what it saw as a failed system in order to set the stage for strong recommendations in its final report.

The Final report is animated by a focus on the idea of recovery. Mr. Hogan told the Committee that they were inspired to adopt this orientation by a remark that former First Lady Rosalynn Carter made to them:

> *Ms. Carter said that…there was one thing that we have going for us today that did not exist a generation ago. One thing has changed that is more significant than anything else: we now understand today that recovery is possible for any individual with a mental illness.*

Recovery is seen by the Commission as a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment that could give people with mental illness a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. The Commission members united around the view that the possibility of improvement and hope should be available to all individuals who have a mental illness. Mr. Hogan amplified this point in his testimony to the Committee:

> *This is a simple but powerful statement that has several meanings in the mind of our commission. First, it is possible for people to get better even if we might have thought years ago that they were "hopeless cases." Second, even if people have a serious illness that may affect them for a decade or longer, they can achieve a good quality of life with the right kind of support. Recovery is not necessarily just a miracle cure but it can be a case of coping well with a devastating illness. Third, recovery for people in the mental health system is beginning to imply hope as a core ingredient of our approach to care, as opposed to a notion that is more passive and oriented to maintenance.*

In its report, the Commission identified the magnitude of the fragmentation of the system and recognized that the complexity of making changes in mental health care makes reform a daunting task. It was clear to the Commission that no single reform measure is sufficient to produce needed change, but also that simultaneous large-scale reform of multiple programs would be unlikely to lead to the desired change. In particular, the Commission emphasized the importance of developing individualized plans for treatment, although, as Mr. Hogan explained:

> *We do not know exactly how to do this, but we believe we need to move in the direction of care being more individualized and geared to a personalized effort so that the family and the individual have greater input and control of their care plan. That does not imply total control but rather a genuine partnership with professionals, as opposed to simply getting a diagnosis and taking the medicine.*

In order to create a shortlist of benchmarks to be tracked and monitored, the Commission proposed six national goals for mental health care, and organized its nineteen major recommendations around the achievement of these goals (see box below). Mr. Emmet stressed to the Committee that:

> *The six goals for transformation of the system laid out by the commission in its final report are actionable…at the local, state and federal levels. While the commission report is intentionally short on detail, it does provide a very useful and farsighted framework for getting at the central problem that was identified by the Surgeon General in his report — that is, we know what services work but we make it very difficult for those who need them to get them.*

The members of the Commission are under no illusion that their report, no matter how well received it is in the mental health community, will by itself transform a fragmented and often troubled system. However there are some signs that the current U.S. administration is prepared to follow through on implementing the report. The director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration (SAMHSA) was charged with taking the lead in developing the implementation approach. The administration also included in its proposed budget for fiscal year 2005 an appropriation of $44 million to fund the implementation of the comprehensive statewide planning recommendation contained in the report. While the budget has yet to be acted on, this proposal has received the strong endorsement of the mental health advocacy community.

The Commission hopes that its diagnosis and treatment plan will be able to build on the many strengths of the system—effective treatments, dedicated clinicians, passionate advocates, and the essential ingredient of hope. As Mr. Hogan noted in an interview, "developing a good treatment plan is necessary—but certainly not sufficient—for progress and recovery."

Mr. Hogan also pointed out that in order to be successful, implementation activities must be both "top-down" and "bottom-up." National leadership is needed for activities such as anti-stigma campaigns and for change in federal programs, while it is also necessary for people recovering from mental illness to demand greater participation in the development of their treatment plans. In his view, "only time will tell whether participants in mental health care can establish a shared commitment to the changes that are needed and whether the political and economic environments that we work in will allow, support, or thwart change."

It is worth noting that two other pieces of legislation, both with bipartisan support, are currently under consideration. They have been passed by the Senate and are awaiting action by the House of Representatives. The first would provide for youth suicide prevention efforts and counseling for college students. The second is the *Mentally Ill Offender Treatment and Crime Reduction Act*, which would authorize grants supporting collaborative community efforts to divert people with mental illness from the criminal justice system.

GOALS AND RECOMMENDATIONS OF THE PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH

GOAL 1 Americans Understand that Mental Health Is Essential to Overall Health.

- Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- Address mental health with the same urgency as physical health.

GOAL 2 Mental Health Care Is Consumer and Family Driven.

- Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- Involve consumers and families fully in orienting the mental health system toward recovery.
- Align relevant Federal programs to improve access and accountability for mental health services.
- Create a Comprehensive State Mental Health Plan.
- Protect and enhance the rights of people with mental illnesses.

GOAL 3 Disparities in Mental Health Services Are Eliminated.

- Improve access to quality care that is culturally competent.
- Improve access to quality care in rural and geographically remote areas.

GOAL 4 Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

- Promote the mental health of young children.
- Improve and expand school mental health programs.
- Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

GOAL 5 Excellent Mental Health Care Is Delivered and Research Is Accelerated.

- Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- Improve and expand the workforce providing evidence-based mental health services and supports.
- Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

GOAL 6 Technology Is Used to Access Mental Health Care and Information.

- Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- Develop and implement integrated electronic health record and personal health information systems.

4.6 COMMITTEE COMMENTARY

The Committee feels that there is much to learn from attempts made in the United States to grapple with the consequences of the fragmentation of mental health care services across multiple jurisdictions and various government departments. Fragmentation limits access to services and hampers the ability of service providers to share innovations and spread excellence.

