

## Comparative mental health policy: Are there lessons to be learned?

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### Summary

The development of an excellent mental health system at the national level or even the state or provincial jurisdiction resembles the search for the Holy Grail. We are not there yet, and some stakeholders doubt we will ever get there. The last 20 years has seen an explosion of progressive mental health policy statements in a number of jurisdictions. However, it is difficult to find national mental health systems that are performing well. This paper reviews the status of national mental health policy in Australia, the UK, the USA and New Zealand. It examines the evolution of mental health policy in Ontario, Canada, and provides some commentary on how the Ontario experience is consistent with the experience of other jurisdictions. Finally it explores whether there are lessons to be learned that can be applied in Canada and elsewhere.

### Introduction

The development of an excellent mental health system at the national level or even the state or provincial jurisdiction resembles the search for the Holy Grail. We are not there yet, and some stakeholders doubt we will ever get there. Senator Michael Kirby, who is conducting a review of Canada's mental health (non) systems recently pointed out that Canada is the only OECD country without a national mental health policy. In November 2004 he will be releasing a report, which will include an analysis of progress in the UK, Australia and New Zealand—countries that do have national mental health policies. The assumption here is that countries with national mental health policies do better than those who don't.

The last 20 years has seen an explosion of progressive mental health policy statements in a number of jurisdictions. However, it is difficult to find national mental health systems that are performing well. In fact it is more likely that there are some communities or regions that perform well even if the national system does not.

In the early 1990's E. Fuller-Torrey and colleagues published a study that showed that Canada's Greater Vancouver Mental Health Service was producing better client outcomes for people with serious mental illness than managed care mental health services in the USA (Fuller-Torrey, Bigelow & Sladen-Dew, 1993). Canadians generally ignored the

results, likely because, as Fuller-Torrey suggested in answer to a question about the study, having a superior mental health system was akin to being the smartest kid in a dumb class. Robert Rosenheck and colleagues compared 18 communities in the USA examining whether the nine communities with mental health authorities produced better outcomes for mentally ill homeless people, than those without authorities, and found no evidence that mental health authorities produced better clinical outcomes (Randolf et al., 2002).

A few years ago the author found that a number of parishes in Jamaica had developed innovative community programs, which targeted people with serious mental illness, even though the national government spent its entire mental health budget on the Bellevue asylum. SCARF in Chennai, India is another example of a community-based psychiatric rehabilitation program that operates in a poor performing national mental health system environment.

This paper will briefly review the status of national mental health policy in Australia, the UK, the USA and New Zealand. It will then examine the evolution of mental health policy in Ontario, Canada, and provide some commentary on how the Ontario experience is consistent with the experience of other jurisdictions. Finally it will examine whether there are lessons to be learned that can be applied in Canada and elsewhere.

Responsibility for mental health care is shared between national and state or provincial levels of

government in Canada, Australia and the USA where state or provincial governments have the main responsibility for funding and service delivery. In the UK and New Zealand the national government has the responsibility for mental health funding and service delivery.

Unlike the USA, UK, Australia, and New Zealand, Canada does not have a national mental health policy, although a number of groups have called for one, and the Romanow Commission on the Future of Health Care (2002) identified mental health care as the orphan child of health care.

We turn now to an examination of each country's national mental health policy.

### **Australia**

Historically, the provision of mental health care has been a responsibility of the state government. Australia's national government showed little interest in mental health care until 1992 when it announced the National Mental Health Policy. The goal was 'a seamless set of relationships from inpatient ward to community support' and the policy framework included increased federal funding, priority for people with serious mental illness, enhanced consumer rights and a strategy to involve general practitioners as providers of primary care (Shera, Aviram, Healy & Ramon, 2002). National government funding was provided on a matching basis to help the states shift care from institutions to a community-focused system and benchmarking was used to measure progress. A second mental health plan followed in the late 1990s. In 2001 an external review was commissioned to assess progress. Betts and Thornicroft's review (2001) commended Australia for policy leadership and tabled numerous recommendations to ensure the shift to a community focused mental health system.

An analysis of these recommendations indicates that while there has been substantial progress since the 1992 National Mental Health Plan, much remains to be done. Betts and Thornicroft (2001) recommended the development and implementation of a third national mental health plan to maintain the reform momentum.

### **The United Kingdom**

The UK began an aggressive program of psychiatric hospital closure in the 1990s. By 2000 it closed 90 of its 120 psychiatric hospitals and moved the bulk of its long-stay psychiatric patients to group homes and community care (Shera et al., 2002). In 1999 the government published a National Service Framework to guide its investment of £700 million

to improve mental health services. The framework has the following features:

- Sets standards and defines service models.
- Standards cover mental health promotion, primary care and access to services, service effectiveness, help for carers, reducing suicide.
- Includes implementation plan and monitoring regime.
- MH trust ratings are now available on the NHS website.
- Promotes pooled funding and partnerships with primary care and social care systems.

The National Service Framework caps a decade of activity which successfully transferred long-stay patients to community settings, but has yet to resolve the care of revolving-door or 'new long-stay' patients. There has been an expansion of community treatment teams since 1985 (Shera et al., 2002). On the legislative front, there is continuing debate on amending legislation to more easily commit patients to hospitals and community treatment.

