Cross Jurisdictional Review: Mental Health and Substance Use Policies

Background Paper No. 7
British Columbia Mental Health and Substance Use Project
<table>
<thead>
<tr>
<th>Background Paper No.</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 1</td>
<td>Preliminary Estimate of the Burden of Disease and Injury in British Columbia: Context for Mental Health Planning</td>
</tr>
<tr>
<td>No. 2</td>
<td>Promoting Mental Health: What Works?</td>
</tr>
<tr>
<td>No. 3</td>
<td>Preventing Mental Health Problems: What Works?</td>
</tr>
<tr>
<td>No. 4</td>
<td>Preventing and Reducing Harms from Substance Use: What Works?</td>
</tr>
<tr>
<td>No. 5</td>
<td>Treating Mental Health Problems, Substance Use Problems and Concurrent Disorders: A Summary of Published Guidelines</td>
</tr>
<tr>
<td>No. 6</td>
<td>Supporting Recovery and Community Integration: What Works</td>
</tr>
<tr>
<td>No. 7</td>
<td>Cross Jurisdictional Policy Review: Mental Health and Substance Use Policies</td>
</tr>
<tr>
<td>No. 8</td>
<td>Overcoming Stigma of Mental Health Problems and Substance Use Problems: What Works?</td>
</tr>
<tr>
<td>No. 9</td>
<td>Cross Jurisdictional Review of Whole Systems Governance Models in Public Policy Implementation: Implications for the Implementation of Mental Health &amp; Substance Use Policy in the British Columbia Context</td>
</tr>
<tr>
<td>No. 10</td>
<td>Stakeholder Engagement: Summary of Input</td>
</tr>
</tbody>
</table>

October 2007
TABLE OF CONTENTS

PREFACE ............................................................................................................................................. 5
I.  INTRODUCTION .......................................................................................................................... 7
II. CANADIAN POLICY REVIEW ...................................................................................................... 8
  Canada ............................................................................................................................................. 8
  Provinces and Territories ................................................................................................................. 11
III. INTERNATIONAL POLICY REVIEW ......................................................................................... 14
  Global Overview ............................................................................................................................. 14
  United Nations ................................................................................................................................. 16
  World Health Organization ............................................................................................................. 16
  European Union ............................................................................................................................... 22
  Australia ......................................................................................................................................... 24
  Chile ................................................................................................................................................. 27
  Denmark .......................................................................................................................................... 31
  Finland ........................................................................................................................................... 33
  France ............................................................................................................................................. 36
  Germany .......................................................................................................................................... 38
  Ireland ............................................................................................................................................ 40
  Italy ................................................................................................................................................ 42
  New Zealand ................................................................................................................................... 45
  Spain, Catalonia ............................................................................................................................... 49
  Sweden ........................................................................................................................................... 52
  The Netherlands ............................................................................................................................... 54
  United Kingdom, England ............................................................................................................... 58
  United Kingdom, Scotland ............................................................................................................... 61
  United States ................................................................................................................................. 64
IV.  LESSONS LEARNED .................................................................................................................. 67
  Why Develop Mental Health Policy? ............................................................................................... 67
  Characteristics of Effective Mental Health Policy .......................................................................... 67
  Challenges for Mental Health Policy Development ....................................................................... 69
V.  RECOMMENDATIONS FOR BRITISH COLUMBIA ................................................................. 73
  Shared Vision ................................................................................................................................. 73
Guiding Principles .................................................................................................................. 73
Policies and Plans .................................................................................................................... 74
Investment ............................................................................................................................... 74
Service System ......................................................................................................................... 74
Workforce Development .......................................................................................................... 75
Monitoring and Evaluation ..................................................................................................... 76
VI. REFERENCES ...................................................................................................................... 77
PREFACE

Good mental health and freedom from harms associated with problematic substance use is crucial to the overall well-being of individuals, communities and societies—positive mental health is a resource for everyday living that enables people and communities to realize their fullest potential and to cope with life transitions and major life events. Unfortunately, around the world, mental health problems and substance use problems are common—affecting men and women of all ages, nations and cultures. Estimates suggest mental disorders affect more than 25 percent of all people at some time during their lives and are present at any point in time in about 10 percent of a given adult population.1

British Columbia is no exception to this trend. Mental health problems and substance use problems are the third largest contributor to the Province’s overall disease burden (after cancer and cardiovascular disease), are the largest contributor to disease burden among British Columbians ages 15—34, and the leading cause of disability in the province.2 British Columbia spends approximately $1 billion each year on mental health and addictions services delivered through the health system.3

It has been more than a decade since government developed a comprehensive plan for mental health in British Columbia. In the intervening period, the health system has been reorganized into health authorities, and mental health services and addictions services have been integrated. Specific Ministry of Health Services policy frameworks, such as Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction4 and Following the Evidence: Preventing Harms from Substance Use in BC5, and a Child and Youth Mental Health Plan developed by the Ministry of Children and Family Development6, have all supported various aspects of sector development. New partnerships have also developed across ministries and sectors. Provincial capacity has expanded through the establishment of the BC Mental Health and Addictions Services at the Provincial Health Services Authority, the Centre for Addictions Research of British Columbia at the University of Victoria, and the Centre for Applied Research in Mental Health and Addictions at Simon Fraser University. Funding from the Province’s Leading Edge Endowment Fund has supported creation of a Leadership Chair in Depression at the University of

British Columbia’s Brain Research Centre. This academic leadership post is dedicated to identifying the underlying causes of mental illness and devising novel, evidence-based responses.

The evidence base to support effective action to promote mental health and prevent and respond to mental health problems and substance use problems has expanded rapidly. Considerable new knowledge is now available in the field. Expanded capacity and growing integration in the mental health and addictions sectors mean that British Columbia is well positioned to take advantage of new relationships and new knowledge at the research, policy and practice levels.

As a next step, the province is developing a 10 Year Plan to Address Mental Health and Substance Use that takes a whole systems approach. The Plan will set out a clear unifying vision, guiding principles, intended population outcomes, strategic directions and evidence-based recommendations for action. The Plan will articulate roles and responsibilities and identify specific milestones for achievement. Finally, it will establish mutually developed mechanisms to monitor progress over time and ensure accountability.

In British Columbia, a disproportionate share of the burden of mental health problems and substance use problems is borne by Aboriginal communities. With the signing of the Transformative Change Accord, the Leadership Council representing the First Nations of British Columbia, the Province of British Columbia and the federal government have agreed to a shared commitment to action on closing health, social and economic gaps between First Nations and other British Columbians.

The Transformative Change Accord specifies “establishing mental health programs to address substance abuse and youth suicide” as one of four actions to close health gaps between Aboriginal British Columbians and the general population by 2015. Therefore, as partners with Aboriginal leadership and communities, and the federal government in the Tripartite process the Ministry of Health Services and the Ministry of Healthy Living and Sport are participating in the development of a plan to address mental health and substance use in BC’s Aboriginal communities.

This background paper forms part of a series prepared for the Ministry of Health Services, Ministry of Healthy Living and Sport and the Ministry of Children and Family Development to inform the development of a 10 Year Plan to Address Mental Health and Substance Use for British Columbia. Each paper in the series addresses a key element in the Plan. As the Plan evolves, additional background papers will be developed and added to the series.

To date, the series presents current data on the relative magnitude of mental health problems and substance use problems in British Columbia. It summarizes policy approaches adopted by other jurisdictions to address similar challenges. The series also examines best available evidence on effective interventions to promote positive mental health, to prevent and reduce associated harms and respond to mental health problems, substance use problems, and concurrent disorders, as well as to support recovery and community reintegration. The series also includes a review of national and international best practices in addressing stigma and discrimination. Taken together, the information, policy approaches and programming options contained in the series will provide valuable evidence to inform overall provincial policy directions and to improve the mental health and well being of British Columbians.

I. INTRODUCTION

The purpose of this cross jurisdictional policy review is to examine public policy responses to mental health and substance use in Canada and elsewhere to inform the development of the 10 Year Mental Health and Substance Use Framework for British Columbia.

In order to promote the mental health of populations and significantly reduce the burden of disease associated with mental health problems and substance-related harm, governments must respond fairly and effectively to the needs of people with serious mental illness and addiction, to the needs of people with emerging, mild or moderate mental health problems and substance use problems, as well as to the needs of people at risk for developing such problems. Governments must also focus their efforts ‘up stream’ to promote and protect the positive mental health of the general population and diverse groups across the life course.

To accomplish this, effective policies must encompass the entire spectrum of evidence-based mental health and substance use interventions from promotion and prevention to treatment, recovery and integration – with the understanding that each intervention necessarily complements and leverages the gains of the other. Taken together, these interventions will contribute to the development of a long term, sustainable approach to population mental health.

This report is a selective review of mental health and substance use policies developed by member countries of the Organization for Economic Cooperation and Development and other jurisdictions that have particular relevance to Canada and British Columbia. Specifically, this review examines public policy in Canada, its provinces and territories, comparable national jurisdictions, supra-national organizations such as the European Union (EU) and World Health Organization (WHO). With increasing global integration, future reviews of policy responses to mental health and substance use will need to include countries whose political institutions and economies are in transition.

For the purposes of this report, policy is defined as the sum of considerations, including options and recommendations, underlying a particular course of action by government and its partners for the promotion of mental health, prevention and treatment of mental disorders, and the control, prevention and treatment of harms associated with substance use. The term ‘substance’ refers here to alcohol, tobacco and illegal drugs.

It is also understood that policy represents only one lever to address mental health and substance use, which are deeply enmeshed in biological, personal, social, economic and societal factors. Policies to address mental health and substance use will be most effective when combined with interventions that influence the broad determinants of mental ill health and the harms associated with substance use.

With this in mind, a mental health policy is a specifically written document of the Government or Ministry of Health containing the goals for improving the mental health of the population, the priorities among those goals, and the main directions for attaining them. A mental health policy may include the following components:

**Advocacy**: a combination of individual and social actions designed to raise awareness and to gain political commitment, policy support, social acceptance and health systems support for mental health and substance use goals

**Promotion**: a process of enabling people to increase control over the determinants of mental health and well-being and to improve their mental health

**Prevention**: all organized activities in the community to prevent the occurrence and progression of
mental health problems and substance use problems, including the timely application of means to promote the mental well-being of individuals and of the community as a whole, and the provision of information and education

**Treatment:** relevant clinical and non-clinical care aimed at reducing the impact of mental health problems, including mental disorders and substance use disorders, and improving the quality of life of people experiencing mental health problems and substance use problems

**Rehabilitation:** care given to people experiencing mental health problems and substance use problems in the form of knowledge and skills to help them achieve their optimum level of social and psychological functioning

For each selected jurisdiction, this report reviews the availability of national and regional policies and plans, resources for implementation, and mechanisms for monitoring and evaluation. Consistent information was not available for all jurisdictions; for some jurisdictions, more detailed information is provided than for others. Where available, the results of policy evaluations have been included, although there is limited evaluation of national policy responses in most jurisdictions. Where such evaluations occur, they tend to focus on implementation rather than effectiveness or cost effectiveness. Nonetheless, taken together, the policy responses examined in this review clearly point to an emerging, international policy consensus in responding to mental health and substance use. Accordingly, this policy review concludes with recommendations for British Columbia based on the lessons learned in these jurisdictions.

While this review examines public policies that predominantly address mental health and the intersection of mental health and substance use, the global burden of harms associated with substance use, including alcohol, tobacco and illegal drugs, is significant and unequivocal.

For reviews of national alcohol-related policies in other countries, the reader is directed to the WHO Global Status Report: Alcohol Policy (WHO, 2004a), Alcohol: No Ordinary Commodity (Babor et al, 2003), and Alcohol in Developing Societies: A Public Health Approach (Room et al, 2002). For reviews of alcohol-related policies in Canada and its provinces and territories, the reader is directed to Alcohol-related Harms and Control Policy in Canada (CCSA, 2004).

For reviews of national tobacco-related policies in other countries, the reader is directed to the WHO Tobacco Control Country Profiles (WHO, 2003a) and WHO Tobacco Atlas (WHO, 2002). For reviews of national drug-related policies (focusing primarily on illegal drugs) in other countries, the reader is directed to the European Monitoring Centre for Drugs and Drug Addiction, which has recently updated its inventory of national drug strategies and action plans of EU member states and candidate countries (http://www.emcdda.europa.eu)

The main sources of information for this policy review were the European Observatory on Health Systems and Policies’ Mental Health Policy and Practice Across Europe: The Future Direction of Mental Health Care (Knapp et al, 2007), European Commission’s Mental Health Promotion and Mental Disorder Prevention across European Member States: A Collection of Country Stories (Jane-Llopis & Anderson, 2006), and the WHO Atlas of Mental Health Resources (WHO, 2005a). Further information was obtained from searches of government and non-governmental organization websites for the selected jurisdictions and reviews of relevant country-specific policy documents.

**II. CANADIAN POLICY REVIEW**

**Canada**
Mental health policy in Canada has largely focused on people experiencing serious mental illness. Services have evolved from institutional care and control to community-based interventions. The move towards deinstitutionalization was prompted by a number of factors, including the economic constraints of institutional care, increased focus on human rights and the development of new drugs and treatments that enabled individuals with a mental illness to be cared for in the community.

In 1988, the federal government released the discussion paper, *Mental Health for Canadians: Striking a Balance*. This paper outlined a set of principles to guide the development of mental health-related policies and programs in Canada. Many of these principles were later reflected in mental health reforms at the provincial and local level, including emphasis on recovery, personal strengths and assets, consumer choice and control, community integration, supported employment and independent housing with flexible supports.

To date, Canada is the only G8 country without a national mental health strategy. Over the years, numerous reports have been published in Canada by various stakeholder groups on the need for a coherent national mental health strategy. In 2001, the Canadian Alliance on Mental Illness and Mental Health released *Call for Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health*. In 2006, the group issued *Framework for Action on Mental Illness and Mental Health* which proposed four priorities: cooperative leadership, national data collection and reporting system, strategic investments in research, and effective mental health promotion.

In 2006, the Standing Senate Committee on Social Affairs, Science and Technology released its final report on mental health and addictions, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (2006), the culmination of a comprehensive, three-year study. The report makes 118 specific recommendations for change, including the formation of a national mental health commission and creation of a mental health transition fund. The Committee’s vision for mental health reform is a recovery-focused system, with people living with mental illness at its centre, underpinned by the principles of choice, community and integration.

In September 2007, the Government of Canada established the Mental Health Commission of Canada with a mandate to fight stigma and discrimination against people living with mental illness, facilitate the development of an evidence-based national approach to mental health issues, catalyze the reform of mental health policies and improvements in service delivery, and educate Canadians about mental health. The Commission is supported in its work by advisory committees on children and youth, seniors, Aboriginal People, workplace, family caregivers, service providers, science and mental health and the law.

The Government of Canada continues to publish regular reports on mental health, mental illness, and concurrent mental health and substance use disorders in Canada to raise public awareness and increase knowledge. *The Human Face of Mental Health and Mental Illness in Canada* (2006) provides information on key concepts in mental health and mental illness, as well as an overview of the burden of disease, known causes and effective interventions for a range of mental disorders. The Federal/Provincial/Territorial Advisory Network on Mental Health and Health Canada developed a best practice document in mental health system reform (1997) and Health Canada produced a best practice document for the delivery of services for concurrent mental health and substance use disorders (2002), both of which continue to inform mental health policy development at the provincial and territorial level.