The Committee was therefore very impressed with the general orientation of the report of the President's New Freedom Commission on Mental Health, especially its focus on patient-centred solutions. These include being animated by a vision of recovery for all, as well as insisting on the need to involve consumers in the design and implementation of individualized care plans. The Committee recognizes that there are many obstacles that stand in the way of transforming the Commission's vision into reality, many of which stem from the fragmentation of the system it describes in its reports.

The Committee also noted the strong place accorded to fostering research on mental health and mental illness and to promoting the adoption of technologies that will enhance care and service delivery, and recognizes that this is consistent with the pre-eminent international role occupied by American researchers and scientists.

Moreover, the Committee considers that the Report's emphasis on the provision of appropriate services at a community level is entirely appropriate and extremely important. Similarly, the Committee believes that American experience points to the critical importance of promoting greater cooperation across the various levels of government, and between various departments within each level of government.

Finally, the Committee notes that such an orientation requires a national focus in order to mobilize as many resources as possible, while simultaneously recognizing that efforts must be sustained at every level if reform is to occur. The fact that the New Freedom Commission eschewed a 'big bang' approach echoes the conclusions that the Committee reached with regard to the acute care sector in Canada in its October 2002 report on the Health of Canadians.

CHAPTER 5:
COMPARING MENTAL HEALTH CARE IN THE FOUR COUNTRIES STUDIED

5.1 INTRODUCTION

As was noted in the introduction to this report, the complexity of health care systems, both in terms of funding arrangements and service delivery mechanisms, as well as their inextricable connections to the history, politics and culture of each nation, mean that it is never possible simply to transpose measures from one jurisdiction to another. The common nature of many of the issues confronting health care policy makers and practitioners throughout the industrialized world means, however, that there is much that can be gained from careful study of both the successes and failures elsewhere in the world. In this chapter, the Committee draws on its review of the experience of four countries to glean some lessons for efforts in Canada to reform mental health care delivery and enhance the mental health of Canadians. The structure of this chapter follows the template that was used in each of the country studies.

5.2 HISTORY AND OVERVIEW

The Committee notes the striking extent to which the experience of deinstitutionalization is similar in all the countries reviewed. In the first place, roughly the same set of factors provided the impetus for deinstitutionalization in all them. These were:

- the introduction of new treatment methods, especially new drugs, accompanied by
- changing attitudes towards the nature of mental illness, and
- growing belief that treatment was most effective when it took place in the community.

Second, in each of the countries studied (as well as in Canada) the process of closing down old psychiatric hospitals proceeded more quickly than the deployment of new resources into the community, creating many situations where people living with mental illness were left to fend for themselves. Moreover, difficulties associated with the lack of resources to accomplish the shift to the community were often compounded by resistance to this transfer in the communities themselves, where attitudes built up over many years were slow to change.

A third point that is worth noting is the way in which, in several of the countries studied, deinstitutionalization was one of the factors that stimulated efforts to establish a national strategy for improving the delivery of services to people living with mental illness. This prompts the question as to why a similar process of deinstitutionalization that occurred in Canada did not yield the same result in this country, where the country remains without a national mental health, mental illness and addiction strategy of any kind to this day, in contrast to all other G8 countries.

It is tempting to look at the structure of Canadian federalism as one factor that may have played a role in discouraging a national focus on mental health. However, given that coherent national planning began in one of the federal countries studied (Australia) as early as 1992, the factor that explains the different trajectory in Canada cannot be federalism, *per se*.

Rather, a plausible hypothesis might be that because the federal government in Canada is not involved in the delivery of services to the population as a whole, it did not feel the pressure to respond to the massive shifts in service delivery that were occurring on the ground. Still, one could wonder why, given its role in the delivery of services to specific population groups (see Vol. 1, Ch. 9), the federal government did not draw the appropriate lessons from the weaknesses in its own delivery system and realize that the provinces had to be facing similar problems.

Finally, it is relevant to note that the trend for the federal government to transfer funds to the provinces with no strings attached (which culminated in the creation of the CHST in the mid-nineties), left the provinces to cope as best they could with the rapidly changing context in which mental health services were being delivered.

5.3 COSTS AND FUNDING OF MENTAL HEALTH SERVICES

A first point that the Committee wishes to emphasize with regard to comparisons of costs and funding across different countries concerns the comparability of the data. In presenting their data on spending on mental health, the authors of the 2002 National Mental Health Report in Australia make the important point that countries measure mental health spending in very different ways and that it is therefore extremely difficult to make direct comparisons. For example, they note (as indicated in the chapter on Australia) that some countries include amounts that are specifically excluded in Australian estimates such as drug and alcohol services, intellectual disability services, dementia care or housing and income security payments for mental health consumers.

In general, then, it would not appear to be possible to establish guidelines based on best practices with regard to overall mental health spending. However, there is enough data on spending trends over time within each country to draw provisional conclusions about the factors that contribute to greater attention being paid to mental health funding needs, and on ways of ensuring the sustainability of that funding. It is also possible to compare the funding priorities of different countries, although here the variability in the extent of data easily available from one country to the next constrains the robustness of the conclusions it is possible to draw.

Readers may have noticed that the data presented from Australia stands out for its level of detail and for the longitudinal comparisons it affords. The Australians have now produced seven National Mental Health Reports that allow for a much more detailed understanding of the evolution of mental health spending over time than is possible in any of the other countries studied. The Committee believes that this provides a clear indication of the value of consistent data collection and reporting.