Despite the policy advances and achievements shifting care to the community, mental health services in the UK are getting mixed reviews. The Commission for Health Improvement (CHI) recently reviewed the performance of mental health trusts. In language remarkably similar to Canada's Romanow Commission, the CHI chief executive said, 'Mental health services have historically been given low priority. Unfortunately, despite evident progress, mental health is still the poor relation of the NHS' (Commission For Health Improvement, 2003).

The report found that while some mental health trusts were performing well, particularly in the areas of user involvement, innovative practices, and links with community organizations, there are significant problems:

- National shortages of psychiatrists and nurses.
- Poor physical facilities for service provision.
- Pressures on inpatient beds.
- Poor information systems and significant lack of management capacity.
- Low priority for services to the elderly and children.

The Commission noted that the mergers of a number of mental health trusts had destabilized local systems and had not contributed to improved care and outcomes.

### **The United States of America**

Between 1960 and 1980 the USA closed the bulk of their state hospital beds and turned their policy attention to the development of community

support systems. During the 1970s the National Institute for Mental health (NIMH) developed a community support system model, which proposed providing a basket of comprehensive, flexible and individualized support services to people with serious and persistent mental illness. During the 1980s and 1990s the USA government and its agencies provided block grants and demonstration project funding to states and local communities to implement 'wrap around' services such as intensive case management, supportive housing, or assertive community treatment teams. During the Carter administration, (1976–1980) legislation that focused on the provision of community support services to the seriously mentally ill was drafted but not passed.

In the late 1980s the Robert Wood Johnson Foundation funded demonstration projects in nine communities to test whether mental health authorities would result in improved care. While the projects were able to demonstrate improved system coordination, expansion of case management and access to housing, evaluations showed no improvements in clinical outcomes (Morrisey et al., 1992).

The 1980s and 1990s also saw the advent of managed care. Some states delegated responsibility for the provision of care to private behavioural health companies and some states such as Tennessee witnessed the collapse of state mental health plans, because the capitation rates were set too low. Other states such as Ohio were successful in shifting their public mental health systems to comprehensive community care for people with serious mental illness.

However, when the President's New Freedom Commission presented its report in 2003, it called for a radical transformation of mental health services, because their review, like the Surgeon General's report before it, found major problems across the country. The report found system problems including: stigma, limitations due to private insurance and fragmented service delivery. The Commission recommended a transformed system to promote recovery and 'replace unnecessary institutional care with efficient, effective community services that people can count on' (President's New Freedom Commission, 2003).

Six goals for USA mental health services are proposed along with recommended implementation strategies:

- Americans understand mental health is essential to overall health through.
- National campaigns to reduce the stigma of mental illness and recognition that government must address mental health with the same urgency as physical health.
- Mental health care is consumer and family driven by providing individual care plans for adults and

children with mental health problems and rights protection.

- Disparities to mental health services are eliminated by improving access to quality care that is culturally competent and improving access to services in rural and remote areas.
- Early mental health screening assessment and referral by promoting the mental health of young children and the expansion of school mental health programs; screening for co-occurring mental health and substance abuse disorders and linking clients with integrated treatment, as well as mental health screening in primary health care that connects people to treatment and supports.
- Excellent mental health care is delivered and research is accelerated through more research on resilience, recovery and cure; knowledge transfer of evidence based practice and work force upgrading.
- Technology is used to access mental health care and information by the use of technology and 'telehealth' to promote access and coordination and the development and integration of integrated e-health records and information systems.

The Commission report is an ambitious attempt to shift the mental health care paradigm to a recovery focus that is responsive to the needs of consumers and families. However, the federal government and many state governments are experiencing fiscal deficits. It therefore appears unlikely that funding to implement the Commission's strategies will materialize any time soon.

### **New Zealand**

In 1997, New Zealand announced its National Mental Health Policy with the publication of '*Moving Forward: National Plan for More and Better Services*' (1997). The plan's goals were simple and straightforward: to decrease prevalence of mental illness (MI) and mental health (MH) problems, and increase health status and reduce impact of mental disorders on consumers, carers and community. The government was told to stop refining objectives and strategies and speed up action. The National Plan had the following objectives:

- Target 3% of adults and 5% of children with severe mental disorders to receive timely mental health services.
- Develop services for adults with mild-to-moderate mental disorders (17%).
- People with high support needs get ACT (assertive community treatment teams).
- People with new illness get early intervention.
- Increased access to psychosocial interventions.
- Integrated treatment for concurrent disorders.

- Cultural needs are recognized and provided for.
- Service providers are to tailor services to needs.

The Plan's objectives are to be achieved by 2005, based on a government commitment to a community-based model backed up by sufficient hospital services for acute and secure care.

The Mental Health Commission monitors progress on national plan implementation and there is a focus on outcomes through HONOS and other national surveys. Currently a second mental health plan is being developed and New Zealand is positioning itself as a mental health leader through membership in the International Institute of Mental Health Leaders.