Between 2003 and 2005, the federal government, provinces and territories worked with community
partners to develop a comprehensive, evidence-based National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. The framework sets out the partners' shared vision, principles, goals and 13 priorities for action. British Columbia was the first province to endorse the national framework. Since 2005, the partners have been working to implement the priorities for action. In 2007, the partners released Reducing Alcohol-Related Harm in Canada: Toward a Culture of Moderation. The partners are currently working on the development of a national treatment strategy, one that will clearly define an integrated, evidence-based continuum of services and supports to treat harmful substance use, including substance disorders. British Columbia is taking a lead in developing this national strategy.

In October 2007, the Government of Canada released a new, federal anti-drug strategy. This strategy is not national in that it was not developed in collaboration with, or endorsed by, provinces and territories. More accurately, it is a federal government strategy. The new anti-drug strategy unilaterally repositions the previous strategy, Canada’s Drug Strategy, a combination of federal policies and programs balancing supply reduction, demand reduction and harm reduction efforts that had been in effect since 1987 and renewed in 1992, 1997 and 2003 (for a historical overview of Canada’s Drug Strategy, see http://www.parl.gc.ca/information/library/PRBpubs/prb0615-e.html)

In a review of the 2003 renewed Canada’s Drug Strategy, DeBeck et al (2006) found that approximately three-quarters of the resources had been directed towards enforcement-related efforts, despite a lack of scientific evidence to support this approach and little, if any, evaluation of the impacts of this investment. The authors conclude that from a scientific perspective, an effective national drug strategy should ensure that federal funds are directed towards cost-effective, evidence-based prevention, treatment and harm reduction services, and that these services should be available to all Canadians.

The new anti-drug strategy abandons harm reduction and emphasizes enforcement and abstinence-based treatment, despite mounting international, peer-reviewed evidence of the ineffectiveness of this approach. New funding from the federal anti-drug strategy adds $32 million per year over two years to the current spending of $368 million per year, for a new total of approximately $400 million annually, of which 71% is for enforcement, 17% for treatment, 8% for coordination/research and 4% for prevention.

**Resources for Implementation**

**Investment**

Canada has a predominantly publicly financed health care system. The national health insurance program is the result of thirteen interlocking provincial and territorial health insurance plans linked through adherence to national principles set at the federal level. The aim of Canada’s health care system is to ensure that all residents of Canada have reasonable access to insured services without direct charges. Insured services include insured health care services, such as medically necessary hospital services, physician services and surgical-dental services, and extended health care services, such as certain aspects of long term residential care and health aspects of home care and ambulatory services. The Canada Health Act establishes five criteria and nine conditions related to insured health care services that the provinces and territories must meet in order to receive the full federal cash contributions under the Canada Health and Social Transfer. This transfer mechanism provides provinces and territories with cash payments and tax transfers in support of health care, post secondary education, social assistance and social services.

**Infrastructure**
In Canada, the division of constitutional powers means that responsibility for health service delivery, including mental health and addiction services, rests with provincial and territorial governments. Each province and territory has its own mental health and substance use-related legislation, policies and plans, funding strategies, service delivery system and surveillance system. The federal government has direct responsibility for the delivery of mental health services and addiction treatment to Status Indians and Inuit, the military and veterans, civil aviation personnel, the RCMP, inmates in federal penitentiaries, arriving immigrants, and federal public servants. The federal government also has responsibility for health promotion and disease prevention, disease surveillance, health research, human rights, drug approval, and employment and disability benefits – all of which have direct or indirect implications for the provision of mental health and substance use services in the provinces and territories.

In 1988, the federal government created the Canadian Centre on Substance Abuse with a legislated mandate to provide objective, evidence-based information and advice aimed at reducing the health, social and economic harms associated with substance use and addictions. Non-governmental organizations (NGOs) in the mental health and substance use areas influence research, policy and practice at the national and provincial levels. These include university-affiliated research centres, consumer advocacy groups and professional associations.

**Monitoring and Evaluation**

Information on the self-reported mental health of the population is collected through the National Population Health Survey, Canadian Community Health Survey, Canadian Health Measures Survey and the National Longitudinal Study of Children and Youth. Information on self-reported substance use of the population is collected through the Canadian Addiction Survey.

**Provinces and Territories**

As noted above, in Canada, health service delivery is the jurisdiction of the provinces and territories, each of which is responsible for the enactment of laws and policies related to health and the delivery of health services. In nine provinces, the ministries of health have divested authority for direct service delivery to elected or appointed regional authorities. These bodies have responsibility for the planning, funding and operation of health services within prescribed geographical areas. It is not yet the norm for both mental health and substance use services to be the responsibility of regional authorities, although it is more common for mental health services to be included in regional mandates (CAMH, 2005).

In all provinces, mental health is a part of the primary health care system to a greater or lesser extent. Treatment of severe mental disorders is available at the primary care level, however, serious patients are often referred to psychiatrists while primary care practitioners take care of stabilized and less seriously ill patients. In addition to primary care, mental health services are also delivered through community-based services and facilities, general hospital care, specialized treatment facilities, psychiatric hospitals, and consumer-run organizations. Implementation of evidence-based therapies and best practice models of service delivery are explicit aims of the mental health policies in most provinces.

In 2004, the government of Alberta released *Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta* which focuses on integrating mental health into the overall health system and addressing service gaps. The plan outlines a vision for mental health in Alberta. The plan clearly articulates the roles and responsibilities of the Alberta Health and Wellness, the Board and the regional health authorities. It identifies priority areas where expanded services are required, new
approaches to funding mental health services, and strategies for ensuring a diverse and adequate supply of well-trained mental health care professionals and providers. The plan articulates a strong commitment to research to advance mental health care and treatment and encourage innovation and implement leading edge practices. It has a clear focus on accountability, evaluation and measuring performance to ensure ongoing improvements in mental health services across the province.

The plan calls for a restructuring of the Alberta Mental Health Board with the devolution of mental health services, including the province’s four tertiary mental health facilities, from the Board to the regional health authorities, and the assignment to the Board of a range of provincial and cross-regional functions. These include the collaborative development of a new funding framework, performance indicators, standards and monitoring process, a provincial mental health research plan, and a framework for treating hard-to-serve clients.

Alberta Health and Wellness identified those aspects of the plan that are the responsibility of the provincial government. The regional health authorities were tasked with developing their own mental health plans to support the implementation of the provincial plan. The health authorities and Alberta Mental Health Board continue to work in partnership with the Alberta Alcohol and Drug Abuse Commission and provincial ministries to implement the provincial Children’s Mental Health Initiative (2001), which focuses on reducing the risk of mental health problems and substance use and on providing support and treatment for children, adolescents and their families.

Manitoba initiated Mental Health Renewal in 2001, which provides the policy framework and plan for mental health services. Work continues on the implementation of the plan, which stresses the incorporation of mental health into primary health care and delivery strategies that focus on promotion, prevention and early intervention. Manitoba has 11 regional health authorities responsible for health service delivery, including most mental health services. There are two remaining psychiatric hospitals in the province and these are governed and managed directly by Manitoba Health.

In Ontario, responsibility for mental health and addiction policy, planning and service delivery rests with the Ministry of Health and Long Term Care. In contrast to other provinces, the health system is not regionalized. There are 16 District Health Councils, but their mandate is limited to advising the Minister on the health matters and needs in their respective districts. They do not control funding of health services. As a consequence, the many mental health and addictions service providers function largely independently of one another. The Ministry also coordinates the provincial forensic strategy in partnership with the Ministry of Community, Family and Children’s Services, the Ministry of the Attorney General, and the Ministry of Public Safety and Security (Kirby, 2004b).

In 1999, Ontario enacted Making it Happen, a mental health policy framework which established a set of principles to guide mental health reform in the province. In 2002, the Provincial Forum of Mental Health Implementation Task Forces released its final report, The Time Is Now: Themes and Recommendations for Mental Health Reform in Ontario (2002), which recommended the establishment of regional mental health authorities with responsibility for funding and delivery of mental health and addiction treatment services. These regional systems would deliver a core basket of community-based services and supports that would enable people living with mental illness to access a continuum of care, when and where they needed it, and to acquire the skills and resources necessary to achieve independence and well being. The Ontario government is still in the process of implementing these recommendations.

In Quebec, the Ministère de la Santé et des Services Sociaux (MSSS) has responsibility for mental health
and substance use policy development, planning and funding. The Minister is guided by the Comité de la santé mentale du Québec and the Comité permanent de lutte à la toxicomanie. The 18 regional health authorities in Quebec are responsible for the provision of inpatient, outpatient and community mental health services and supports, as well as treatment for substance dependence in their respective regions. Across Quebec, 95 local service networks, comprised of community health centres, hospitals and long term care facilities, have responsibility for local health and social service delivery, including primary mental health care.

In 2005, the Quebec government released *Plan d’Action en Sante Mentale: La Force des Liens 2005-2010* with a commitment to reducing the stigma of mental illness and providing improved mental health services for the entire population. The Plan calls for increased provision of mental health services by primary care practitioners. The MSSS also coordinates Québec’s suicide prevention strategy. The purpose of this strategy is to consolidate the various suicide prevention efforts to ensure equitable access to essential services in all regions. The strategy involves not only governmental departments, but also health authorities and community health centres, hospitals, suicide prevention centres, police, schools, youth centres and community organizations.

In 2003, Nova Scotia released *Strategic Directions for Nova Scotia’s Mental Health System and Standards for Mental Health Services in Nova Scotia*. Nova Scotia was the first province to introduce formal standards for mental health service delivery. These standards were developed through collaborative efforts involving individuals with mental illness and substance dependence, their families, community groups and the Mental Health Services Section of the Department of Health.

In 2007, Nova Scotia released *Changing the Culture of Alcohol Use in Nova Scotia: An Alcohol Strategy to Prevent and Reduce the Burden of Alcohol-Related Harm in Nova Scotia*. Entrenched in the strategy is the vision of broad cultural change, where individuals, families, and neighbourhoods support responsibility and risk reduction in alcohol use. The vision describes a future where alcohol-related harm has been eradicated through effective prevention and targeted interventions. It reflects a culture of moderation in which people consume alcohol without harm to themselves, their families, or their communities.

The goal of the Nova Scotia alcohol strategy is to prevent and reduce alcohol-related acute and chronic health, social, and economic harm and costs among individuals, families, and communities in Nova Scotia. The strategy has five interrelated strategic directions: community capacity and partnership building; communication and social marketing; strengthening prevention, early intervention, and treatment; healthy public policy; and research and evaluation. Recognizing that many of the solutions to prevent and reduce alcohol-related harm are beyond the scope of a single entity, the strategy emphasizes the need to foster partnerships across sectors and jurisdictions.

The Government of Newfoundland and Labrador released *Working Together for Mental Health* in 2005, which sets out a comprehensive and long term strategy for the mental health and addictions system that encompasses all age groups and the full continuum of services. The strategy recognizes that addictions services are an essential component of the broader mental health system and emphasizes the need for more attention to the prevention of substance dependence and other mental health problems. The strategy is intended to address some of the long standing challenges within the mental health system, including isolation and discrimination of people who experience mental illness, a lack of home and community supports, and little consumer and family participation in care and treatment decisions. The five strategic directions are: enhancing prevention and early intervention, involving consumers and significant others, building bridges for better access, providing quality mental health and addictions, and demonstrating accountability. In 2006, the
Newfoundland Parliament passed a new *Mental Health Act*.

In most provinces, responsibility for mental health and substance use policy development and service planning rests with the provincial department of health. A number of provincial reports have noted, however, that policy development which impacts on individuals with mental illness and substance dependence has not been well coordinated across various social policy ministries. This has diminished the impact which would be derived from more thorough, consultative and inclusive inter-ministerial planning among the several ministries that must inevitably be involved in the provision of services to individuals with mental illness and substance dependence (Kirby Report, 2004b).

Reform of the mental health system is occurring in most jurisdictions. While there are variations across provinces, a number of best practices criteria have been identified and largely agreed upon (Kirby Report, 2004b). These are:

- a shift from hospital to community-based services to create a more balanced approach to the delivery of mental health and substance use services
- specified, protected funding for an integrated mental health and substance use treatment system, including community, hospital-based and community-based tertiary care
- a single point of accountability where responsibility for the operation of an integrated system at the local/regional level
- mechanisms for the meaningful involvement of individuals with mental health problems and substance use problems and communities in decision-making

### III. INTERNATIONAL POLICY REVIEW

#### Global Overview

Mental disorders contribute significantly to the global burden of disease and are associated with economic and social costs to individuals, families and countries. Reducing this burden is possible given an important evolving information base to guide policy, service development and clinical practice. However, there remains a sizeable gap between what we know in terms of what works and what is actually available on the ground.

The WHO *Mental Health Atlas 2005* highlights the gap between the burden of mental disorders and available resources. Survey results indicated that 38% of countries, representing approximately one third of the global population, do not have a national mental health policy. For those countries with a national mental health policy, approximately 62% have formulated their policies since the 1990s and, of these, 10% have done so since 2001.

There was a significant association between the presence of a mental health policy and that of a number of different variables: policy to address substance-related harms, a national mental health program, disability benefits, primary care training facilities in mental health, community care facilities in mental health and presence of NGO activities in mental health. The presence of policy, although an essential part of planning, does not guarantee an effective response to the mental health burden of any particular country. This depends on the comprehensiveness and relevance of the policy as well as its degree of implementation.
Approximately 69% of countries worldwide have a policy to address substance-related harms. Nearly two thirds of these policies were formulated after 1990. In the European Region, only 14% of countries are without such a policy compared to 50% of countries in the African Region. In the Americas, despite high prevalence of alcohol and drug related disorders, 27% of countries in the region do not have a policy to address substance-related harms.

Mental health legislation contains legal provisions for the protection of the basic human and civil rights of people with mental disorders and deals with treatment facilities, personnel, professional training and service structure. Despite the need for legislation and the useful role it can play in policy development and implementation, mental health legislation is absent in 22 percent of countries, covering nearly 31 percent of the world’s population. Of the countries which have mental health legislation, 25 percent have legislation that was enacted after 2000, 48 percent have legislation that was enacted before 1990, and a striking 16 percent of countries have legislation that was passed before 1960 when the majority of the current effective methods for treating mental disorders were not available.

The presence of legislation, even if it has been formulated recently, does not guarantee the protection and promotion of rights of persons with mental disorders. Legislation in many countries is outdated or in many instances takes away rights of persons with mental disorders rather than protects their rights. Furthermore, even progressive legislation is of little use if it fails to be implemented effectively, as is the case in many countries.

In terms of the global provision of human resources for mental health, almost half the countries of the world have less than 1 psychiatrist and psychiatric nurse per 100,000 population. The median number of psychiatrists worldwide varies from 0.04 per 100,000 population in the African Region to 10 per 100,000 in the European Region. There are approximately 1800 psychiatrists for 702 million people in the African region, compared to almost 90,000 psychiatrists for 879 million people in Europe. All countries in the South East Asia Region and 90% of countries in the African Region have less than one psychiatrist per 100,000 population.

The median number of psychiatric nurses per 100,000 population ranges from 0.10 in South East Asia to 24.8 in Europe. In 76% of low income countries worldwide, covering 86% of the global population, there is less than one psychiatric nurse per 100,000 population. The total number of psychiatric nurses in some countries may actually be less as countries may have reported general nurses who work in psychiatric facilities, as psychiatric nurses, without specific training.