Moreover, as the debate over the adequacy of mental health funding in England indicates, it is also important to look not only at absolute increases in the funding for mental health, but also at whether new investments in mental health are keeping pace with those in the broader health care sector. Thus, if growth in mental health spending lags behind growth in overall health care spending, then the relative position of the mental health sector suffers, even if more money is being spent. This is of particular importance in the context of attempting significant reform or when particular efforts are being made to bring spending in mental health into line with broader health spending.

A related point concerns the advisability of 'ring-fencing' mental health spending in order to ensure that funds allocated to treating mental illness do not get absorbed into general health spending, or to guarantee that transfers from one level of government to another represent real increases in mental health spending and are not clawed back by cutting existing services even as new ones are added. The Australian experience in this regard is worth highlighting. As witnesses told the Committee, new federal money was initially ring-fenced, but as the importance of this funding became widely appreciated over time by all levels of government, measures specifically designed to protect mental health resources were no longer needed.

The Committee believes that it is significant that in three of the four countries examined, the development of national mental health strategies correlates with increases in funding for mental health services and activities. As witnesses noted, the existence of a carefully documented set of needs in the mental health sector can constitute a powerful tool in lobbying government for the resources that are required. Moreover, the existence of clear benchmarks and targets are essential to making it possible to monitor the implementation of a national strategy, and to make sure that funding commitments are sustained over time. The evidence clearly indicates that the development and implementation of a national mental health strategy can only be successful if adequate resources are allocated to the task.

The Committee also notes the important efforts being made in some of the countries examined to decentralize funding decisions and bring them closer to the communities in which people live and access services. In particular, the experience of devolving the 'commissioning' of mental health services to the Primary Care Trusts in England provide a valuable reference point for attempts to bring control of funding closer to the ground and to have funding better adapted to local priorities. At the same time, the evidence also indicates that devolution is a complex undertaking and that along with the decentralization of decision-making must come a broad dissemination of the expertise needed to successfully manage the increased budgets involved.

Measures to control escalating costs are also important and, in particular, the rising costs of pharmaceuticals is of ongoing concern. In Canada, particular attention will have to be paid to this question, given the significant variations that exist in publicly funded prescription drug insurance across the country. Finally, the American experience with managed care is also relevant with regard to balancing efforts to contain costs against the importance of ensuring access to needed services and therapies.

5.4 SERVICE DELIVERY AND ORGANIZATION

As noted earlier, the first observation that needs to be made with regard to the delivery of mental health services is that a shift from primary reliance on institutional care to the primary emphasis being placed on services delivered in the community has happened in all the countries studied. This shift has been accompanied by concerns over the adequacy of the resources available at the community level to cope with the demand, as well as by the recognition of the need to coordinate and integrate service delivery so that the many 'silos' are broken down and each person has access to the services they require, regardless of which government department or agency (or non-governmental body) is responsible for their delivery.

Two institutions that stand out as having contributed to facilitating this transition are the independent Mental Health Commission in New Zealand and the National Institute for Mental Health in England (NIMHE). The Committee notes in particular that the former has played an important role both in helping to set service standards and in monitoring the implementation of mental health planning, while the latter has played a vital role in actual implementation and in spreading best practices. It is worth emphasizing that both countries developed highly detailed targets and standards (the Blueprint in New Zealand and the National Service Framework–Mental Health in England) as part of their respective strategies.

The importance placed on the individualization of care plans in New Zealand, the U.S. and England is also highly noteworthy. The growing emphasis on the ability of people living with mental illness to recover as well as on the need for practitioners to develop individualized, consumer-centred (and controlled) plans is having a significant effect on the approach to delivering mental health services in the community.

It would seem fair to conclude, as did Michael Hogan in the United States, that overcoming the fragmentation of service delivery requires action both from the top down and the bottom up. Managing the plethora of agencies and government bodies involved in the delivery of services can be assisted by having some outside, independent body that can take a 'whole-of-government' perspective. At the other end, the individualization of care plans and the coordination of service delivery can help all those who need them to access the services they require.

In every country reviewed, physicians and other providers involved in the delivery of primary care shoulder most of the responsibility for the largest portion of people receiving mental health services. At the same time, people living with serious and persistent mental illnesses continue to rely on the availability of more specialized mental health services. This has presented common challenges in all the countries surveyed. In the first place, there has been concern that family physicians are poorly remunerated for their efforts to provide mental health counseling and treatment by fee for service payment systems. Second, there has been concern that family physicians do not have access to sufficient resources to adequately deal with the scale of the demands they face relating to mental health care. Finally, the relative lack of coordination between primary and secondary care has repeatedly been raised as an issue and points to the crucial importance of delivering integrated, efficient care.

Despite, or perhaps because of, the shift in emphasis to providing care and service delivery in the community, inequities in access persist across a number of axes. It was noted in several countries that services to people living in rural areas are significantly less available than they are to people living in urban areas.

As well, there is widespread agreement that services targeted at minorities are not sufficiently tailored to their needs. Services need to be culturally appropriate if they are to be as accessible to these communities as they are to the majority ones. In particular, the training of health care professionals from minority groups, especially from Aboriginal or Indigenous communities, was identified by several countries as one means of encouraging a greater cultural appropriateness of mental health services.

