

Comparative Mental Health Policy: Are there lessons to be learned?

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In the early 1990's E. Fuller Torrey and Douglas Bigelow 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 United States (Torrey and Bigelow 1993). Canadians generally ignored the results, likely because, as 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 US 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, Blasinsky, Morrissey, Rosenheck, Cocozza, and Goldman, 2002). 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 twenty years has seen an explosion of progressive mental health policy statements in a number of jurisdictions. Ontario, the province of Canada that the author works in, has published four such policy documents that seem to coincide with a change in government. Each policy document has taken an incremental approach to shifting the mental health system paradigm from an institutional system to a community focused system that promises consumers and their families a home, a job and a friend as well as access to treatment services as close to home as possible.

The UK, Australia and New Zealand have published similar national policy documents and set national standards to measure system performance. The recent report of the President's New Freedom Commission (2003) indicts US state mental health service systems (many of which have been handed off to behavioral health companies) and proposes major reforms to ensure that the mentally ill and their families have good access to recovery focused services and supports.

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. For example Vermont, Ohio and New Hampshire have been cited as state jurisdictions that have managed to dramatically decrease their long stay beds, invest in comprehensive community support services and achieve positive outcomes for consumers and families despite the problems identified by the New Freedom Commission.

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 US and New Zealand. It will then examine the evolution of mental health policy in Ontario 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 US 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 US, the 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. It proposed increasing funding for homecare, which is to be directed at enhancing community mental health services and supports. There is currently a Senate Committee reviewing mental health that is likely to make recommendations in 2005 to strengthen mental health systems and improve services across the country.

For Canadians an examination of national mental health policy appears to be a bit of an oxymoron. In Canada, over the past thirty years the federal share of health spending has declined to less than 20% from 50%. Even when costs were shared more equitably between the provinces and the federal government, expenditures on provincial psychiatric hospitals did not receive federal funding while general hospital psychiatric costs did. At the same time federal law dictates how people who are not criminally responsible for criminal acts committed while mentally ill are to be treated, assessed and supervised, while provinces are responsible for carrying out the provisions of the Criminal Code dealing with mentally ill offenders. The funding of supportive housing for homeless mentally ill, is increasingly being seen as an area requiring both federal and provincial funding.

Therefore while delivery of mental health services may be a provincial responsibility, the funding and regulation of some aspects of delivery may be shared between the federal and provincial governments. In the context of Canada's national debate on the future of Medicare, the federal government is seen as responsible for ensuring that each province meets standards under the Canada Health Act. The Romanow Commission proposed the development of a basket of services approach to the federal funding of home care services in each province that includes community mental health. This is now being implemented under a federal provincial agreement.

Australia has a system of government that is similar to Canada's in that both the state and national governments share responsibility for health care, while delivery of health

services is a state responsibility. In 1992 Australia announced a mental health policy that increased national and state government funding for mental health services and required the states to implement strategies to build community focused mental health systems.

The UK has introduced mental health reforms that are being implemented in England and Wales, while Scotland is pursuing its own approach. Service delivery in the UK is the responsibility of local health trusts that have to meet national standards.

In the United States the federal government's funding of Medicaid represents a funding stream for individual states to provide some services to people with mental illness and the federal government has passed legislation that ensures parity or similar benefits for mental health and physical health services under private health plans. Over the past thirty years, the lack of parity coverage for people with mental illness, has forced states to provide inpatient and outpatient mental health services to people who had insufficient coverage under private health plans, as well as provide mental health care to any of the estimated 40 million Americans without health insurance who experience mental illness. Thus in the US mental health is a shared jurisdiction, with the states primarily responsible for mental health delivery and the federal government having regulatory and funding authority for Medicaid and block grant funding to the states.

New Zealand does not have a division of powers between the national and state or provincial governments. Delivery of mental health services is a responsibility of the national government, which is delegated to local health trusts, as occurs in the UK.

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, and 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 nineties. In 2001 an external review was commissioned to assess progress. Betts and Thornicroft's review commended Australia for policy leadership and tabled numerous recommendations to ensure the shift to a community focused mental health system (Betts and Thornicroft, 2001). Their report recommended the following:

- Enhance consumer and carer networks
- Refocus on stigma reduction
- Organize respite care
- Fund training for consumers, carers and advocates

- Consolidate promotion and prevention programming and funding for homelessness, suicide, substance abuse and mental health
- Nurture shared care and acknowledge and reward NGO contributions
- Implement awareness programs (beyond blue and MindMatters)
- Enhance the mental health workforce especially nurses
- Increase services for high prevalence disorders, focus on early intervention
- Eliminate financial and service silos amongst mental health, housing, education, disability, geriatrics, child and family services
- Enhance services for children and adolescents
- Develop more community based crisis care
- More funding for NGO services including advocacy
- Develop high support housing
- Expand vocational rehabilitation and disability supports
- Eliminate barriers between mental health and substance abuse agencies, leading to full integration
- Build seamless care for mental health consumers with comorbidities
- Develop dual diagnosis evidence and training network
- Develop a national strategy for improvement of mental health services in justice and forensic systems
- Improve telehealth
- Centre of excellence on rural mental health
- Establish accountability mechanisms
- Fund based on evidence based practice
- Establish networks to develop and evaluate clinical guidelines and protocols
- Develop a national network for mental health service research

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 recommended the development and implementation of a third national mental health plan to maintain the reform momentum. (Betts and Thornicroft, 2001).