With respect to community-based care, only 68% of countries worldwide have community care facilities. In high income countries, 97% have community care facilities, compared to 52% of low income countries. In the African, Eastern Mediterranean and South-East Asian Regions approximately 50 percent of countries do not have community care facilities.

The provision of preventive and curative mental health services in primary health care is present in 87% of countries worldwide. Mental health in primary care is present in 76% of low income countries compared to 97% of high income countries. However, 38% of countries worldwide do not provide treatment for severe mental disorders at the primary care level, including the United States.

The mean number of psychiatric beds in the world is 4.36 beds per 10,000 population. This varies from 0.33 beds in the South East Asia Region to 8.0 beds in the European Region. In 40% of countries worldwide there is less than one psychiatric bed per 10,000 population. In 84% of low income countries, there is less than one bed per 10,000 population. In spite of policy shifts to deinstitutionalization, approximately 69% of psychiatric beds in the world are still in mental
In low income countries, 74% of psychiatric beds are in mental hospitals, compared to 55% in high income countries. The Western Pacific Region has the highest proportion of psychiatric beds in general hospitals at 35 percent.

Worldwide, only 65% of countries have essential psychotropic medicines available at the primary care level. In the Eastern Mediterranean Region, this drops to 50% of countries and rises to 80% of countries in the Western Pacific Region.

These figures are concerning as the level of financial resources being invested to improve mental health is proportionately low compared with the disability and burden of disease resulting from mental disorders. Thirty one percent of countries worldwide do not have a specified mental health budget and of those countries reporting actual mental health expenditure, 21% spend less than 1 percent of their total health budget on mental health. In the South East Asia Region, 50% of countries spend less than 1% of their health budget on mental health. In the African Region, this rises to 70% of countries. In the European Region, 61% of countries spend more than 5% of their health budget on mental health.

**United Nations**

The United Nations General Assembly adopted the *Convention on the Rights of Persons with Disabilities* on December 13, 2006. The Government of Canada became a signatory in April 2007. The Convention recognizes the full legal rights of all people with a disability, including those living with mental illness and substance dependence. The Convention also recognizes the right to seek support and, in the acceptance of human frailty, it establishes the standards for providing support and safeguards against abuse.

People experiencing mental illness and substance dependence have always faced difficulties participating in society because of pressure to conform to normal social and legal standards. This pressure has been eased by the Convention, which accepts the principle of reasonable accommodation and allows the norms to be modified to accommodate people's diversity. The Convention also recognizes that people with disabilities, including those living with mental illness and substance dependence, have a right to be consulted in the formulation of all laws, policies and practices that affect them.


**World Health Organization**

The World Health Organization (WHO) Department of Mental Health and Substance Abuse provides leadership and guidance for the achievement of two broad objectives: (a) closing the gap between what is needed and what is currently available to reduce the burden of mental disorders worldwide; and, (b) promoting mental health. These objectives are pursued through strong linkages within the WHO, collaboration with regional and country offices and collaborating centres around the world, and through combined action in education, social welfare, justice, rural development and women's affairs.
In 2001, the WHO devoted its annual World Health Report to mental health. Entitled, *Mental Health: New Understanding, New Hope*, this report provided a comprehensive review of what is known about the burden of mental disorders and the principal contributing factors. It examined the scope of prevention and the availability of, and obstacles to, treatment. It provided a critical review of service provision and planning and concluded with a set of far-reaching recommendations to be adapted by countries according to their resources and needs.

As follow-up to the 2001 World Health Report, WHO established the mental health Global Action Program (mhGAP). This program focuses on forging strategic partnerships to enhance countries’ capacity to combat stigma, reduce the burden of mental disorders and promote mental health. The mhGAP prioritizes services for the most vulnerable population groups and focuses on prevention, treatment and rehabilitation for people with six priority conditions: depression, schizophrenia, alcohol and drug dependence, dementia, epilepsy, and the risk of suicide.

The WHO MIND Project: Mental Health Improvements for Nations Development supports countries in the development of human rights-oriented mental health policies, strategic plans and laws to ensure that effective treatment, prevention and promotion programs are made available to all people who need them. The WHO MIND Project focuses on four key areas: action in countries; mental health policy, planning and service development; mental health, human rights and legislation; and mental health, poverty and development.

**Mental Health Policy, Planning and Service Development**

Mental health policy defines the vision for the future mental health of the population, specifying the framework which will be put in place to manage and prevent priority mental and neurological disorders. When clearly conceptualized, a mental health policy can coordinate essential services and activities to ensure that treatment and care is delivered to those in need, while at the same time preventing fragmentation and inefficiencies in the health system.
A mental health plan is a detailed scheme to implement the vision and objectives defined in the policy. A plan should include the concrete strategies and activities that will be implemented to tackle mental disorders and associated disability, as well as specifying the targets to be achieved by the government. It should also clarify the roles of the different stakeholders in implementing the activities of the mental health plan.

In order for a mental health policy and service planning to be successful, thorough consultation must take place with the key stakeholder groups. This is not yet common practice in most countries. Without wide stakeholder involvement, the resulting policy and plan may be too narrowly framed and may not adequately meet population mental health needs. However, a stakeholder involvement process that is ill-defined may result in stalemate, confusion or a policy and plan that are so diffuse they do not adequately meet population mental health needs.

WHO recommends three priorities for mental health policy, planning and service development: deinstitutionalize mental health care, integrate mental health into general health care, and develop community mental health services. Primary health care is the foundation for the delivery of formal services for mental health in all countries.

This is reflected in the WHO optimal mix of services:

The majority of mental health care can be self-managed or managed by informal community mental health services. Where additional expertise and support is needed, a more formalized network of services is required, including -- in ascending order -- primary care services, specialist community mental health services and psychiatric services based in general hospitals, and specialist and long-stay mental health services.

Optimal treatment and care for people with mental disorders under this ‘ideal’ model of service organization requires that a number of key principles are respected in the design, distribution and delivery of services. These principles include accessibility, comprehensiveness, effectiveness, continuity and coordination, needs-based care, equity and respect for human rights.

The WHO optimal mix of services has proven to be an effective tool for helping countries to map
their existing mental health services and identify both gaps in services and sub-optimal distribution of services. In 2005, Chile underwent a global health system reform guided by the principles of right to health, equity, solidarity, efficiency in the use of resources, and social participation in health. National health objectives and goals were formulated for 2010. Thirteen regional health authorities were created and the 28 existing local health districts were given more autonomy. The development of a national public health plan, supported by regional public health plans, explicitly based on the social determinants of health is currently underway.

The most visible step of this reform process has been the implementation of a system of treatment for health problems with guarantees of access, opportunity, service quality and financial protection. Among 56 health problems with guarantees are three mental health problems: schizophrenia, depression, and problematic substance use and substance dependence.

As part of this general health reform process, Chile mapped its mental health services and facilities against the WHO model and found the following distribution. Efforts are currently underway to bring the distribution of mental health services in line with the WHO model:


**Mental Health, Human Rights and Legislation**

Many people with mental disability are exposed to a wide range of human rights violations, both within psychiatric institutions and in the community. In many countries, people do not have access to basic mental health care and treatment. In others, the only care available is in psychiatric institutions, which are often associated with gross human rights violations. People are exposed to inhuman and degrading living conditions, as well as harmful practices from intentional overmedication to physical restraints.

The stigma and misconceptions associated with mental disabilities often mean that people are marginalized and ostracized from society. In many countries, people are left to fend for themselves, excluded from family and community life and denied basic rights such as shelter, food and clothing. They are often discriminated against in the fields of employment, education and housing due to their mental disability. Many are denied the right to vote, marry and have children. As a consequence, people with mental disabilities often live in poverty which, in turn, affects their ability to gain access to appropriate care, integrate into society and recover from their illness. These violations are an issue
for both developing and developed countries.

The international human rights framework, which creates legally binding obligations on governments to respect, protect and fulfill human rights, apply to all people including people with mental disabilities. Furthermore, many of the rights outlined in UN and regional human rights instruments are particularly important to people with mental disabilities, given their exposure to wide ranging violations. Concrete action needs to be taken at international and national level to prevent human rights violations and promote these rights.

In accordance with international human rights law, governments should:

1. improve access to quality mental health care
2. respect the rights of users of mental health services to confidentiality and access to information
3. protect against cruel, inhuman and degrading treatment
4. provide a safe and hygienic environment
5. promote voluntary admission and treatment including free and informed consent
6. ensure the review and appeal of all case of involuntary admission and treatment

To accomplish this, governments can focus on three key strategies:

1. Develop mental health policies and laws that promote human rights.
   Mental health policies and laws are absent or inadequate in most countries of the world and yet they critical to improving conditions for people with mental disabilities.

2. Create mechanisms to monitor human rights conditions.
   People with mental disabilities are often assumed to be incapable of making decisions on their own and, as a result, can be detained in psychiatric institutions unjustifiably and treated against their will.

3. Train key stakeholders on the rights of people with mental disabilities.
   All people and professionals who have an impact on the lives of people with mental disabilities should receive training on human rights issues. Specifically, training needs to be provided to:
   - people with mental disabilities and their families so that they can claim their rights
   - health and mental health professionals so that they understand the rights of their patients and apply these in practice
   - police who are in daily contact with people with mental disabilities
   - lawyers, magistrates and judges who make important decisions concerning the lives of people with mental disabilities

**New Movement for Global Mental Health**

Health, Human Rights and Legislation (2005b) to support the development of mental health legislation that respects and protects the human rights of people with mental disorders. As mentioned earlier, WHO published the World Health Organization Mental Health Atlas (2005a), which contains comprehensive global data on mental health resources, including country level assessments of mental health policy, legislation, financing, facilities, numbers of psychiatric beds and professionals, availability of therapeutic drugs, and programs for special populations.

In April 2008, the WHO and World Family Doctors Caring for People (WONCA) are expected to release a report that will outline the rationale and advantages for integrating mental health into primary health care settings. The report will present seven case studies illustrating how mental health services have been successfully integrated into primary health care settings. The case studies will be based in different countries with vastly different resources and provide a detailed analysis of the country context and set-up process. The report will provide best practice recommendations for integrating mental health services into primary health care.

However, despite these reports, WHO leadership and partnership efforts have had limited success converting mental health policy recommendations into action at the country level. This has been attributed to both a lack of dedicated resources at WHO to support its policy recommendations and the lack of a sustainable mechanism across global and country institutions to hold WHO and others accountable for policy implementation and achievement of population mental health outcomes.

In response, the WHO is appealing to countries to increase their support for mental health services. The WHO has joined forces with the Lancet to produce a series of six reviews of global mental health. The intent of the Lancet Global Mental Health Series, together with the WHO call to action and a commitment to monitor progress across a range of mental health indicators, is to change the culture of lost opportunity and create a new global movement for mental health. Over the next two years, the Lancet will make mental health one of its campaign focal points leading up to a global summit on mental health in 2009.

Written by an internationally diverse Global Mental Health Group, the papers address a range of issues, including global disease burden due to mental disorders, scarcity and inefficiency of resources for mental health, cost effectiveness of treating depression and other mood disorders in primary care settings, and the need for human rights-based mental health legislation, policies and delivery systems. Lancet editor, Richard Horton, summarizes the key messages of the series:

1. Mental health is a neglected aspect of human well-being, which is intimately connected with many other conditions of global health importance.
2. Resources for mental health are inadequate, insufficient, and inequitably distributed.
3. There is already a strong evidence base on which to scale up mental health services.
4. Most low-income and middle-income countries currently devote far too few resources to mental health.
5. There are critical lessons to learn from past successes and failures for political leadership and priority setting, increasing financial support, decentralizing mental health services, integrating mental health into primary care, increasing health workers trained in mental health, and for strengthening public health perspectives in mental health.
6. Any call to action demands a clear set of indicators to measure progress at country level.

All review papers and commentaries can be accessed without payment at the following link:
European Union

Policies and Plans

WHO European Declaration and Action Plan

At the WHO European Ministerial Conference on Mental Health, held in Helsinki in January 2005, The WHO Mental Health Declaration for Europe and the WHO Mental Health Action Plan for Europe were signed and endorsed on behalf of ministers of health of the 52 member states in the European Region.

These key documents give impetus to the development of mental health care in the European region and aim to support the implementation of policies and activities to improve mental health promotion, prevention, care and treatment. They focus on 12 key areas of action:

1. Promoting mental well-being for all
2. Demonstrating the centrality of mental health
3. Tackling stigma and discrimination
4. Promoting activities sensitive to vulnerable life stages
5. Preventing mental health problems and suicide
6. Ensuring access to good primary care for mental health problems
7. Offering effective care in community-based services for people with severe mental health problems
8. Establishing partnerships across sectors
9. Creating a sufficient and competent workforce
10. Establishing good mental health information
11. Providing fair and adequate funding
12. Evaluating effectiveness and generate new evidence

Lisbon Strategy

In 2000, in Lisbon, Portugal, the European Council launched an ambitious and far-reaching strategy aimed at making the European Union (EU) the most competitive economy in the world and achieving full employment by 2010. The Lisbon Strategy rests on three pillars:

- Economic pillar to prepare the ground for the transition to a competitive, dynamic, knowledge-based economy
- Social pillar to modernize the European social model by investing in human resources and combating social exclusion
- Environmental pillar to draw attention to the need to separate economic growth from the use of natural resources

Clear policies with targets and timelines were developed for each pillar. Given that the policies fall almost exclusively within the jurisdiction of the EU Member States, an open method of
coordination (OMC) was introduced to coordinate the development of national action plans to achieve policy targets. The Lisbon Strategy also provides for the adaptation and strengthening of existing coordination mechanisms: the Luxembourg process for employment, the Cardiff process for the functioning of markets (goods, services and capital) and the Cologne process on macroeconomic dialogue.

In 2005, after a poor mid-point review, the European Council approved a new partnership aimed at focusing efforts on the achievement of stronger, lasting growth and the creation of more and better jobs. Council also recommended the development of a single progress report to monitor implementation of the national plans in achieving the policy targets over a three-year period.

**European Commission New Social Agenda**

The European Commission launched its new Social Agenda (2005-2010) for modernizing Europe's social model under the revamped Lisbon Strategy for growth and jobs. The Agenda is the social policy dimension of the Lisbon Strategy and is an essential tool in implementing the strategy. The Agenda has two key priorities: (1) moving towards full employment and (2) fighting poverty and extending equal opportunities to all. By modernizing labour markets and social protection systems, the Agenda will help people take advantage of the opportunities created by international competition, technological advances and changing population patterns, while protecting the most vulnerable in society. It is this economic growth agenda that is influencing new trends in mental health policy, with significant weight attached to economic arguments that the mental health of the European population is a resource for long term prosperity.

**European Commission Green Paper**

The purpose of the European Commission’s 2005 Green Paper, Improving the Mental Health of the Population: Towards a strategy on mental health for the European Union, was to launch a debate about the relevance of mental health for the EU, the need for a strategy at the EU level and potential priorities with European institutions, governments, health professionals, stakeholders in other sectors, civil society including patient organizations, and the research community.

Consistent with the WHO European Declaration and Action Plan, the Commission proposed that an EU strategy could focus on the following aspects:

- promote the mental health of all;
- address mental ill health through preventive action;
- improve the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity;
- develop a mental health information, research and knowledge system for the EU.

The Commission is expected to publish the results of the consultation with a proposal for an EU strategy on mental health in 2007.