This ties in with the final point the Committee wishes to note, namely the human resource shortages that exist in all of the countries studied, and that affect just about all providers involved in the delivery of mental health services. Shortages were still noted even in some countries, such as Australia and New Zealand, where increased mental health funding had led to increases in the supply of some provider groups. On the positive side, the Committee was impressed by efforts to formalize and credentialize the qualifications of community mental health workers as one way of increasing the human resource supply.

5.5 PROMOTION AND PREVENTION

The Committee notes that the evidence from its review of four countries would seem to support one of the lessons that was drawn in the recent (June 2004) British report on *Mental Health and Social Exclusion*. It concluded that uncoordinated campaigns of limited duration did not result in measurable change in stigmatizing attitudes, and pointed to the need for long-term funding for efforts to combat stigma and discrimination. On the other hand, according to witnesses and documentary evidence from both Australia and New Zealand, these countries have been able to measure changes in attitudes and behaviours as their ongoing campaigns against stigma and discrimination have unfolded over a number of years.

While it would be unwise to read too much into this evidence, there is nonetheless every reason to see it as supporting the need for sustained funding, long term planning, and ongoing evaluation, if campaigns against stigma and discrimination are to maximize their effect. Moreover, these campaigns would seem to benefit from being adaptable to a variety of circumstances so that they can be acted on by different jurisdictions.

Thus, the 'Like Minds, Like Mine' campaign in New Zealand started out using famous New Zealanders to communicate its message, but later shifted to a focus on 'ordinary' people and their families. It is also worth noting that as they began to see some progress in changing stigmatizing attitudes, the campaign in New Zealand has evolved towards placing greater emphasis on reducing discrimination. Australian experience suggests the value of having campaigns operate at national, regional and local levels, as well as the need to target the stigmatization of specific illnesses alongside broader themes.

The design of the American National Strategy for Suicide Prevention also points to the importance of using national resources in a way that can set an example for smaller jurisdictions and encourage them to adapt national models to their particular requirements. At the same time, the experience in a number of countries underscores the importance of having a body that can become the focus for national efforts to combat stigma and discrimination and can play a role in coordinating them at the national level.

Building a strategy for monitoring the outcomes of these efforts into the design of the campaigns themselves is also strongly suggested by our international review. This, in turn, points to the need for there to be widespread consultation from the outset amongst the various levels of government, providers, NGOs as well as users of mental health services and their families. In addition, there is evidence that reaffirms the benefits of enabling people with experience of mental disorders to tell their stories as a way of combating stigma, as well as of the importance of working with the media to try to eliminate negative stereotypes and replace them with more positive accounts of people living with mental illness.

Finally, the Committee found that the design of the new English campaign proposed in the report on *Mental Health and Exclusion* to be quite comprehensive, and wishes to highlight its main emphases. It will:

- target key audiences, in particular employers, young people and the media;
- deliver consistent, tested messages under a single brand;
- promote the positive contribution that people with mental health problems can make to society;
- have sustained funding to plan ahead;
- address issues of ethnicity and gender;
- provide a framework and materials to support local campaign work, targeting in particular issues facing deprived neighbourhoods;
- be clearly evaluated by a regular survey.

5.6 PROSPECTS FOR FUTURE REFORM

It is clear to the Committee from this four-country survey that reform strategies must be carefully adapted to the particular circumstances confronted by each country. Not only must the state of mental health services and care be carefully assessed to establish priorities for action, but the complex realities of each country's political system and social values must be taken into account in the design of any reform program.

In this vein, the Committee notes that the precise design and implementation of reform strategies in countries that have unitary forms of government are likely to prove difficult to adapt to the Canadian federal context, where the delivery of health care services to the general population remains the constitutional responsibility of the provinces. Nonetheless, the specific and detailed targets and standards that have been the hallmark of reform efforts in both England and New Zealand (which are both unitary states) provide an invaluable reference point. Moreover, each country, whether it is structured as a unitary or federal state, has multiple levels within its health care system, and ongoing attempts to coordinate mental health reform across these various jurisdictions constitute a further indication of the importance of undertaking action at all levels.

The Committee also notes the obvious advantages of engaging in a long term, integrated planning process to improve the state of mental health and the delivery of mental health care services in all the countries surveyed. Only such a process allows for the possibility of systematically building on each successive iteration of reform planning, and also greatly increases the chances of adapting reform efforts to changing circumstances.

Finally, the complexity and range of services involved in promoting mental health and providing for the needs of people living with mental illness suggest that a 'big bang' reform initiative that attempts to do everything at once is unlikely to succeed. This further implies that reform efforts must simultaneously tackle problems from the 'top down' and the 'bottom up'.

5.7 COMMITTEE COMMENTARY

With regard to the broad outlines of the mental health strategies that have been adopted in the four countries studied, the Committee believes that there are a number of trends that are worth highlighting:

- A tendency to focus on recovery as the vision that animates mental health thinking, where recovery is understood as a process of positive adaptation to illness and disability that could give people with mental illness a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness;
- A growing emphasis on the need for individualized plans for treatment and care (especially for people living with serious mental illness) as well as a recognition that family and consumer participation in the planning of treatment should be encouraged;
- The reaffirmation of the need to deliver services in the community, as well as insisting on the importance of the ongoing monitoring of their delivery and of striving to integrate them to the greatest extent possible (so that the limitations imposed by service delivery in 'silos' can be overcome);
- The importance of deploying national resources towards mental health promotion, in particular with regard to campaigning against stigma and working to diminish discrimination;
- The need to eliminate disparities in the extent of services available to people, whether these disparities are caused by services being offered in culturally inappropriate ways, or by the unavailability of some services in rural regions of the country.