United Kingdom

The UK began an aggressive program of psychiatric hospital closure in the 1990's. 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, Aviram, Healy, and Ramon, 2002). In 1999 the government published a National Service Framework to guide its investment of 700 million pounds 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, Aviram, Healy, and Ramon, 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 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. Staff shortages, under investment and the impact of major organizational change were seen as contributing to the low ratings of trusts, but there were also many instances of promising practices at the local level.

United States:

Between 1960 and 1980 the United States closed the bulk of their state hospital beds and turned their policy attention to the development of community support systems. During the 1970’s 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 1980’s and 90’s the US 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, (1976-80) legislation that focused on the provision of community support services to the seriously mentally ill was drafted but not passed.

In the late 1980’s 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, Calloway, Burko, Ridgely, Goldman and Paulson, 1992).

The 1980's and 90's also saw the advent of managed care. Some states delegated responsibility for the provision of care to private behavioral 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. The city of Philadelphia closed their state hospital and shifted resources to a local mental health authority, which provided team based assertive community treatment services and housing and was able to demonstrate improved quality of care.

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" (New Freedom Commission 2003)

Six goals for US 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 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 MH 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 straight forward, to decrease prevalence of MI and 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.

Short and medium term targets were set for the following strategic directions:

- More mental health services
- More and better services for Maori
- Better mental health services
- Balancing personal rights with public protection
- Develop and implement and National drug policy
- Develop mental health services infrastructure
- Strengthen promotion and prevention

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:

Between 1959 and 1979, the province of Ontario closed 7,000 of its 11,000 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.

The origins of each component were historically quite different. Ontario's provincial asylums had their origins in the 19th century, when confinement of the mentally ill and their separation from community was the norm. General hospital psychiatric units were the product of mainstreaming mental health services in the 1960's, following publication of *More For the Mind* (1963), which recommended that people with mental illness should be treated the same way as people with physical illness in local general hospitals. Community mental health programs first received funding in the late 1970's when it was recognized that alternatives to inpatient care needed to be created.

While some interdependence developed, as provincial and general hospital psychiatric programs needed access to community housing and case management programs in order to discharge patients, much of the debate since 1988 has been about approaches to building a community focused mental health system.

The debate has focused on three elements:

- Who has voice in decisions about the system?
- What is the lens by which the system should be viewed, i.e. medical model or something else?
- How should the component parts be integrated?

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.

In response to the report the government convened work groups to report on legislation, funding and training and district health councils were asked to develop plans based on the Graham Report. While funding for community mental health services was increased, a funding envelope for mental health services was not developed. A change in government and stakeholder disagreements on system governance thwarted progress on the legislative front.

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.

District health councils were again asked to develop plans and a small amount of transitional funding was injected into the system. It was thought that the Community Investment Fund, which totaled \$23 million, would facilitate the reallocation of funding from institutional to community services over time.

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.

District health councils redid their plans and a number of them proposed the establishment of mental health authorities as a means of coordinating local systems. Hospitals and physicians did not support authorities, expressing concerns about the marginalization of mental health services if they were governed separately from other health services.

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 modeled on legislation passed in the province of Saskatchewan. However there was limited action on the policy, legislative or funding fronts until 1998.

In 1996 the government passed legislation setting up the Health Services Restructuring Commission in order to merge and close general hospitals and create efficiencies in the health system. The Commission recommended divestment of the provincial psychiatric hospitals from the government, increased community investments in mental health services before psychiatric beds were closed, the creation of mental health agency boards in each region to guide divestment, and investments in new community mental health services. These organizations were to have full funding authority, be in place for a transition period of four years, after which mental health services would be integrated with health services.

The Commission's recommendations and 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. Prior to the 1999 election the official opposition party introduced a private members bill providing for broadened committal criteria under the mental health act and community treatment orders. 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, following extensive media coverage of the murder of a broadcaster in Ottawa and a number of subway pushings involving people with mental illness, 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.

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 consulted with stakeholders and submitted their reports in December 2002. The chairs of the task forces also tabled a report focusing on provincial issues (Provincial Forum, 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
- Stream lined 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 and Lurie, 2001).

The task force reports propose building a system that is recovery and community focused. The recovery focus is evidence that placing the consumer at the centre and providing a range of medical and non-medical services and supports may now be the lens for mental health policy in Ontario. It also suggests that the consumer and family involvement in planning and service delivery with service providers since the publication of the Graham Report has had an impact on the articulation of policy. At the same time the passage of Bill 68 indicates that there is a tension between public safety, best interest, medical treatment and consumer empowerment in Ontario's mental health policy.

An examination of funding shows that while community mental health funding is now 1.45% of health spending compared to .45% in 1985. 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.

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 US 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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