**Resources for Implementation**

Many countries across the EU have policies, strategies and action plans that include a commitment to mental health promotion and prevention. Although each country will have its own unique challenges and opportunities in moving from policy to delivery, there are some common factors that support effective implementation.

The following determinants of effective implementation have been drawn from analysis of the experiences of national partners in the European Mental Health Implementation Project.
These determinants are the factors or conditions that influence the level and quality of mental health promotion and prevention activity in a given country. They include:

- marketing mental health and well-being
- making the case across different sectors and with different stakeholders
- demonstrating how mental health promotion contributes to effective service reform and improved outcomes for people with mental health problems
- developing a system of governance linked to wider targets in other sectors with clear lines of accountability for mental health promotion and mental illness prevention
- describing what success would look like and how it will be measured
- building capacity across all sectors
- evidence base and evaluation

**Australia**


**Policies and Plans**

In 1992, Australian Health Ministers approved a *National Mental Health Policy* (the Policy), to be implemented under a five-year *National Mental Health Plan, 1993-1998* (the First Plan). This represented the first attempt to coordinate mental health care reform through national action. The First Plan focused on state/territory-based public sector and specialist mental health services. It increased the emphasis on community-based care, decreased reliance on stand-alone psychiatric hospitals, and mainstreamed acute beds into general hospitals. In 1997, Australian Health Ministers endorsed the further development of the original reform agenda under the *Second National Mental Health Plan, 1998-2003* (the Second Plan).

The Second Plan was designed to consolidate ongoing reform activities and expand into additional areas of focus. It built on the First Plan by adding a focus on mental health promotion and mental illness prevention, and attending to the question of how the public mental health sector could best dovetail with other sectors to maximize treatment outcomes and opportunities for recovery. Whereas the First Plan focused largely on severe and disabling low-prevalence illnesses, particularly psychoses, the Second Plan expanded the emphasis to include high-prevalence illnesses such as depression and anxiety disorders.

The Policy and the First and Second Plans were underpinned by the Mental Health Statement of Rights and Responsibilities which embodies the values of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. Together, these documents are known as the National Mental Health Strategy.

The broad aims of the National Mental Health Strategy are to:

- promote the mental health of the Australian community
- prevent the development of mental disorder

(http://mentalhealth.epha.org/index.html)
reduce the impact of mental disorder on individuals, families and the community

assure the rights of people with mental disorder

Priority areas under the First National Mental Health Plan were:

- consumer rights
- relationship between mental health services and the general health sector
- linking mental health services with other sectors
- service mix
- promotion and prevention
- primary care services
- caregivers and non-governmental organizations
- mental health workforce
- legislation
- research and evaluation
- standards
- monitoring and accountability

Additional priority areas under the Second National Mental Health Plan were:

- promotion and prevention
- development of partnerships in service reform
- quality and effectiveness of service delivery

The First and Second Plans were operationalized through bilateral funding agreements between the Commonwealth and each State and Territory.

The *Third National Mental Health Plan, 2003-2008* (the Third Plan), builds on the priorities of the First and Second Plans. It consolidates existing reforms which have been regarded as consistent with international best practice and enhances the focus in four areas: promoting mental health and preventing mental health problems and mental illness, improving service responsiveness, strengthening quality, and fostering research, innovation and sustainability. For each area, or priority theme, there are a set of outcomes and key directions for achieving the outcomes. In some cases, responsibility for achieving the outcomes rests with the Australian Government. In others, it lies with State/Territory governments. The achievement of most outcomes will require the governments to work with each other as well as with service providers, consumers and their families and other key stakeholders.

The Third Plan explicitly adopts a population health approach which acknowledges that the determinants of mental health at the population level comprise a range of psychosocial and environmental factors, including income, employment, education and social support, as well as demographic factors. This population health approach recognizes the importance of mental health across the life course and across diverse groups within the population. It also recognizes the effect
of mental health on physical health, including the effect of mental health problems co-occurring with other conditions, such as substance use problems, and the role of mental illness in vulnerability to communicable diseases and chronic diseases.

The Third Plan stresses the importance of monitoring mental health and mental illness within populations, at both a single point in time and longitudinally, to provide information to match services to population needs and identify unmet needs for services. This epidemiological information is critical in determining the impact of policies and programs on rates of mental health problems and mental illness and their associated disability. The population health approach requires interventions to be supported by an appropriate evidence base and informed by ongoing monitoring and evaluation. This, in turn, assumes capacity for research and evaluation at the local level.

The Third Plan can be viewed as an ongoing agenda for service and community development that sets priorities for 2003–2008. It represents a partnership between the key stakeholders in mental health. The Third Plan does not specify projects to be funded within the new reform agenda, but rather identifies priority areas of work within an agreed policy framework. It recognizes that some initiatives will bear fruit within the five year timeframe, while others will lay the groundwork for achievements that may take much longer.

**Supporting Policies and Plans**

Over the years, the Australian Government’s National Mental Health Strategy has provided the impetus for the development of more detailed plans at the national, state and territorial level that focus on one or more of the broad aims of the Strategy and/or priority areas under the First, Second and Third Plans. For example, in response to the Second Plan's emphasis on promotion and prevention, the Australian Government developed the *Mental Health Promotion and Prevention National Action Plan (1999)*. This action plan was revised the following year as the *National Action Plan for Promotion, Prevention and Early Intervention (2000)*.

The Victoria Health Promotion Foundation (VicHealth) identified mental health promotion as a priority area for investment and developed its own *Mental Health Promotion Plan 1999–2002*. That plan involved the mapping of key international, national and state activity in mental health promotion. A fundamental component of the VicHealth plan was the development of a mental health promotion framework to guide innovations. Implementation involved a three-year program of intervention trials, advocacy and co-funded activity aimed at improving the capacity of individuals, organizations and communities to promote mental health and wellbeing. It was accompanied by an extensive program of research and evaluation.

In response to the promotion and prevention priority identified in the Third Plan, VicHealth released its *Mental Health Promotion Framework 2005-2007*, which outlines key directions for research and implementation activity. The Framework is intended to serve as an information resource for policy makers, researchers, community organizations and practitioners working across sectors. It draws on the lessons learned in the course of implementing and evaluating the previous plan, as well as emerging evidence and policy directions at the national and international level.

**Monitoring and Evaluation**

Evaluations undertaken at the end of the First and Second Plans indicated substantial policy reforms had been achieved during each five-year period.

By 1998, national spending on mental health care increased by 30 percent in real terms, while spending on community-based services grew by 87 percent. The amount of mental health spending dedicated to caring for people in the community had increased from 29 to 46 percent. Resources
released through institutional downsizing funded 48% of the growth in community-based and general hospital services. The number of clinical staff providing community care rose by 68 percent, in parallel with increased spending. Stand-alone psychiatric institutions, which had accounted for 49 percent of total mental health resources, were reduced to 29 percent of those resources and the number of beds in institutions fell by 42 percent. At the same time, the number of acute psychiatric beds in general hospitals rose by 34 percent. The non-governmental sector increased its overall share of mental health funding from two to five percent and funds allocated to non-governmental organizations to provide community support to people with psychiatric disability grew by 200 percent (Whiteford et al, 2000).

By 2003, the mental health system had strengthened its capacity to respond to the needs of people with mental illness by moving towards the provision of mental health care within the mainstream health system and through community care. The nature of the mental health workforce had changed substantially with the acknowledgement of the critical and complementary role of primary care providers in mental health service delivery. The mental health agenda had broadened from a narrow focus on treatment to one that incorporated the entire spectrum of interventions, including mental health promotion, prevention of mental health problems and mental illness, early intervention, and rehabilitation and recovery. Action in the area of consumer rights had moved from concern over open human rights abuses to awareness of problems of neglect. However, while formal mechanisms for consumer and caregiver participation had been put in place, these were not seen as constituting meaningful participation. Similarly, community expectations were higher regarding access to quality mental health care.

Chile


Policies and Plans

In 1990, Chile formulated its first mental health policy and supporting plans. A mental health team was established within the Ministry of Health and at least one professional was placed in charge of mental health in each of the 28 health districts. The main strategies involved the integration of mental health into primary health care, the psychosocial rehabilitation of people with psychiatric disabilities, the prevention and treatment of alcohol and drug abuse and domestic violence, and the treatment of victims of torture and other human rights violations that had occurred between 1973 and 1990.

In 2000, a new national mental health plan was developed in response to a political crisis involving the Ministry of health and trade unions at the country’s main psychiatric hospital. The crisis arose because of inadequate psychiatric care available in the community for discharged patients. This was resolved through the development of a comprehensive mental health plan backed by a substantial increase in mental health funding. The National Plan on Mental Health and Psychiatry (2000) contains the vision, principles and strategies for mental health in Chile. The national plan is implemented in the public sector through the following mental health programs:

Depression

This program includes psychotropic medication and psychosocial interventions for persons 15 year sand older. Approximately 90% of persons are treated in primary care and 10% are referred to
specialist care due to the severity of their disorder.

**Schizophrenia**

Specialist care is available for persons of any age with this diagnosis. Medications have been improved, including the use of atypical antipsychotic drugs, and people increasingly have access to psychosocial rehabilitation.

**Substance abuse and dependence**

There is a joint program between the Ministry of Health and the National Illicit Drugs Council that offers ambulatory and residential services with different levels of intensity. Each type of service provides individual, group, family and community interventions.

**Integral health program for victims of military dictatorship**

There is one specialized multidisciplinary mental health team in each of the 28 health districts to treat the most severe cases of psychological trauma associated with torture and other human rights violations experienced during the military dictatorship. These individuals and their families can also access general health and mental health programs.

**Domestic violence**

This program focuses on women and children and is carried out mainly in primary health care facilities. The program has important intersectoral links with others services.

**Attention deficit/hyperactivity disorder**

This is a new program under the 2000 national plan to treat children in primary health care facilities for attention deficit/hyperactivity disorder who have been referred by the school system.

**Forensic psychiatry**

Short and medium-stay forensic inpatient units are available in psychiatric hospitals and prisons. The general mental health system is being reinforced to provide people with mental disorders who are caught up in the justice system with forensic evaluation, ambulatory and inpatient care, psychosocial rehabilitation, and sheltered homes.

Since 2000, there has been a significant increase in the number of people who have access to good quality mental health care—without discrimination—in primary health care settings, as well as in the number of people who are able to access psychotropic medications. Community-based services are progressively offering an alternative to traditional mental health care that is provided by psychiatric institutions. Between 1999 and 2004, the budget for psychiatric hospitals decreased from 57 to 33 percent and the budget for community-based services increased from 43 to 67 percent. People with mental disorders can now be treated in ambulatory services, day hospitals, different community mental health services, general hospitals and sheltered homes and residences.

**Resources for Implementation**

**Infrastructure**

The Ministry of Health consists of two ‘streams’ -- healthcare networks and public health. In the Sub-Secretary of Public Health, the Mental Health Department develops mental health legislation, regulations, policy, plans and programs. In the Sub-Secretary of Health Care Networks, the Mental Health Unit supports the 28 Health Districts, which oversee public sector service provision, with the implementation of mental health programs and coordinates national networks. Mental health
professionals in each Health District support health and mental health facilities with the implementation of programs and coordinate local public networks. In addition to the Health Districts, there are 13 Regional Health Authorities which oversee a mix of public and private sector service provision. The mental health professionals situated in the Regional Health Authorities contribute to the implementation of the Public Health Plan and to the authorization and regulation of public and private mental health facilities.

**Workforce**

Human resources for general and mental health in Chile include psychiatrists, psychologists, physicians, nurses (including psychiatric nurses), pharmacists, social workers, occupational therapists and other workers, such as traditional healers, paraprofessional psychosocial counselors, and non-doctor primary health care workers.

<table>
<thead>
<tr>
<th>Health Professional</th>
<th>Density (per 100,000 population)</th>
<th>Number currently working in mental health (public or private facilities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>4.7</td>
<td>742</td>
</tr>
<tr>
<td>Psychologists</td>
<td>12.3</td>
<td>1964</td>
</tr>
<tr>
<td>Social workers</td>
<td>1.7</td>
<td>273</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>3.1</td>
<td>501</td>
</tr>
<tr>
<td>Other</td>
<td>7.5</td>
<td>1193</td>
</tr>
<tr>
<td>Physicians</td>
<td>0.7</td>
<td>109</td>
</tr>
<tr>
<td>Nurses</td>
<td>1.7</td>
<td>264</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Professional</th>
<th>Mental Health Training Available in Chile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>3 years after MD</td>
</tr>
<tr>
<td>Psychologists</td>
<td>2 years after 5 year general psychology degree</td>
</tr>
<tr>
<td>Social Workers</td>
<td>No formal training in mental health</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>No formal training in mental health; OT training is 5 years, including undergraduate mental health training</td>
</tr>
<tr>
<td>Traditional healers</td>
<td>No formal training in mental health</td>
</tr>
<tr>
<td>Other</td>
<td>N/A</td>
</tr>
<tr>
<td>Profession</td>
<td>Training Details</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Physicians</td>
<td>Medical doctor (MD) training is 7 years</td>
</tr>
<tr>
<td>Nurses</td>
<td>General nurse training is 5 years</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>No formal mental health training</td>
</tr>
</tbody>
</table>
Monitoring and Evaluation

The Health Statistics Department collects data on the activities of the mental health system which is covered by the public health system. The National Plan for Mental Health and Psychiatry Information System covers the activities of primary and specialist care, including inpatient and outpatient care, and outcome evaluation of specific programs. Further information on the mental health of the population will be obtained through general household surveys.

Denmark


Policies and Plans

During the last 15 years, there has been an increasing focus in Denmark on public policy responses to mental health disorders. In the early 1990’s, a national policy was established to change the system of psychiatric services from predominantly institutional care to community care. This led to the implementation of three consecutive national agreements between the Danish government and the counties, which are responsible for health care service delivery, including mental health services. These agreements represent a nation-wide strategy to improve mental health care and treatment. The agreements also contain arrangements for financing and regular evaluation of progress.

The policy change initially concentrated on the needs of psychotic and severely ill psychiatric patients. Over the years, however, there has been a growing awareness of mental health and mental health problems, as well as an increasing political commitment to improve mental health services. For example, the WHO has estimated that depressive disorders account for the greatest cause of disability adjusted life years (DALY’s) in Denmark, amounting to over 8% of all DALY’s. Today, the policy focus includes people with mild to moderate mental disorders and specific groups of mentally ill persons, such as people with depression, eating disorders and dementia.

At the system level, improvements in mental health care have included the education of more specialists, such as psychiatrists, psychiatric nurses and other professionals; new hospital facilities, including single rooms for psychiatric patients; further development of community-based psychiatry; improvement in capacity for treatment of children and adolescents with mental disorders; and, better inter-sectoral co-operation. From the consumer perspective, one of the key improvements has been increased cooperation between the health and social service sectors. In 2005, the Danish government outlined core values for inter-sectoral collaboration in caring for mentally ill patients, with the goal of creating greater coherence between treatment and social assistance for patients.

Supporting Policies, Plans and Programs

In 2002, the Danish Government launched ‘Healthy throughout Life’ with the goal of increasing life expectancy, improving the quality of life and reducing social inequality in the health of the Danish population. This initiative maintains a special focus on collective efforts to reduce major, preventable diseases through primary prevention. Mental disorders are one of eight groups of preventable diseases targeted in the policy. The specific target in relation to mental disorders is to reduce the prevalence of mental disorders, with an emphasis on children in families with a parental substance use disorder or mental disorder. As part of ‘Healthy throughout Life’, the National Board
of Health initiated the Project on Major Preventable Diseases and Disorders in 2003. The overall aim of the Project is to develop and strengthen the prevention of eight major preventable disease groups, and to better integrate disease prevention and health promotion in the treatment efforts of the health care system.