The unifying factor behind all these elements would appear to be a stronger focus on the organization of services to best meet patient or service user needs, an emphasis the

Committee strongly endorses, and which echoes the patient-centred approach the Committee advocated for the acute care sector as well. The means for achieving these objectives that stands out from our survey of four countries is to set actionable targets that engage the entire mental health community, and to establish measurable criteria for the ongoing monitoring of reform efforts. Comprehensive human resource planning in the mental health field, as well as adequate funding for research and its dissemination are also suggested as key elements of a national strategy to foster mental health and treat mental illness.

APPENDIX A:
LIST OF WITNESSES IN THIRD SESSION OF THE 37TH PARLIAMENT
(FEBRUARY 2, 2004 – MAY 23, 2004)

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Alzheimer Society of Canada	Steve Rudin, Executive Director	June 4, 2003	17
As individuals	Thomas Stephens, Consultant	March 20, 2003	11
	Nancy Hall, Mental Health Consultant	May 28, 2003	16
	J. Michael Grass, Past Chair, Champlain District Mental Health Implementation Task Force	June 5, 2003	17
	Loïse David Murray Ronald	February 26, 2003	9
Canadian Academy of Psychiatric Epidemiology	Dr. Alain Lesage, Past President	March 19, 2003	11
Canadian Academy of Psychiatry and the Law	Dr. Dominique Bourget, President	June 5, 2003	17
Canadian Coalition for Senior Mental Health	Dr. David K. Conn, Co-Chair; President, Canadian Academy of Geriatric Psychiatry	June 4, 2003	17
Canadian Institute for Health Information	Dr. John S. Millar, Vice-President, Research and Analysis	March 20, 2003	11
	Carolyn Pullen, Consultant		
	John Roch, Chief Privacy Officer and Manager, Privacy Secretariat		
Canadian Institutes of Health Research	Bronwyn Shoush, Board Member, Institute of Aboriginal Peoples' Health	May 28, 2003	16

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Canadian Institutes of Health Research	Jean-Yves Savoie, President, Advisory Board, Institute of Population and Public Health	June 12, 2003	18
	Dr. Rémi Quirion, Scientific Director, Institute of Neurosciences, Mental Health and Addiction	May 6, 2003	14
Canadian Mental Health Association – Ontario Division	Patti Bregman, Director of Programs	June 12, 2003	18
Canadian Paediatric Society	Dr. Diane Sacks, President-Elect	May 1, 2003	13
	Marie-Adèle Davis, Executive Director		
Centre for Addiction and Mental Health	Jennifer Chambers, Empowerment Council Coordinator	May 14, 2003	15
	Rena Scheffer, Director, Public Education and Information Services	May 28, 2003	16
Centre hospitalier Mère-enfant Sainte-Justine	Dr. Joanne Renaud, Child and Adolescent Psychiatrist; Young Investigator, Canadian Institutes of Health Research	April 30, 2003	13
Children's Hospital of Eastern Ontario	Dr. Simon Davidson, Chairman, Division of Child and Adolescent Psychiatry	May 1, 2003	13
CN Centre for Occupational Health and Safety	Kevin Kelloway, Director	June 12, 2003	18
Douglas Hospital	Eric Latimer, Health Economist	May 6, 2003	14
	Dr. James Farquhar, Psychiatrist		
	Dr. Mimi Israël, Head, Department of Psychiatry ; Associate Professor, McGill University		

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Douglas Hospital	Myra Piat, Researcher	May 6, 2003	14
	Ampara Garcia, Clinical Administrative Chief, Adult Ultraspecialized Services Division		
	Manon Desjardins, Clinical Administration Chief, Adult Sectorized Services Division		
	Jacques Hendlisz, Director General		
	Robyne Kershaw-Bellmare, Director of Nursing Services		
Global Business and Economic, Roundtable and Addiction and Mental Health	Rod Phillips, President and Chief Executive Officer, Warren Sheppell Consultants	June 12, 2003	18
Hamilton Health Sciences Centre	Venera Bruto, Psychologist	June 4, 2003	17
Health Canada	Tom Lips, Senior Advisor, mental Health, Healthy Communities Division, Population and Public Health Branch	March 19, 2003	11
	Pam Assad, Associate Director, Division of Childhood and Adolescence, Centre for Healthy Human Development, Population and Public Health Branch	April 30, 2003	13
Laval University	Dr. Michel Maziade, Head, Department of Psychiatry, Faculty of Medecine	May 6, 2003	14
Louis-H. Lafontaine Hospital	Jean-Jacques Leclerc, Director, Rehabilitation Services and Community Living	May 6, 2003	14
	Dr. Pierre Lalonde, Director, Clinique jeunes adultes		