### Ontario, Canada

Between 1959 and 1979, the province of Ontario in Canada closed 7000 of its 11000 provincial psychiatric hospital beds. Since that time the mental health policy debate has revolved around what to do with the remaining provincial hospital beds and the hospitals themselves, general hospital psychiatric programs and community mental health programs. Often referred to as the three solitudes, these components of what should be a mental health system have historically not been well connected.

In 1988 the government published *'The Graham Report: Building Community Support for People'*, which for the first time identified a need for partnerships between consumers, families and providers. The Graham Report found that while community mental health spending was increasing, mental health spending was actually declining as a proportion of health spending.

The lens it proposed was a whole system view with comprehensive services. This included psychiatric rehabilitation services, housing, as well as improved access to treatment services close to home, leading to the development of local and regional mental health systems that effectively linked provincial psychiatric hospitals, general hospital and community services; in other words, a community-focused mental health system. The report also called for interministerial collaboration on income, employment and housing.

The 1990 election of a new government with an interest in policy frameworks led to the publication of *'Putting People First'* in 1993, which set targets for a funding shift and focused on the core functions of crisis, case management, housing, consumer and family supports. The funding targets proposed shifting spending from 80% hospital and 20% community to 60% community and 40% hospital services over a 10-year period.

The policy lens of the government and many stakeholders focused on community-based supports,

rather than treatment services, and for the first time the provision of supports by consumers and families themselves was given legitimacy and funding.

1995 brought another change in government. The new government was committed to increasing health spending while cutting spending on social assistance and housing. During the election campaign the Schizophrenia Society promoted an agenda of broadening the committal criteria under the Mental Health Act and implementing community treatment orders modelled on legislation passed in the province of Saskatchewan. However there was limited action on the policy, legislative or funding fronts until 1998.

Concerns from stakeholders about the lack of progress on mental health reform caused the Minister of Health to ask her parliamentary assistant to conduct a review of mental health services. The review found that all stakeholders supported the policy direction of the Graham Report and *'Putting People First'*, but were critical of the failure to implement the policy direction. There was no consensus on the need to change the Mental Health Act as advocated by the Schizophrenia Society and some psychiatrists.

The Minister accepted the report, immediately announced an infusion of funding to establish new community mental health services and announced that a new policy framework would be developed to guide implementation of mental health reform.

The implementation framework *'Making It Happen'* was released in 1999. It confirmed the previous policy direction but added a focus on system integration. Services were categorized as first line, intensive and specialized and were to span the continuum from crisis intervention to services for people with complex disorders. Strategies to reduce fragmentation and improve access to services, ranging from shared care agreements among providers to agency mergers were proposed as well as the development of common assessment protocols.

Following the release of *'Making It Happen'* the government continued to invest money in new community services. This included funding for 60 ACT (assertive community treatment teams) and funding to develop 2000 supportive housing units for the homeless. The government received advice from its provincial advisory committee on mental health to draft mental health systems legislation rather than amend the Mental Health Act.

In 2000, despite this advice, the government passed Bill 68 which broadened committal criteria under the Mental Health Act and established community treatment orders for people with serious mental disorders following extensive media coverage of the murder of a broadcaster in Ottawa and a number of subway pushings involving people with mental illness.

In 2001 the government established nine mental health implementation task forces to make recommendations on how 'Making It Happen' should be implemented within regions. The task forces submitted their reports in December 2002. The chairs of the task forces also tabled a report focusing on provincial issues (Ontario Ministry of Health, 2002). It proposes:

- A renewed commitment to mental health reform over the next 10 years.
- Continued investments in community mental health services such as supportive housing and consumer initiatives.
- Completing the divestment of the provincial psychiatric hospitals.
- Legislation and policy work to devolve funding and management of regional and local mental health systems to regional authorities.
- Public education to combat the stigma of mental illness.
- Improved accountability through performance measurement.
- Streamlined access and early intervention.

A number of the task forces have also recommended mergers of community mental health agencies even though the evidence from both public and private sector is that mergers are often unsuccessful (Everett, Higgins & Lurie, 2001).

Despite the numerous reports and policy documents, an examination of funding shows that mental health spending has declined slightly in proportion to health spending since 1989, and the targets for community mental health spending relative to institutional spending have not been reached. However community mental health funding is now 1.45% of health spending compared to 0.45% in 1985.

### Are there lessons to be learned?

This review suggests while progress on mental health reform is possible, it is generally incremental and needs to be sustained over a long period of time. Government policy documents and reviews play a role in focusing political, bureaucratic and stakeholder attention on the need for improvements. There appears to be little evidence that structural reforms improve system performance, but reviewing system performance itself can generate change and improvements.

The themes of recovery, stigma reduction, developing services for particular client populations, use of new technology, workforce training, improved performance measurement and research are common across jurisdictions. The role of government as funder, regulator and catalyst for regional or local

system development, rather than service provider is also common.

This paper has focused on mental health policy in the developed world, where the mental health system competes with other health issues for public funding and attention. As reports in Canada, the USA and UK have noted, under-funding is a problem. However all the systems reviewed are focusing on strategies to shift services away from large institutions to community solutions based on choice and entitlement. This holds promise for the future.

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