A number of initiatives have been developed to meet the aim of the Project. One example is the implementation of physical activity for psychiatric in-patients. The evidence indicates that among people with mental disorders, physical exercise has a positive effect in supplementing or replacing pharmacological treatment of mild to moderate depression. In addition, people with certain mental disorders have an excess prevalence of obesity and type 2 diabetes and excess mortality from cardiovascular diseases. The reasons include lack of physical activity, inappropriate diet, smoking habits and the side effects of medication. Psychiatric in-patients have longer hospital stays than other in-patients, which makes it important to maintain and expand meaningful and appropriate patterns of activity.

In 1980, the suicide rate in Denmark was among the highest in the world, with 35 suicides per 100,000 population. In 2001, the age-adjusted rate was 14 suicides per 100,000 population, a 60% reduction. The decreasing number of suicides over time can be attributed to the reduced availability of means to commit suicide, better physical and psychiatric treatment after attempted suicide, increased social and cultural stability in society, more general focus on prevention, and increased access to telephone counselling and psychiatric emergency services. Since 1990, the overall suicide attempt rate has remained steady at 180-200 per 100,000 population. Within the last few years, however, there has been a disturbing rise in suicide attempts among women aged 15-29 years.

The National Committee on Prevention of Suicidal Behaviour, under the Ministry of Social Affairs and the Ministry of the Interior and Health, implemented a series of recommendations for suicide prevention between 1999 and 2004. The recommendations focused mainly on co-ordinating the joint efforts of the Danish government, counties, municipalities and voluntary organizations in suicide prevention. Some of the important initiatives during this period were knowledge generation and dissemination, capacity building, support of networks and research, and the evaluation of model projects.

The National Board of Health published national guidelines for health professionals in the assessment and management of people at risk of suicide. The Danish Network of Health Promoting Hospitals launched suicide prevention as a special area of focus and is in the process of implementing the national guidelines for health professionals. In 2005, the Ministry of Social Affairs allocated new resources to increase suicide prevention activities over a four year period (2005-2008), with special focus on young girls, elderly people and the mentally ill.

**Resources for Implementation**

The Danish welfare system guarantees free access to prevention and treatment of mental health problems. The Danish health care system provides free access to diagnosis, treatment and care for psychiatric disorders. There is a long tradition in Denmark of health promotion and prevention efforts across the life course, with an emphasis on children, to promote physical and mental health and diminish the consequences of disability. These efforts span the health, social service and education sectors. Non-governmental organizations are actively involved in advocacy, promotion, prevention and rehabilitation activities at national and local levels.
Infrastructure

In Denmark, the counties are responsible for hospital-based health service delivery, including psychiatric services, and for community-based health service delivery, including community psychiatric services. The municipalities are responsible for health promotion and prevention across the life course, including mental health promotion and mental illness prevention. Non-governmental organizations in the mental health area provide information and support for people with mental disorders and their families.

Workforce

The mental health workforce consists of professionals in promotion, prevention, treatment and care, and rehabilitation, located in various sectors and systems. Social workers, psychologists and others in the social service and education sectors play an important role in mental health promotion and mental illness prevention. Community-based physicians, nurses and others in the primary health care system are responsible for caring for the majority of the mental health problems in the population. People with serious mental disorders are referred to hospital-based psychiatric specialists and psychiatric departments with interdisciplinary teams of psychiatrists, psychologists, physiotherapists, occupational therapists, nurses and social workers.

Monitoring and Evaluation

There are a number of governmental organizations that are responsible for monitoring health services. The National Board of Health has national registers of mortality, patients treated in hospitals and in the primary health care system, as well as a register for monitoring involuntary psychiatric treatment. These data are published regularly in the public domain. Statistical reviews and special reports about mental disorders are published periodically which deal with specific objectives and quality of care. The prevention and treatment of psychiatric disorders are considered integral to the health of the Danish population and to the effectiveness of the health care system and are often the focus of policy development and quality improvement initiatives.

Finland


Policies and Plans

In Finland, a unifying policy of mental health does not exist at the national level. Mental health is an integral component of general health policies. *Health 2015* is the overarching health policy in Finland.


Over the past decade, the Ministry of Social Affairs and Health has organized several national mental health programs in areas such as suicide prevention, schizophrenia and depression. In 1992, Finland was the first country in the world to adopt a comprehensive national suicide prevention program. There has been a gradual movement away from a sickness orientation to a positive health orientation. The health system has moved from a predominantly service provider orientation to a client and family-centred orientation, from institutional care to community care, and from the
implementation of specific mental health initiatives at the local level to broad holistic approaches delivered on a regional level.

The regional expansion of mental health services has been the focus of two national projects, one launched in 2002 to secure the future of health care services, and one launched in 2003 to expand the development of social services.

Today, the vision for Finnish society is one where individuals and society as a whole are more tolerant of diversity, citizens create supportive activities for themselves and realize their social capital, politicians understand the human consequences of their legislation, and the promotion of mental health and prevention of mental disorders are an integrated dimension of society at the local, regional and national level.

In 2005, Finland co-hosted the WHO European Ministerial Conference on Mental Health in Helsinki, which resulted in the unanimous endorsement by 52 member states of the WHO Mental Health Declaration for Europe and Mental Health Action Plan for Europe. Since then, the National Research and Development Centre for Welfare and Health (STAKES) has been defining relevant tasks within the context of the WHO Declaration. The recently designated WHO Collaborating Centre of Mental Health Promotion, Prevention and Policy Implementation, a joint venture of STAKES, National Public Health Institute and the Institute of Occupational Health, is responsible for developing key areas of the action plan, in particular those dealing with promotion and occupational health.

Supporting Policies, Plans and Programs

The Finnish National Schizophrenia Project, carried out in the 1980s, recommended the establishment of acute psychosis teams in every catchment area to engage newly psychotic patients in care through active intervention involving the family. In 1992, the 10-year follow-up verified that most of the catchment areas had established these multi-disciplinary teams.

The Meaningful Life program, which operated from 1998 to 2002, was a nation-wide and multi-sectoral program to improve the quality of life for people experiencing mental disorders and their consequences. The main target areas were the enhancement of the social value of mental health, development of mental health indicators, and the promotion of mental health in children, adolescents, older adults and in relation to working life and employment policy.

In the last few years, the government has allocated special resources to improve services for children and adolescents, including increased funding of psychotherapy for children. Specialized outpatient departments and a few wards in psychiatric hospitals have been created for substance abuse patients. The government has also allocated funds to expand primary care services for persons with substance use problems. There is still, however, a shortage of rehabilitative services for chronic drug users.

In 2004, the Finnish government introduced the Drug Policy Action Program 2004-2007, which outlines the government’s strategies for reducing harms from drug use. This program represents a continuation of the work begun under previous program (2001-2003), which focused on reducing drug demand, supply and drug-related crime. The renewed program has a greater emphasis on cross-sectoral cooperation.
Resources for Implementation

Investment

The primary sources of mental health financing in descending order are tax-based funding, social insurance, out of pocket expenditure by the patient or family and private insurances. In 1993, financing of the Finnish health care system was decentralized to the municipal level. Today, the 450 municipalities are responsible for providing health care services for their inhabitants. The average municipal population is 6000 people. The biggest municipality is Helsinki, with approximately 500,000 people, but the smallest have only a few hundred inhabitants. Municipalities provide health care services directly or buy services from regional health care districts, other municipalities or private providers. The municipalities have the right to collect their own taxes to finance health care and other expenditures. The national government provides a subsidy to each municipality but funds are not specifically earmarked for health. This has led to increasing regional and local differences in the provision of mental health care.

Infrastructure

Social welfare and health care are integrated at the national and provincial levels. At the national level, the Ministry of Social Affairs and Health has the highest administrative responsibility and STAKES is the lead agency in mental health research and development activities. In every provincial administration, there is a Department for Social Affairs and Health. At municipal level, the models and degree of cooperation vary. In some, the social welfare and primary health care services are integrated at the policy and program level. In others, they still operate independently from each other, although during the 1990s there has been increasing integration of services across Finland.

Mental health services are organized around the concept of catchment areas, which are currently governed by health care districts. Mental health is a part of the primary health care system and is provided mainly through community-based outpatient services. Emergency treatment of severe mental disorders is available at the primary level. There are community care facilities for patients with mental disorders. Roughly two-fifths of psychiatric services, mostly outpatient care, have been moved administratively to primary care in many districts. Most psychiatric wards belong to the administration of general hospitals. Other settings include state hospital beds for forensic psychiatry, prisoners, military psychiatric wards, and psychiatric wards in general hospitals and in private hospitals.

Traditionally, the mental health care system has been hospital-centred, and the deinstitutionalization process started later than in many other developed countries. At the beginning of the 1980s, Finland still had about 20,000 psychiatric beds, almost all situated in separate psychiatric hospitals. However, these hospitals were not large; psychiatric beds were spread between 60 hospitals located across the country, and no hospital had more than 300 beds. During the last two decades, there has been a 75 percent reduction in the number of beds in psychiatric institutions.

From 1982 to 1992, the decrease in the number of psychiatric beds was compensated for by increasing outpatient resources and the development of community-based outpatient care. The main problem in implementing community care has been the scarcity of supporting services for long term patients living in general communities. There is a need for more supported housing, day centres, support persons and guided leisure activities. Patients’ families also need more help and support. Extramural rehabilitative facilities used to be provided mainly by the public health sector and a few semi-private foundations. In the 1990s, a large number of private complementary services were founded, and now they provide nearly 90% of all extramural residential services. Currently, nearly as many patients stay in such facilities as in psychiatric hospitals. However, the standard of care in these
facilities is variable as the control of authorities over private institutions is weak.

The 1990 Mental Health Act forbade the treatment of minors in the same hospital wards as adults. As a result, separate psychiatric hospital services were developed for children and adolescents, although adult and child and youth psychiatric services are often combined in outpatient care. The mental health system is characterized by multidisciplinary team work. Outpatient teams are generally comprised of a psychiatrist, psychologist, psychiatric nurse and social worker. Each occupational group receives a high standard of training and is, therefore, recognized as an equal part of the team. For example, many nurses receive formal training in psychotherapy.

Four psychiatric specialties are recognized today: general psychiatry, child psychiatry, adolescent psychiatry and forensic psychiatry. About one-fifth of psychiatrists work as private practitioners only and one-third of psychiatrists working in the public sector have part-time private practice. Currently there is a shortfall of psychiatrists in Finland, despite the intensified training program implemented in the 1980’s.

**Workforce**

The mental health work force is comprised mainly of service providers with STAKES, other NGOs and organizations that report directly to the Ministry of Social Affairs and Health. Finland offers undergraduate and post graduate education in mental health but, to date, there is no dedicated academic post in mental health promotion or mental illness prevention at the universities. Mental health is a part of basic training for physicians and nurses, however, systematic further education is not provided to primary care workers in mental health.

NGOs are involved with mental health advocacy, promotion, prevention, treatment and rehabilitation. The Finnish Mental Health Association is the world’s oldest NGO in the mental health field.

**Monitoring and Evaluation**

At present, no comprehensive system exists for monitoring the implementation of mental health policies or programs and evaluating their efficacy and cost effectiveness. The National Public Health Institute periodically carries out comprehensive surveys of the health of the population, including mental health. STAKES hosts the National Health Care Register, which provides information on the use of mental health services. Statistics Finland provides information that can be linked to the mental health of the population. This official picture is complemented by academic research on relevant health and social issues. The Ministry of Social Affairs and Health submits a social and health report to the Parliament every two years, which includes a section on mental health. Health 2000, a large national epidemiological health study found that the prevalence of mental disorders was the same in 2000 as it was 20 years earlier.

**France**


**Policies and Plans**

Psychiatric services in France were first defined legislation in 1838. The first open psychiatric unit was set up in 1920 and the first outpatient unit in 1930. Since the 1960s, French public mental health
services have been organized into sectors, with each sector serving an average population of 54,000 inhabitants. The goal of 'sectorization' is to ensure equal access to care for people, regardless of where they live. In each of the 1000 sectors in France, there are teams responsible for inpatient, outpatient and community care. There are different sectors for adult psychiatry, child and adolescent psychiatry and forensic psychiatry.

A national mental health policy was initially formulated in 1960 and updated in 1990 and 1992. The latest national mental health and psychiatry plan recommends the development of mental health networks to support collaboration between general practitioners and psychiatrists, enabling general practitioners to be more effective in managing most mental disorders, particularly depressive disorders (Verdoux, 2003). Today, the Ministry of Health is guided in its mental health policy and planning efforts by the WHO Declaration and Action Plan for Mental Health (2005).

One of the most developed areas of French mental health policy is suicide prevention. France has a comprehensive national suicide prevention program with regional policies and programs targeting young people, people attempting suicide, older people and socially fragile populations. Building on this success, the government has recently launched a national depression prevention program.

**Resources for Implementation**

*Investment*

The government spends approximately 8% of the total health budget on mental health. The primary sources of mental health financing are social insurance and tax based funding. Much of mental health care, including psychotherapy of long duration is financed by social security system. Patients have free access to private or public mental health professionals of their choice. The cost of private treatment is partly financed by the social security system (fully for severely mentally ill and severely deprived patients) and partly through private insurance. However, psychotherapy by psychologists and many psychoanalysts working in the private sector are not financed by social security. The country has disability benefits for persons with mental disorders.

*Infrastructure*

Mental health is a part of primary health care system. General physicians manage most of the minor psychiatric illnesses, with support from consulting psychiatrists. There are community care facilities for patients with mental disorders. Treatment of severe mental disorders is available at the primary level. In the 1990s, 20% of psychiatric beds were reduced. Although psychiatrists work in close cooperation with physicians and allied professionals, a true multidisciplinary approach to treatment is not yet fully developed in France. More than half of psychiatrists are in private practice or work at private institutions. A large proportion of private psychiatrists are exclusively practicing psychotherapy. Psychiatrists are concentrated in big cities, with posts lying vacant in rural areas and in northern regions.

NGOs are involved with mental health advocacy, promotion, prevention, treatment and rehabilitation. Since the 1970’s, families have taken an active role in psychiatric management of affected family members, service design and, more recently, in policy and program development at the national, regional and level.

INPES is the main national body that provides public education and training on a wide range of health issues, including mental health. INPES co-ordinates a nation-wide network of health educators, who act at the regional level along with regional health education committees. A major public campaign is being prepared by INPES to inform people about the most frequent mental disorders. It will begin with depressive disorders to facilitate self assessment and help seeking.
Workforce

The mental health workforce consists of sector workers, physicians, psychiatrists, psychiatric nurses, psychologists, occupational therapist, social workers and allied professionals. The public sector is largely responsible for sectorization and includes more than 80% of the mental health inpatient facilities. However, there is a significant variation in the manpower and structural resources between sectors. There is no dedicated work force for mental health promotion or mental illness prevention. These services are delivered through sector teams and local and regional teams with responsibility for general health promotion and disease and injury prevention.

Monitoring and Evaluation

Regional suicide prevention programs have been evaluated by the National School of Public Health with findings of decreased suicide rates in those regions which have implemented plans. INPES conducts regular surveys to determine the extent to which its mental health information campaigns modify public attitudes and knowledge.