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
McGill University	Dr. Howard Steiger, Professor, Psychiatry Department; Director, Eating Disorders Program, Douglas Hospital	May 1, 2003	13
Province of British Columbia	Patrick Storey, Chair, Minister's Advisory Council on Mental Health	May 14, 2003	15
	Heather Stuart, Associate Professor, Community Health and Epidemiology	May 14, 2003	15
Queen's University	Dr. Julio Arboleda-Florèz, Professor and head, Department of Psychiatry	March 20, 2003	11
Registered Nurses of Canada	Margaret Synyshyn, President	May 29, 2003	16
Statistics Canada	Lorna Bailie, Assistant Director, Health Statistics Division	March 20, 2003	11
St.Joseph's Health Care London	Maggie Gibson, Psychologist	June 4, 2003	17
St. Michaels Hospital	Dr. Paul Links, Arthur Sommer Rothenberg Chair in Suicide Studies	March 19, 2003	11
Université du Québec à Montréal	Henri Dorvil, Professor, School of Social Work	May 6, 2003	14
	Dr. Michel Tousignant, Professor, Centre de recherche et intervention sur le suicide et l'euthanasie		
University of British Columbia	Dr. Charlotte Waddell, Assistant Professor, Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, Faculty of Medecine	May 1, 2003	13

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
University of Calgary	Dr. Donald Addington, Professor and Head, Department of Psychiatry	May 29, 2003	16
University of Manitoba	John Arnett, Head, Department of Clinical Health Psychology, Faculty of Medicine	May 28, 2003	16
	Robert McIlwraith, Professor and Director, Rural and Northern Psychology Program		
University of Montreal	Laurent Mottron, Researcher, Department of Psychiatry, Faculty of Medicine	May 6, 2003	14
	Dr. Richard Tremblay, Canada Research Chair in Child Development, Professor of Pediatrics, Psychiatry and Psychology, Director, Centre of Excellence for Early Childhood Development		
	Dr. Jean Wilkins, Professor and Paediatrics, Faculty of Medecine		
	Dr. Renée Roy, Assistant Clinical Professor, Department of Psychiatry, Faculty of Medecine		
University of Ottawa	Tim D. Aubry, Associate Professor; Co-Director, Centre for Research and Community Services	June 5, 2003	17
	Dr. Jeffrey Turnbull, Chairman, Department of Medicine, Faculty of Medicine		

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
University of Toronto	Dr. Joe Beitchman, Professor and Head, Division of Child Psychiatry, Department of Psychiatry; Psychiatrist-in-Chief, Hospital for Sick Children	April 30, 2003	13
	Dr. David Marsh, Clinical Director, Addiction Medicine, Centre for Addiction and Mental Health	May 29, 2003	16

APPENDIX B:
LIST OF WITNESSES
IN THE SECOND SESSION OF THE 37^{TH} PARLIAMENT
(SEPTEMBER 30, 2002 – NOVEMBER 12, 2003)

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Alberta Mental Health Board	Ray Block, Chief Executive Officer	April 28, 2004	7
Alberta Mental Health Board	Sandra Harrison, Executive Director, Panning, Advocacy & Liaison	April 28, 2004	7
Anxiety Disorders Association of Canada	Peter McLean, Vice-President	May 12, 2004	9
As individuals	Charles Bosdet	April 29, 2004	7
	Pat Caponi		
	Don Chapman		
Australia, Government of *(by videoconference)*	Dermot Casey, Assistant Secretary, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing	April 20, 2004	6
	Jenny Hefford, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing		
British Columbia Ministry of Health Services	Irene Clarkson, Executive Director, Mental Health and Addictions	April 28, 2004	7
Canadian Association of Social Workers	Stephen Arbuckle, Member, Health Interest Group	March 31, 2004	5
Canadian Medical Association	Dr. Sunil Patel, President	March 31, 2004	5
	Dr. Gail Beck, Acting Associate Secretary General		
Canadian Mental Health Association	Penny Marrett, Chief Executive Officer	May 12, 2004	9

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Canadian Nurses Association, the Canadian Federation of Mental Health Nurses and the Registered Psychiatric Nurses of Canada	Nancy Panagabko, President, Canadian Federation of Mental Health Nurses	March 31, 2004	5
	Annette Osten, Board Member, Canadian Nurses Association	March 31, 2004	5
Canadian Psychiatric Association	Dr. Blake Woodside, Chairman of the Board	March 31, 2004	5
Canadian Psychological Association	John Service, Executive Director	March 31, 2004	5
Centre for Addiction and Mental Health	Christine Bois, Provincial Priority Manager for Concurrent Disorders	May 5, 2004	8
	Wayne Skinner, Clinical Director, Concurrent Disorder Program		
	Brian Rush, Research Scientist, Social Prevention and Health Policy		
Centre for Suicide Prevention	Diane Yackel, Executive Director	April 21, 2004	6
Cognos	Marilyn Smith-Grant, Senior Human Resources Specialist	April 1, 2004	5
Correctional Service of Canada	Larry Motiuk, Director General, Research	April 29, 2004	7
	Françoise Bouchard, Director General, Health Services	April 29, 2004	7
Douglas Hospital	Dr. Gustavo Turecki, Director, McGill Group for Suicide Studies, McGill University	April 21, 2004	6
House of Commons	The Honourable Jacques Saada, P.C., M.P., Leader of the Government in the House of Commons and Minister responsible for Democratic Reforms	April 1, 2004	5

Human Resources and Skills Development Canada	Bill Cameron, Director General, National Secretariat on Homelessness	April 29, 2004	7
Human Resources and Skills Development Canada	Marie-Chantal Girard, Strategic Research Manager, National	April 29, 2004	7
Institute of Neurosciences, Mental Health and Addiction	Richard Brière, Assistant Director	April 21, 2004	6
McGill University *(by videoconference)*	Dr. Laurence Kirmayer, Director, Division of Social and Transcultural Psychiatry, Department of Psychiatry	May 13, 2004	9
Mood Disorder Society of Canada	Phil Upshall, President	May 12, 2004	9
Native Mental Health Association of Canada	Brenda M. Restoule, Psychologist and Ontario Board Representative	May 13, 2004	9
New Zealand, Government of *(by videoconference)*	Janice Wilson, Deputy Director General, Mental Health Directorate, Ministry of Health	May 5, 2004	8
	David Chaplow, Director and Chief Advisor of Mental Health		
	Arawhetu Peretini, Manager of Maori Mental Health		
	Phillipa Gaines, Manager of Systems Development of Mental Health		
Nova Scotia Department of Health	Dr. James Millar, Executive Director, Mental Health and Physician Services	April 28, 2004	7
Ontario Federation of Community Mental Health and Addiction	David Kelly, Executive Director	May 5, 2004	8
Ontario Hospital Association	Dr. Paul Garfinkel, Chair, Mental Health Working Group	March 31, 2004	5

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Privy Council Office	Ron Wall, Director, Parliamentary Operations, Legislation and House Planning	April 1, 2004	5
	Ginette Bougie, Director, Compensation and Classification		
Public Service Alliance of Canada	John Gordon, National Executive Vice-President	April 1, 2004	5
	James Infantino, Pensions and Disability Insurance Officer		
Schizophrenia Society of Canada	John Gray, President-Elect	May 12, 2004	9
Simon Fraser University *(by videoconference)*	Margaret Jackson, Director, Institute for Studies in Criminal Justice Policy	April 29, 2004	7
Six Nations Mental Health Services	Dr. Cornelia Wieman, Psychiatrist	May 13, 2004	9
Treasury Board Secretariat	Joan Arnold, Director, Pensions Legislation Development, Pensions Division	April 1, 2004	5
U.S. Campaign for Mental Health Reform	William Emmet, Coordinator	April 1, 2004	5
U.S. President's New Freedom Commission on Mental Health *(by videoconference)*	Michael Hogan, Chair	April 1, 2004	5
United Kingdom, Government of *(by videoconference)*	Anne Richardson, Head of the Mental Health Policy Branch, Department of Health	May 6, 2004	8
	Adrian Sieff, Head of the Mental Health Legislation Branch		

APPENDIX C:
LIST OF INDIVIDUALS WHO RESPONDED TO A LETTER FROM THE COMMITTEE ON PRIORITIES FOR ACTION

CANADIAN RESEARCH GROUP

CancerCare Manitoba	Harvey Max Chochinov, MD, PhD, FRCPC, Canada Research Chair in Palliative Care, Director, Manitoba Palliative Care Research Unit, CancerCare Manitoba, Professor, Department of Psychiatry, Community Health Sciences and Family Medicine(Division of Palliative Care) University of Manitoba
Carleton University	Dr. Hymie Anisman, Canadian Research Chair in Neuroscience, Ontario Mental Health Foundation Senior Research Fellow
Douglas Hospital Reseach Centre	Ashok Malla, MD, FRCP Canada Research Chair in Early Psychosis, Professor of Psychiatry, McGill University, Director, Clinical Research Division
McGill University Health Centre	Eric Fombonne, MD, FRCPsych, Canada Research Chair in Child Psychiatry, Professor of Psychiatry, University McGill, Director, Montreal Children's Hospital
University of Alberta	Glen B. Baker, PhD, DSc, Professor and Chair, Canada Research Chair in Neurochemistry and Drug Development
University of Manitoba – Faculty of Medecine	Brian J. Cox, Ph.D., C. Psych., Canada Research Chair in Mood and Anxiety Disorders, Associate Professor of Psychiatry, Adjunct Professor, Departments of Community Health Sciences and Psychology

DEANS OF MEDICAL SCHOOLS

Kingston General Hospital	Samuel K. Ludwin, M.B.B., Ch., F.R.C.P.C., Vice-President, (Research Development)
McGill University Health Centre	Joel Paris, M.D., Professor and Chair, Department of Psychiatry
University of Alberta	Dr. L. Beauchamp, Dean, Faculty of Eduction
University of Sherbrooke	Pierre Labossière, P. Eng., Ph.D., Associate Vice-Rector, Research
University of Western Ontario	Dr. Carol P. Herbert, Dean of Medicine and Dentistry

ILLNESS RELATED GROUP

Canada's Research-Based Pharmaceutical Companies	Murray J. Elston, President
Eli Lilly Canada Inc.	Terry McCool, Vice-President, Corporate Affairs
GlaxoSmith Kline	Geoffrey Mitchinson, Vice-President of Public Affairs
Merck Frosst Canada	André Marcheterre, President
NSERC	Thomas A. Brzustowski, President
Ontario Mental Health Foundation	Howard Cappell, Ph.,D. (C.Psych) Executive Director
Roche Pharmaceuticals	Ronnie Miller, President & C.E.O.
Schizophrenia Society of Canada	Fred Dawe, President

MENTAL HEALTH ETHICS GROUP

Centre for Addiction and Mental Health	Paul E. Garfinkel, MD, FRCPC, President and CEO
McGill University – Douglas Hospital Research Centre	Maurice Dongier, Professor of Psychiatry