Germany


Policies and Plans

Germany first embarked upon a major reform of psychiatric care in 1975 with the creation of the Expert Commission on Mental Health Care (1970-1975). The reform effort was evaluated in 1988 and further actions were identified on the basis of recommendations from the Central Institute of Mental Health of Baden-Württemberg and the Expert Commission. These recommendations led to an extensive national pilot program in which a host of individual projects were financed by the federal and state governments through to the end of 2002. The pilot program has resulted in a greater orientation towards community-based care, availability of mental health services for all those in need, and policies to give mental disorders the same status as physical illnesses.

In 1999, the Advisory Council for Concerted Action in Health Care was asked by the federal government to examine the capacity of the German health care system to address seven chronic diseases. The Council looked at quality assurance, new approaches for the reimbursement of health care services, the role of health objectives, prevention, and the competence of the insured and general medical practice. This led to the federal government’s reform of the healthcare system in 2000, which has given health promotion and prevention a higher policy status. In particular, prevention has been reinforced by the development of health targets. Building on the progress in mental health care reform, the Council called for the continuation of efforts to increase public awareness of mental health in the context of a broad concept of health and to continue to reduce existing social prejudices against psychiatric diseases.

Health promotion is now an obligation for the health insurance funds in Germany. The general aim is to improve the health condition of members of the insurance and their families and to reduce social inequalities in health. Because of the legal base, there is a clear commitment of all social security carriers to promotion and prevention. In 2003, there were 638 different documented programs in 955 different settings, with coverage of 539,000 persons. Nearly 66% of these activities were oriented to mental health promotion. Thirty percent of interventions in schools were oriented
to mental health promotion, and 15% to drugs and addiction. In 2003, there were 1,555 workplace health promotion programs which covered 680,000 persons at work; 24% of all programs dealt with health-oriented leadership, 20% with stress management and 13.4% with addiction.

In June 2003, the Federal Cabinet approved the *Action Plan on Drugs and Addiction*, a 10-year plan to implement the national drug and addiction policy. The plan focuses on changing health awareness and avoiding or reducing harmful consumption. The plan is based on the four pillars of the national drug and addiction policy: prevention of drug consumption, offering advice and treatment to consumers, survival assistance and harm reduction, enforcement and supply reduction. This plan differs from its predecessor in its inclusion of legal substances – alcohol and tobacco – and emphasis on harms associated with illegal drug use and harm reduction strategies. The 2003 plan also includes targets for different population groups, such as children of drug dependent parents, high-risk groups, and poly-drug users.

**Resources for Implementation**

**Investment**

The primary sources of mental health financing in descending order are social insurance, private insurances, tax based and out of pocket expenditure by the patient or family. Statutory or private health insurance covers all services that are medically necessary and are performed in a cost-effective manner. Rehabilitation is financed by the health insurance, statutory pension insurance and/or the social welfare system. Psychiatrists are paid on a fee-for-service basis in a strictly regulated market with semi-statutory professional associations exerting stringent control and negotiating fees with health insurance organizations. The country has disability benefits for persons with mental disorders.

Because the costs of health promotion are covered by the health insurance funds, there is a well established health promotion infrastructure at the federal, state and local levels. At the federal level there is the German Forum for Prevention and Health Promotion, a platform established in 2001 by the federal Ministry for Health and Social Affairs, involving associations, institutions, public authorities and co-operatives. The Forum develops health goals and co-ordinate the policies in this field with all relevant stakeholders. Mental health promotion is part of the work of this Forum. Linked to the Forum is the German Network for Workplace Health Promotion. The Network aims to strengthen the development and dissemination of good workplace health practices in Germany, including workplace mental health.

**Infrastructure**

In Germany, a federal republic with 16 states, the health care system is characterized by the sharing of decision making powers between the states, federal government, and quasi public corporations representing health care payers and providers. National consumer and family organizations, with their regional and local affiliates, play an important role in policy development and implementation. The German constitution requires that living conditions be of equal standard in all states, however, health promotion or health protection is not specifically mentioned as a goal. Public health, primary health care and hospital-based care are implicitly understood to be the responsibility of the state governments. Mental health and addictions services are within state jurisdiction and most states have formulated central psychiatric plans.

There are several national mental health initiatives that have been developed jointly by the federal and state governments and their NGO partners, including the *National Suicide Prevention Program* (2002) and the *National Program for the De-Stigmatization of Mental Illness* (2002). There are no national or federal mental health programs for special populations, although there are mental health
programs for specific populations at the state and local level, such as programs for refugees, disaster-affected populations, and indigenous peoples. The mental health needs of children and older adults are taken into account in more general health and social programs at the national level.

In Germany, mental health is a part of primary health care system. The treatment of severe mental disorders is also available at the primary level. There are community-based care facilities for patients with mental disorders. At present, there are almost 9,000 places in nearly 360 day-clinics and more than 15,000 beds for rehabilitative services. The current population of people with mental illness in sheltered homes is approximately equal to the number of beds in psychiatric inpatient services.

Since the late 1960s, psychiatric hospitals have reduced their beds by about 50%, with a further 15% reduction since 1999, and the closure of one psychiatric hospital. As a result of the shift to community-based care and the inclusion of psychiatric beds in general hospitals, more than 220 general psychiatry units have opened, although there is significant regional variation in the number of beds. There are approximately 7000 beds in 65 forensic psychiatry clinics. Staffing and funding of inpatient facilities are now based on the type of patients in a given service. Hospital treatment has improved with the introduction of a federal staffing directive in 1991, which has brought an additional 6500 multidisciplinary staff members to inpatient treatment. In Germany, the trend has been to reduce the size of psychiatric hospitals without closing them down while simultaneously developing general hospital services and community care.

Research

In 1999, the Federal Ministry of Education and Research started funding the German Research Network on Depression and Suicidality as part of a large-scale national program addressing various diseases, including psychiatric disorders like schizophrenia, dementia and depression. Today, the research network links more than 15 university hospitals and other research institutions, as well as key institutions of the German health care system (e.g. health insurance funds and associations of consultant practitioners), scientists, general practitioners, psychotherapists, self-help groups, patients, and many other institutions and individuals involved in the care for depressed or suicidal patients.

Since 1999, more than 20 projects have been initiated with the goal of improving awareness of depression, suicidality and related problems, as well as options for diagnosis and treatment, among affected persons and their families, health and allied professionals, and the general population.

A physician competency network entitled Depression and Suicide was created as part of research network. The project is aimed at increasing doctors’ competence in the detection and treatment of depressive disorders, in particular by initiating cooperation among research centres, specialist clinics and office-based doctors, especially those working in family practice. A priority action of the network is to develop, improve, and disseminate easy-to-apply guidelines, ranging from simple screening procedures to strategies for correct diagnosis and detailed treatment guidelines for pharmacological treatment of depression. The identification and definition of the interface between general practice and specialists is closely linked to these tasks.

Ireland


Policies and Plans
Within the Republic of Ireland, there has been increasing recognition in recent years at both the policy and practice level of the importance of mental health promotion and prevention of mental disorders for overall population health and well-being. The 2001 National Health Strategy - Quality and Fairness: A Health System for You, calls for the development of a new action program for mental health, including mental health promotion and stigma reduction.

An Expert Group on Mental Health Policy was established in 2004 to devise a new national mental health policy. A sub-group on Mental Health Promotion and the Prevention of Mental Ill-health was set up in April 2004 to inform the Expert Group’s recommendations on the inclusion of mental health promotion and prevention as an integral part of the new National Mental Health Policy. The National Health Promotion Strategy (2000-2005) includes, as one of its strategic aims, the promotion of positive mental health through identifying models of best practice, and initiating research into the development of a national positive mental health strategy.

The Report of the National Task Force on Suicide (1998) makes several recommendations concerning the use of mental health promotion and primary prevention strategies in preventing suicide, now the leading cause of death among young men in Ireland. A National Strategy for Action on Suicide Prevention “Reach Out” was published in 2005 and a National Office for Suicide Prevention was established within the Health Services Executive. A number of strategies and initiatives have also been developed by national voluntary organizations and the health promotion departments in the regional health service areas.

At present, mental health promotion and prevention of mental ill-health are included within the following national government policy documents: the National Health Strategy (2001), the National Health Promotion Strategy (2000-2005), and the National Strategy for Action on Suicide Prevention (2005). Unlike in Northern Ireland, where a specific mental health promotion strategy has been developed (Promoting Mental Health: Strategy and Action Plan, 2003-2008), there is no discrete national strategic policy or action plan on mental health promotion in the Republic of Ireland. There is however, cooperation in the border regions between Northern Ireland and the Republic, in developing mental health promotion initiatives through the work of Co-operation and Working Together.

Mental health promotion and prevention initiatives are also supported through a number of related government policy documents, such as National Children’s Strategy- Our Children, Their Lives (2000), and the National Anti-Poverty Strategy, as well as through a number of school, workplace and related health promotion policies and initiatives. NGOs have also produced policies and actions on promotion and prevention.

**Resources for Implementation**

**Infrastructure**

Responsibility for the development and implementation of mental health policy and practice rests with the Department of Health and Children and the Health Service Executive at national and regional levels. Other statutory bodies, non-governmental mental health organizations, professional bodies and the university sector also play an active role in knowledge and research development, policy and program implementation, evaluation and dissemination. The participation by key players at the national level in cross border, European and international policy, practice and research networks and initiatives has played an important role in ensuring the development of high quality, innovative and sustainable initiatives in Ireland.

**Workforce**

In relation to the mental health promotion workforce, there has been considerable progress and
investment in the health promotion infrastructure in Ireland over the last 15 years. This includes the establishment of national strategies and policies concerned with promoting positive health together with the appointment of teams of dedicated Health Promotion specialists and senior managers at the regional level. In recent years, Mental Health Promotion Officers have been appointed in the regional health promotion departments. There is evidence of increased engagement with other statutory, non-statutory agencies and community and social partners in implementing mental health promotion initiatives.

Education and Training

In terms of mental health promotion, the Academic Department of Health Promotion at the National University of Ireland, Galway provides postgraduate level training in Health Promotion to Masters and PhD level, which includes specific input on mental health promotion. Through its research centre, the Department of Health Promotion also conducts a program of research and evaluation in mental health promotion.

In relation to mental illness prevention, funding has been provided through the Report of the National Task on Suicide (1998) for the appointment of Suicide Resource Officers in each of the regional health service areas. Increased funding has been made available for suicide prevention activities and research through the National Suicide Review Group and the work of the National Suicide Research Foundation. In many regional health service areas, staff members have dual responsibility for both suicide prevention and mental health promotion.

The situation regarding specific training on prevention of mental disorders at the national level is less clear. Knowledge development and dissemination is, however, facilitated through the organization of national and regional conferences on both mental health promotion and prevention of mental disorders. These include conferences, such as the annual meeting of the Irish Association of Suicidology which addresses suicide prevention, together with seminars and other training initiatives by the Irish College of Psychiatrists, NGOs and regional health service agencies.

Monitoring and Evaluation

At a national level, there are quite limited data sets concerning the mental health status at a population level, in particular in relation to positive indicators of mental health among Irish adults. From those national surveys that have been carried out, the most commonly used scales are GHQ-12 and the SF-36.

A 2004 review of the National Health Promotion Strategy provides an overview of current mental health promotion practice at national and regional level. The report found a high level of mental health promotion program activity at the national and regional level, which was bolstered by recommendations from the Report of the National Task Force on Suicide (1998). Funding provided through the report has led to the appointment of Suicide Resource Officers in each of the regional health service areas and increased funding for suicide prevention activities and research. The National Suicide Review Group also funded a range of specific initiatives and research projects and produces an annual report on progress.

Italy

**Policies and Plans**

The National Government establishes health policy in a number of areas, including mental health, through the National Health Plan. Central policy sets targets, highlights priority interventions, and recommends outcome assessments. Detailed planning within the parameters of the central policies are carried out by the Regional Councils and implemented by the Regional Governments. The Regional Governments issue regional health plans, prevention plans, and mental health plans. The interpretation and implementation of the central policies differ across regions with corresponding differences in quality and coverage of services. This is especially true for mental health services.

The *National Target Project on Mental Health Protection (1994-1996)* directed the process of deinstitutionalization and the creation of community care facilities across the country. The renewed *National Target Project on Mental Health Protection (1998-2000)*, focused on monitoring progress and maintaining uniform levels of care. The *National Health Plan (2003-2005)* broadened the mental health focus and called for mental health promotion across the life cycle, primary and secondary prevention of mental disorders - with special reference to risk-taking behaviours, early identification of psychosocial distress - especially in young people, and provision of proper therapeutic interventions. In response, Lombardy and Lazio, two of Italy’s largest regions, included the following elements in their regional mental health plans: mental health promotion and mental illness prevention across the life course, early detection of distress in youth, early intervention for psychosis, suicide prevention, employment opportunities for people with mental illness, and treatment for dual diagnosis patients.

In 2001, the National Centre of Epidemiology, Surveillance and Health Promotion published a declaration that outlined opportunities to enhance mental health promotion. The main points were promotion of self-help groups and recreational activities at community level, mental health promotion in the workplace, skills building in communication, coping and problem solving for unemployed people and young people, provision of effective support to single mothers, cognitive-behavioural treatment for children exposed to adverse events in the family, and parent training.

**Resources for Implementation**

**Investment**

The primary sources of mental health financing are tax-based funding, out of pocket expenditure by the patient or family, and private insurances. The mental health budget is defined by each region then more precisely at the level of local health units. Each citizen is registered with a primary care doctor under the National Health Service. Citizens have unlimited coverage, but need to contribute some portion of drug prescription costs, laboratory charges and diagnostic tests. There are local health districts catering to the needs of the catchment population, but it is not compulsory for residents to go to their local doctors only. The country has disability benefits for persons with mental disorders.

**Infrastructure**

Mental health is part of the primary health care system. Treatment of severe mental disorders is also available at the primary level. Mental health departments at the district level provide treatment for persons with mental disorders. These departments coordinate four different types of service: community facilities, day care facilities, residential facilities, and general hospital psychiatry wards. Though the implementation of comprehensive community care network has made mental health care more accessible, the distribution and quality of care is not uniform across the country.

All mental hospitals were gradually phased out by 1999. General hospital psychiatry wards have a
maximum of 15 beds. Non-residential medium and long term facilities now account for more beds than the hospital sector. The units which provide mental health services are the community mental health centres, psychiatric services for diagnosis and care, day hospital, day centre, and residential facilities. Private care facilities have more than 50% of the acute short term beds in the country. Patients requiring long term residential care are served by non-hospital residential facilities.

At present, there are 707 community mental health centres operating in the country. There are more than more than 1552 residential facilities and 612 day care facilities. There are also more than 13,000 vocational organizations operating in the social sector that involve over 260,000 participants. Regional distribution of these facilities, however, is uneven, with only 20% located in the south. Substance disorders, mental disorders in children and adolescents, and the forensic psychiatric sector are managed by specialist services which are not under the mental health departments. In the past, these facilities rarely had contacted mental health, but now there is better integration of services.

Territorial Pacts for Mental Health are a new strategy promoting the functional integration of health, social, economic and vocational resources (both public and private) available in a given catchment area. The community itself is also expected to play a crucial role through vocational and self-help organizations. NGOs are involved with mental health advocacy, promotion, prevention, treatment and rehabilitation. Families are fundamental stakeholders in health administration and their associations have become very influential in the development of national and regional mental health policies. They are involved in 60% of the organizations working in the mental health sector.

**Workforce**

Mental health services in Italy, although strongly community-oriented, have focused their attention on treatment, care and rehabilitation of severe mental disorders in young or adult patients. The current orientation of mental health providers is towards treatment or early detection of mental disorders, rather than prevention. To date, prevention programs in Italy have seldom targeted mental illness. There are no specific institutions or workforce devoted to the implementation of mental health promotion and prevention activities. Mental health promotion and mental disorder prevention programs are the outgrowth of local initiatives, with little co-ordination at regional or national level. These local programs are seldom disseminated and even more rarely evaluated and published in scientific literature. Promotion, prevention and treatment services must also compete for limited mental health resources.

**Monitoring and Evaluation**

At present, mental health data is collected at the district and regional level by regional reporting systems. A national mental health reporting system is being developed and is expected to become operational in 2006-2007.

Between 1997 and 2001, the National Institute of Health co-ordinated the National Research Program on Mental Health which involved the National Health System and several universities and research institutions. A total of twenty seven research projects were funded, of which two referred to primary prevention.
New Zealand


Policies and Plans

New Zealand first developed a coordinated mental health policy in 1994. Looking Forward (1994) established mental health as a priority for the Government and targeted the three percent of the New Zealand population most severely affected by mental illness. It also emphasized the need for more community-based services, in particular the delivery of mental health services in primary care. Three years later, New Zealand developed Moving Forward (1997), a mental health plan that emphasized the need for better services. This was followed one year later by the Mental Health Commission’s Blueprint for Mental Health Services (1998), which detailed the service developments needed to put Moving Forward into action.

Taken together, these three documents comprise New Zealand’s first mental health strategy and, combined with substantial increases in government funding of the mental health sector (ranging from $465 million in fiscal 1997 to $863 million in fiscal 2004), it has resulted in a number of significant achievements. These include a steady growth in access to specialist services and in clinical capacities, continued progress in helping people move from institutional care into the community, and a rapid growth in the non-government sector and in the number of Maori mental health providers. In 2001, the Government released Te Puawaitanga: Maori Mental Health National Strategic Framework to address Maori mental health issues.

In 2005, in response to key changes in the health sector and emerging societal trends, the Government launched Te Tahuhu – Improving Mental Health: The Second Mental Health and Addictions Plan 2005-2015 which outlines policy and investment priorities for mental health and addictions over the next ten years. Te Tahuhu broadens Government interest from people who are severely affected by mental illness and addiction to all New Zealanders, while continuing to place an emphasis on ensuring people with the highest needs can access specialist services.

Te Tahuhu builds on the successes of the first mental health strategy. However, unlike its predecessor, it identifies clear outcomes for people and services, as well as 10 leading challenges that must be addressed in order to achieve the outcomes. Together, the outcomes and challenges establish the basis for Government investment in mental health and addiction services.

Outcome Framework

In Te Tahuhu, the intended outcomes are divided into two categories: general and service outcomes. General outcomes describe what people should be able to do for themselves and others, whereas service outcomes describe what people should expect of mental health and addiction services. General and service outcome statements have been developed for three population groups: all New Zealanders in their communities, people with experience of mental illness and addiction, and family/whanau and friends who support and are affected by people with experience of mental illness and addiction.
1. All New Zealanders in their communities

**General** - All New Zealanders in their communities make informed decisions to promote their mental health and wellbeing. They value diversity and support and enable people with experience of mental illness and addiction to fully participate in society, the everyday life of their communities and whanau.

**Service** – All New Zealanders in their communities have a trusted and high-performing mental health and addiction sector. They have confidence that they can access high-quality mental health and addiction services if and when they need them.

2. People with experience of mental illness and addiction

**General** - People with experience of mental illness and addiction have the same opportunities as everyone else to fully participate in society and in the everyday life of their communities and family/whanau.

**Service** - People with experience of mental illness and addiction have access to trustworthy agencies that work across boundaries and enable service users to lead their own recovery. They have access to recovery-focused mental health services that provide choice, promote independence, and are effective, efficient, responsive and timely.

3. Family/whanau and friends who support and who are affected by people with experience of mental illness and addiction

**General** - Family/whanau and friends of people with experience of mental illness and addiction maintain their own well-being and fully participate in society and in the everyday life of their communities and family/whanau.

**Service** - Family/whanau and friends of people with experience of mental illness and addiction have access to agencies that operate in a way that enables service users to support their family members’ recovery and maintain their own well-being.

*Ten Leading Challenges*

1. Promote mental health and well being and prevent mental illness and addiction, with immediate emphasis on:
   - increasing people’s awareness of how to maintain mental health and well being
   - how employers and others in frequent contact with people with mental illness and addiction can be more inclusive and supportive
   - ensuring that people who are discriminated against can receive effective support, protection and redress when they are discriminated against
   - implementing the Government’s strategy to reduce suicide and suicide attempts, and the negative impacts of depression
   - improving understanding of the nature of addictive behaviours and the use of early interventions to prevent or limit harm

2. Build and broaden the range and choice of services and supports for people who are severely affected by mental illness, with immediate emphasis on:
   - increasing services that are funded for children and young people and for older people
broadening the range of services and supports that are funded for adults

3. Build responsive services for people who are severely affected by mental illness and/or addiction, with immediate emphasis on improving responsiveness of services for:
   - Pacific peoples
   - Asian peoples and other ethnic communities
   - refugee and migrant communities
   - people with specific disabilities
   - family and whānau
   - Māori

4. Build a mental health and addiction workforce that supports recovery, is person centred, culturally capable, and delivers an ongoing commitment to assure and improve the quality of services for people, with immediate emphasis on:
   - building a workforce to deliver services for children and young people, Māori, Pacific peoples, Asian peoples, and people with addiction
   - supporting the development of a service user workforce
   - creating an environment that fosters leaders across the sector
   - developing a culture amongst providers of involving whānau/families and significant others in treatment and recovery
   - fostering a culture among providers that promotes service user participation and leadership
   - developing a culture of continuous quality improvement in which information and knowledge is used to enhance recovery and service development

5. Continue to broaden the range, quality and choice of mental health and addiction services for Māori, with immediate emphasis on:
   - enabling Māori to present earlier to mental health and addiction services
   - promoting choice by supporting the implementation of kaupapa Māori models of practice
   - increasing Māori participation in planning and delivery of mental health and addiction services for Māori

6. Build and strengthen the capability of the primary health care sector to promote mental health and well being and respond to the needs of people with mental illness and addiction, with immediate emphasis on:
   - building the capability of primary health care practitioners to assess the mental health and addiction needs of people and to meet these when they can best be met within primary health care settings
   - building linkages between Primary Health Organizations (PHOs) and other providers of
mental health and addiction services to ensure integration occurs to meet the needs of all people with mental illness and addiction

- strengthening the role of PHOs in communities to promote mental health and well being and prevent mental ill health

7. Improve availability and access to quality addiction services and strengthen alignment between addiction services and services for people with mental illness, with immediate emphasis on:

- broadening the range of services that are funded for substance use problems
- maintaining and developing responsive and effective problem gambling services
- building the expertise of addiction and mental health providers to conduct complementary assessments and treatment planning

8. Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration, with immediate emphasis on funding models, contracting processes and service frameworks that:

- foster learning and evaluation
- promote the seamless delivery of services between providers and across boundaries
- remove incentives that can keep some service users tied to certain services and enable providers to adapt the services they provide to better meet the needs of service users
- enable the development of provider capability

9. Strengthen trust, with immediate emphasis on:

- increasing the availability of information and information systems to underpin service development, which support decision making and improve services for people
- creating an environment that enables DHBs to demonstrate their investments in mental health and/or addiction deliver value for money, are results-focused, and have regard to service impacts on people who are severely affected by mental illness and addiction
- creating an environment where mental health workers and service users can readily use information to support and enhance recovery

10. Strengthen cross-agency working together, with immediate emphasis on:

- regional and national collaboration between DHBs to promote the optimal use of resources, minimize clinical risk and maximize in-demand work force capabilities
- alignment between the delivery of health services and the delivery of other government-funded social services

Resources for Implementation

In 2006, the Government launched Te Kokiri: The Mental Health and Addiction Action Plan 2006–2015 to implement the priorities identified in Te Tahuhu. The action plan identifies specific measures to improve mental health and prevent addiction and outlines key milestones, stakeholders and responsible organizations. Te Kokiri focuses on providing earlier access to mental health and addiction services and strengthening linkages between primary and specialist health care. It also
contains key actions to meet the needs of people with mild to moderate mental illness. *Te Kokiri* includes the implementation of related national strategies, such as those for suicide prevention, depression, alcohol and gambling-related harm. It also identifies the importance of sectors outside of health in the provision of services, alignment of policies to promote and maintain mental health, and the removal of barriers to recovery. These include the justice, corrections, education, housing, employment and social service sectors.

**Monitoring and Evaluation**

The Ministry of Health is responsible for assessing performance related to mental health standards, through contractual requirements or to receive accreditation. Alcohol and Drug standards are currently separate but there is a plan to merge them. A National Mental Health Information Strategy and a Mental Health Standard Measures of Assessment and Recovery Initiative are underway to improve information collection and reporting.

As noted above, an arms length National Mental Health Commission was established by statute in 1996, with a specific mandate to monitor and make recommendations to government on performance of the Ministry of Health and 21 District Health Boards, reduce discrimination against people with mental illness, and ensure the development of the mental health workforce. In 1998 the Commission released the *Blueprint for Mental Health Services in New Zealand*, which presents system targets for specialist mental health services and has been useful for clarifying capacity goals and monitoring progress. The Blueprint document has become the method for informing the funding levels required to build more and better services for those with severe mental illness. Having benchmarks with attached costing has been a powerful advocacy tool in negotiations with the national treasury. Since then the Commission has regularly published a *Report on Progress* on implementation of the first national strategy.

**Spain, Catalonia**


Spain is a unitary state but functions as a highly decentralized Federation of Autonomous Communities. It is regarded as the most decentralized nation in Europe. The Spanish Constitution of 1978 created a decentralized state through a procedural framework for optional autonomy. By 1983, Spain had reorganized itself into 17 Autonomous Communities, each sharing common historical, cultural and economic characteristics. Unlike Canada, which has a prescribed division of powers that applies to all provinces, the Spanish Constitution allows Autonomous Communities to select which powers they want with the understanding that certain powers remain with the State. In practice and over time, this has meant that Spain has become more of a federal state than a decentralized state.

Catalonia is one of 17 Autonomous Communities in Spain. The Catalan Parliament is authorized to legislate on all aspects of health. The Government of Catalonia is divided into 13 Departments, including the Health Department. In 2003, the health budget represented approximately 34% of total government expenditures. The Catalan health care model was established in 1990 under the *Health Care Organisation in Catalonia Act* (LOSC). The LOSC established the Catalan Health Service (CatSalut), consolidated a mixed private and public health system, reorganized health care goods and services, and created an integrated network of public health services and facilities. The Catalan
The health system is a publicly funded system with comprehensive coverage accessible to all citizens of Catalonia. Primary health care (PHC) is the first point of access to the health care system and there are 347 PHC centres throughout Catalonia. PHC centres are composed of multidisciplinary teams and integrate health promotion strategies with preventive and curative interventions. In 2006, the Catalan Government formed the Catalan Public Health Agency with a mandate to formulate policies and implement strategies in health promotion, prevention and protection.

**Policies and Plans**

Over the last decade, substantial effort has been made to strengthen community-based mental health services and convert psychiatric hospitals into centres capable of meeting the mental health needs of the general population. The current mental health model is based on building community capacity to support the de-institutionalization of psychiatric patients and the provision of more comprehensive mental health services for the general population. This has been accompanied by a gradual conversion of health services, such as child and youth mental health centres, adult mental health centres, hospitals, medium and long-stay centres, day hospitals and day centres, into community rehabilitation services.

Psychiatric patients are now treated in the community through the Mental Health Network, which offers specialized treatment, support to the PHC centres, and hospital-based care of varying levels of intensity. Care is provided by multidisciplinary teams, comprised of psychiatrists, psychologists, social workers, nurses and other professionals.

In the *Health Plan for Catalonia (2002-2005)*, the priority interventions for mental health were aimed at mental health promotion in the community and improving the detection, care and rehabilitation of people with mental disorders, support for their families, and respect for the fundamental rights of patients. Mental health prevention priorities included:

- fostering the capacity and skills of primary health care professionals in the early detection and care of the most-frequent mental health problems
- improving the detection and treatment of emergent pathologies and in people with learning disabilities
- reinforcing cross-sectoral work, especially with the Education, Welfare and the Family, Justice, and the Presidency on the prevention and care of mental disorders
- supporting and collaborating with family support groups and voluntary associations
- overcoming the social stigma carried by mental disorders through increased awareness, information and education

Additional activities included the preparation of a guide on mental health promotion and the detection of risk situations in childhood and adolescence for teachers; the training of professionals to encourage the early detection and adequate treatment of mental disorders, especially in primary health care; community work to encourage social integration; and improvement of information systems to monitor the incidence and prevalence of mental disorders.

A wide range of activities to promote the mental health of the population has been implemented, such as strategies to achieve greater awareness that mental disorders can be prevented and effectively treated, and to overcome the stigma of mental disorders. Actions include using mass media campaigns to project a positive image of people with mental disorders, as well as advances in care and treatment; encouraging support, recognition and positive values with respect to all persons in
schools and workplaces; and giving support to families from social and health services. More general measures fall within the political and economic areas, such as those aimed at reducing inequalities, creating healthy urban settings, guaranteeing respect for rights, access to services and occupational and social integration.

In 2003, the Catalan Government launched an Integrated Governmental Plan for Mental Health to ensure the involvement of relevant ministries, health institutions, professional associations, and municipalities in mental health promotion and mental disorder prevention, particularly in those areas requiring cross-sectoral engagement. Ministries that participated in the development of this plan included the Presidency, Health, Education, Justice, Employment and industry, Environment and Housing, and Trade, Tourism and Consumer Affairs.

In 2006, the Health Department, in collaboration with other government departments, professional associations, scientists, service providers and patients and their families, developed the Director Plan on Mental Health and Addictions (DPMHA) which included the following priorities:

- implement strategies on mental health promotion and mental disorder prevention, including addictions
- promote the role of PHC in the prevention and treatment of the most prevalent mental disorders and addictions
- promote co-operation with the Family and Well-being Department
- promote awareness and education to reduce the stigma associated with mental health and addiction in collaboration with mass media and other social agents
- improve accessibility of data on mental health prevalence and promote epidemiological research
- prevent problems associated with drug consumption in schools, the workplace, and community
- increase community involvement and the role of municipalities

The newly formed Catalan Public Health Agency will be developing an integrated mental health strategy to strengthen the commitment of the Mental Health Network to the prevention of both mental disorders and addictions, and to focus the efforts of the Network on increasing the competency and capacity of primary health care to respond to people with mental disorders and addictions across the continuum of promotion, prevention, treatment and rehabilitation.

**Resources for Implementation**

**Investment**

The DPMHA allocates specific funds for the development and maintenance of mental health promotion and mental disorder prevention. In the past, mental health was not funded separately in the general health budget.

**Workforce**

There are several university programs providing higher education in mental health, but they are mainly focused on mental illness treatment. Generally, mental health professionals do not have the training necessary to carry out mental health promotion or mental illness prevention.