Parkwood Hospital, St.Joseph's Health Care London	Maggie Gibson, Ph. D., Psychologist, Veterans Care Program
Queen's University	J. Arboleda-Florèz, Professor and Head, Department of Psychiatry
Salvation Army – Territorial Headquarters Canada and Bermuda	Glen Shepherd, Colonel, Chief Secretary
St-Paul's Hospital	Mark Miller, C.S.s.R., Ph.D. Ethicist
University of Alberta	Wendy Austin, RN, Ph. D., Canada Research Chair, Relational Ethics in Health Care, Faculty of Nursing and John Dosseter Health Ethics Centre
University of Alberta, Faculty of Nursing	Genevieve Gray, Dean and Professor, Faculty of Nursing
University of British Columbia	Peter D. McLean, Ph.D. Professor and Director, Anxiety Disorders Unit
University of Western Ontario	Nancy Fedyk, Executive Assistant to the Dean
Winnipeg Regional Health Authority	Linda Hughes, Chair, WRHA Mental Health Ethics Committee
York University	David Shugarman, Director

PRESIDENT OF UNIVERSITY

Institute of Mental Health Research – University of Ottawa	Zul Merali, Ph. D., President and CEO
McGill University	Heather Munroe-Blum, Professor of Epidemiology and Biostatistics
University of Lethbridge	Lynn Basford, Dean, Health Sciences

GOVERNMENT RESPONSIBILITY

Canadian Coalition for Seniors	J. Kenneth Le Clair, MD, FRCPC, Co-Chair, Canadian Coalition for Seniors Mental Health, Professor and Chair, Geriatric Division, Department of Psychiatry, Queen's University, Clinical Director, Specialty Geriatric Psychiatry Program
Canadian Coalition for Seniors Mental Health	David K. Conn, MB., FRCPC, Co-Chair Canadian Coalition for Seniors Mental Health, Psychiatrist-in-Chief, Department of Psychiatry, Baycrest Centre for Geriatric Care, Associate Professor, Department of Psychiatry, University of Toronto, President, Canadian Academy of Geriatric Psychiatry
Canadian Institute of Health Research	Dr. Jeff Reading, PhD, Scientific Director – Institute of Aboriginal Peoples's Health
Canadian Mental Health Association	Bonnie Pape, Director of Programs & Research, Canadian Mental Health Association – National Office
Dalhousie University – Department of Psychology	Patrick J. McGrath, OC, PhD, FRSC, Co-ordinator of Clinical Psychology, Killam Professor of Psychology, Professor of Pediatrics and Psychiatry, Canada Research Chair, Psychologist IWK Health Centre
Dalhousie University, Faculty of Medicine	David Zitner, D. Ph., Director, Medical Informatics
Department of Health and Wellness New-Brunswick	Ken Ross, Assistant deputy Minister
Douglas Hospital Research Centre	Michel Perreault, Ph. D., Researcher, Douglas Hospital, Professor, Department of Psychiatry McGill University
Douglas Hospital Research Centre - Institute of Neurosciences, Mental Health and Addiction	Rémi Quirion, Scientific Director, (INMHA)

Faculty of Medicine – University of Ottawa	Jacques Bradwejn, MD FRCPC, DABPN, Chair of the Department of Psychiatry, Psychiatris-in-Chief, Royal Ottawa Hospital, Head of Psychiatrist, The Ottawa Hospital
Family Council: Empowering Families in Addictions and Mental Health	Betty Miller, Coordinator, The Family Council
Global Business and Economic Roundtable on Addiction and Mental Health – Affiliated with the Centre for Addiction and Mental Health	Bill Wilkerson, Co-Founder and Chief Executive Officer
Human Resources Development Canada	Deborah Tunis, Director General, Office for Disability Issues
McGill University Health Centre	Juan C. Negrete, MD, FRCP(C) Professor of Psychiatry, McGill University, Chair, Addictions Section, Canadian Psychiatric Association
McMaster University	Dr. Richard P. Swinson, MD, FRCPC, Morgan Firestone Chair in Psychiatry, Psychiatry & Behavioural Neurosciences, McMaster University, Chief, Department of Psychiatry, St.Joseph's Healthcare
NAHO National Aboriginal Health Organization	Judith G. Bartlett, M.D. CCFP, Chairperson
Ottawa Hospital	Paul Roy, MD, FRCPC, Assistant Professor of Psychiatry, University of Ottawa, Director, Ottawa First Episode Psychosis Program
Royal Ottawa Hospital	J. Paul Fedoroff, M.D., Associate Professor of Psychiatry, University of Ottawa, Research Director, Forensic Unit, Institute of Mental Health Research
Six Nations Mental Health Services	Cornelia Wieman, M.D., FRCPC, Psychiatrist
Syncrude	Eric P. Newell, Chairman & Chief Executive Officer

University of British Columbia – Mental Health Evaluation & Community Consultation Unit, Department of Psychiatry	Elliot Goldner, MD, MHSc, FRCPC, Head, Division of Mental Health Policy & Services
University of Ottawa – Office of the Vice-President, Research	Yvonne Lefebvre, Ph.D., Associate Vice-President, Research
University of Ottawa- School of Psychology	John Hunsley, Ph.D., C. Psych., Professor of Psychology
University of Toronto – Sunnybrook & Women's College Health Sciences Centre	Nathan Herrmann, M.D., F.R.C.P. (C)