**Knowledge development and dissemination**

Knowledge development, implementation and information dissemination for general health and
mental health professionals are the responsibility of the Health Department and the future Catalan Public Health Agency. The information dissemination for health care professionals will be the responsibility of the Health Department together with the Health Studies Institute and all the professional associations, scientific societies and mental health providers of Catalonia.

**Monitoring and Evaluation**

There were two operational targets related to mental health promotion and mental disorder prevention in the Health Plan for Catalonia (2002-2005), specifically, the availability of a guide for the early detection of eating disorders in primary health care and a guide for mental health promotion and the detection of risk situations in childhood and adolescence. There is a plan to establish a set of resources and indicators to report and evaluate DPMHA policies and programs.

**Sweden**


**Policies and Plans**

In 2003, the Swedish Parliament approved a comprehensive national public health plan with goals in 11 key areas, all of which are considered to have an influence on mental health. The plan is purposefully directed towards the determinants of health at the individual and community level, rather than specific health conditions, such as cancer, cardiovascular disorders or mental disorders.

The areas for national action include: participation and influence in the community, economic and social security, safe and good conditions for growing up, improved health in working life, sound and secure milieus and products, more health promoting health care, good protection against infectious diseases, secure and safe sexuality and good reproductive health, increased physical activity, good eating habits and safe food, decreased use of tobacco and alcohol, and a community free from narcotics and reduced negative effects of gambling.

In 2000, the government developed a national plan for the development of health care, which targeted mental health problems in children, adolescents and the elderly, and persons with mental disabilities. There is no dedicated national funding for promotion and prevention as these areas are understood to be integrated with work undertaken in the health care sector, schools, and the workplace. National funding has been allocated to promote activities to reduce alcohol and narcotic use. At the county level, almost all county councils have adopted health plans in which mental ill health is noted as one of the largest public health problems. In some counties, specific measures are being taken to prevent mental disorders, mainly through secondary prevention activities, such as early detection and intervention of depression, anxiety and psychotic disorders.

To date, the most comprehensive national mental health prevention project in Sweden has been the alcohol policy, first developed in 1917 at a time of high alcohol consumption and serious related health and social problems in the general population. This policy was developed to reduce the total consumption of alcohol in the country and to care for those individuals who developed alcohol dependence. The policy established a state monopoly to sell alcohol, restricted the amount of alcohol that could be purchased by an individual, and established local committees to provide care for individuals who developed alcohol dependence. These ‘temperance’ committees were also responsible for supervising restaurants and bars that sold alcohol in the community. In addition to
these provisions, the policy prescribed increasingly high taxes on alcohol to reduce consumption. The 1917 policy remains the basis for current Swedish drug and alcohol policy. Entrance into the European Union has made this policy difficult to maintain and the Swedish government is negotiating with the European Union to ensure acceptance of the principles laid down in the policy.

The prevention of mental disorders and promotion of mental health is mentioned in most key government health documents. This includes health and care legislation, health plans and a number of parliamentary committees which have been dealing with different aspects of health and mental health. The most important recent parliamentary committees are those which considered the development of psychiatric care, child and adolescent psychiatric care and public health issues, which also included mental health prevention and promotion.

Mental health issues are not considered separate from other health issues. In Sweden, the promotion of mental health and primary prevention of mental disorders is achieved through strengthening the welfare state and supporting the citizens in their daily life. Historically, mental health issues have been dealt with under existing health care legislation and national goals on public health. Until recently, there has been no decision to follow the WHO Declaration and Action Plan for Mental Health, adopted at the ministerial conference in Helsinki in 2005.

Supporting policies, plans and programs

In 1995, a national program for suicide prevention was established as a collaboration between the National Board of Health and Welfare, the National Institute of Public Health, and a number of researchers interested in suicide and suicide prevention. This national program, which is comprised of seven regional networks that support suicide prevention activities across the country, is not funded by the Swedish government or the county councils. It depends entirely on voluntary work of people in psychiatric services, social services, schools, churches and NGOs at the regional level. The Swedish Parliament has recently requested a national plan for suicide prevention from the government.

The government supports community-based projects to prevent mental ill health in children and adolescents. In schools, there are a number of programs aimed at reducing bullying, alcohol and tobacco use, and the adverse effects of sexual activity, unwanted pregnancy and sexually transmitted diseases. In recent years these programs have been integrated into comprehensive life skill programs. A number of schools also participate in the Healthy Schools program, where activities are directed towards strengthening conflict resolution capacity and supporting emotional and personal growth.

In the primary health care setting, there are special services for pregnant women, very young children, and youth. In most communities there are youth health clinics, where midwives, nurses, psychologists, social workers, paediatricians and psychiatrists address health promotion and prevention. Originally, these services were directed towards the prevention of unwanted pregnancies and sexually transmitted diseases, but today they more frequently address emotional problems. The system of youth health clinics is intended to support young women and men in developing and keeping good health. They offer services free of charge and are easily available within communities. The youth health clinics offer young people who are in health-threatening situations an acceptable way to access help. There are approximately 200 clinics in Sweden.
Resources for Implementation

Infrastructure

In Sweden, the responsibility for health care resides with 24 county councils. These councils are governed by elected bodies and have the right to impose taxes to finance medical services. The primary health care system is responsible for caring for the majority of the mental health problems in the population. Only cases needing specialist care are directed to psychiatric services and facilities.

The local municipalities are responsible for the care of children and the elderly, for social services in general, and for the education system up to university. They are also responsible for local policies regarding the marketing of alcohol in restaurants and bars. The counties and municipalities have a high degree of self determination and the national government does not directly influence their decisions or operations. Employers are responsible by law for workforce rehabilitation and many have partnered with private occupational health care organizations. Most employers have developed special programs to prevent stress and mental distress among their workers.

Workforce

The majority of people working in the mental health field are employed by county councils in primary health care or psychiatric and child and adolescent psychiatric services. In the social service system, the workforce is directly involved in mental health promotion and prevention activities. In some of the local communities there are also health planners, whose primary task is to develop prevention and promotion activities in the community, some of which have implications for mental health.

Monitoring and Evaluation

The National Institute of Public Health monitors the goals for public health set by Parliament. The National Board of Health and Welfare oversees the health care system and the social service system. The Epidemiological Centre of the National Board of Health and Welfare has been tasked by government to develop a national system to monitor the mental health of children and adolescents. To date, the lack of national programs dedicated specifically to mental health promotion and mental illness prevention has hindered evaluation of mental health issues at the national level.

The Netherlands


Policies and Plans

In the Netherlands, governmental and non-governmental policies reflect a collective commitment to mental health promotion and prevention of mental disorders, either as part of overall mental health policy or general health promotion and prevention policy. Health promotion and prevention activities are supported by national policy documents, a national professional association for health promotion and prevention, a national research and development program, and a network of graduate and postgraduate training programs for health promotion and prevention, with an explicit emphasis on mental health.
In 2003, the Ministry of Health, Welfare and Sport released *Longer Healthy Living 2004–2007*, a national policy document on prevention. This policy focuses on four major health issues: smoking, obesity, diabetes and mental health. In 2004, the Dutch Mental Health Association, published a vision document, *Joining Forces*, describing its long term goals for mental health services. *Joining Forces* recognizes prevention as one of the four core tasks in mental health services and advocates the doubling of investment in preventive services. While Dutch mental health care has long recognized the importance of prevention, this domain constitutes a small part of overall mental health service delivery, at approximately five percent of the capacity for out-patient services.

In 2005, the Dutch National Institute for Mental Health and Addiction published the *Third Prevention Guide*, as part of a comprehensive public mental health strategy. The Guide aims to support innovation in prevention in local mental health services, addiction clinics, primary health care services and public health services. The current challenge in The Netherlands is to better embed mental health promotion and the prevention of common mental disorders in the public mental health policies of municipalities and health districts. The role of municipalities in health promotion, prevention and enhancing well-being is defined in the *Collective Prevention Act* and the new *Social Support Act*.

The Ministry of Health and the Ministry of Justice are collaborating on incentives to encourage municipalities to develop policies and action for parenting support. Statistics Netherlands has provided a national report on social and mental health problems in children to support local agencies and municipalities with relevant epidemiological data. The Netherlands Institute for Care and Welfare published a review in 2001 of ongoing preventive program on parenting support in The Netherlands and Flanders (Belgium), and a database on effective and promising prevention program for youth.

**Resources for Implementation**

**Investment**

To date, most prevention activities in mental health have been financed under the *Special Disease Costs Act*, which defines several categories of health costs directly covered by a national health budgeting system. This national financing system covers preventive interventions implemented by local mental health services that target persons and groups at risk. In 2007, a new budgeting system for mental health services will be more restricted in its coverage of prevention costs. The system will likely cover only evidence-based preventive services for indicated patients with early symptoms or those at risk for relapse.

The 2007 *Social Support Act* states that financing of all other prevention and mental health promotion activities directed at universal populations or at populations at risk will become the responsibility of municipalities and will have to fit into their local health and social policies. Mental health services and other agencies will be expected to apply to local governments for financing of these services. The 1980 *Collective Prevention Public Health Act*, which remains in force, specifies that public health services must provide universal prevention and prevention program for large-scale populations at risk. These services must include a focus on mental hygiene. In addition, the public health services have been given the task to stimulate coordination and common policy between local health promoting agencies.
Infrastructure

The Netherlands is divided into approximately 50 mental health districts, each with a comprehensive system of inpatient and outpatient mental health services. Each of the district mental health centres and addiction clinics provide preventive services and have a team of trained prevention experts. Similarly, all district public health services provide health promotion and prevention services that by law have to include interventions targeted at mental health.

On average, district mental health services have approximately six full time equivalent experts (FTE) on their prevention teams, ranging from organizations with only a few prevention experts to organizations with 36 full-time equivalents, especially in the four largest cities (Voordouw & Schaefer, 2005). It is estimated that in addition to prevention experts, district mental health services invest on average almost three FTE of their curative workforce in the implementation of prevention programs, for a total average investment of nine FTE per mental health district. In 2004, the national investment in prevention activities provided by mental health services was approximately 540,000 hours or almost \( 38 \text{million} \) (Voordouw & Schaefer, 2005). These figures do not include investments by agencies outside the mental health sector.

Mental health promotion and mental illness prevention are provided by district mental health services and public health services through their health promotion and prevention teams. These local organizations each have their national organizations that support policy development and service quality. In addition, promotion and prevention in mental health is provided by a range of other local organizations, such as youth care services, child protection agencies, parent education agencies, primary health care, addiction clinics, and workplace-related health agencies.

At the national level, several national institutes and university departments invest in the development and dissemination of new knowledge and program in health promotion and prevention, and in supporting local organizations to improve service quality. Four national institutes play a significant role in the development and dissemination of relevant knowledge, dissemination of evidence-based program, and in enhancing the quality of local practices by providing consultation and training opportunities. These include: the Netherlands Institute for Health Promotion and Disease Prevention, Netherlands Institute for Mental Health and Addiction (Trimbos Institute), Netherlands Institute for Care and Welfare, and the National Institute for Public Health and Environment.

The Trimbos Institute hosts a range of national task forces, where local prevention experts meet periodically to discuss emerging trends and new developments, exchange best practices and materials, enhance program quality, and to stimulate national policy making. This includes prevention task forces on children of mentally ill parents, work and mental health, and depression and anxiety disorders. In addition, the Trimbos Institute runs impact studies on local prevention programs, disseminates fact-sheets, enhances national standardization of prevention program, monitors national and local developments in prevention, advises the government, develops new opportunities for e-mental health education, and develops comprehensive, community-oriented strategies for depression prevention. In June 2005, the Dutch Trimbos institute released a report on the organization, scope and content of preventive interventions implemented by local mental health services.

The Netherlands Institute of Health Promotion and Disease Prevention has developed a Prevention/Health Promotion Effect Management Instrument (Preffi 2.0) that is used by many health promotion and prevention teams throughout the country to improve service quality and effectiveness. In addition, the Institute organizes a series of bi-annual national conferences on health promotion and prevention, co-ordinates the Dutch monitoring system of prevention and health
promotion programs throughout the country, stimulates the development and implementation of school-based health promotion programs, and supports local health promotion and prevention agencies in developing successful relationships with municipalities.

The Netherlands Institute for Care and Welfare is especially focused on health promotion and wellbeing for children and parents. The Institute runs the national database of effective and promising programs for children and youth. They support local, non-governmental agencies through expert reports and materials. In addition, they advise governmental agencies and municipalities on youth-related issues and policies. Together with a coalition of caregivers, policy makers, representatives of parents and children they have distributed a one-page ‘Proclamation on Parenting without Violence’.

The Netherlands Organization for Health Research and Development coordinates the enhancement and planning of prevention and health promotion research. This organization is the main grant-giving agency for prevention research in the Netherlands. Basic and postgraduate professional training is provided by Universities, national institutes and the National School of Public and Occupational Health.

*Workforce*

The Netherlands has a long history of investing in the mental health workforce. In the 1970s, the first group of health educators was appointed in primary care services and mental health services, supported by grants of the Ministry of Social Work and Well-Being. Since then, a comprehensive national infrastructure has been developed for health promotion and prevention which includes a network of health promoters, prevention workers and trained caregivers at the local and district level.

The development of a professional, quality workforce for health promotion and disease prevention is the primary aim of the Dutch Federation of Health Education and Prevention. The federation provides education and training, knowledge dissemination, quality assessment and enhancement, and represents the professional workforce in contract negotiations with employers, financing agencies, governmental agencies and other professional organizations. The Federation operates a national accreditation system for training programs and a practitioner registration system for expertise levels in prevention and health promotion based on participation in accredited training programs. In 2004, the Federation had approximately 1177 members, including health promoters, health educators and/or prevention experts, of which approximately 54% worked in public health, primary care and national institutes (where a substantial proportion were involved in mental health promotion and mental illness prevention), 30% worked in mental health services, and 16% worked in addiction clinics.

Mental health promotion and the mental illness prevention are delivered by two categories of professionals: those who are trained and employed as health promoters, health educators or prevention experts and other professionals who contribute to the implementation of prevention or promotion activities, but for whom these activities are not part of their primary field of expertise (e.g. caregivers in primary health care and mental health services, school teachers, school counsellors, personnel officers). Professionals in the first category have a basic training in one of the following disciplines: psychology, educational sciences, health sciences, social work or nursing. They receive specialized, science-based training in health promotion, health education or prevention as part of these basic training programs or through post-graduate programs.
Maastricht University offers a bachelor and masters program in health education and health promotion, including a basic course in prevention of mental disorders and mental health promotion. In addition, the university organizes international summer courses in health promotion. The Prevention Research Centre of the Radboud University, Nijmegen, provides specialized courses on promotion and prevention in mental health as part of its bachelor, master and post-graduate programs in psychology. The Netherlands School of Public and Occupational Health and the Netherlands Institute for Health Promotion and Disease Prevention also offer post-graduate courses in mental health promotion and mental illness prevention.

Monitoring and Evaluation

The mental health of the Dutch population is monitored mainly through the NEMESIS-project of the Netherlands Institute for Mental Health and Addiction. NEMESIS is a longitudinal epidemiological survey of representative samples of the Dutch population. It assesses the prevalence and incidence of mental disorders, identifies populations at risk and potential risk factors, and trends in the use of health and mental health services. In addition, several public health services and some mental health services are involved in mental health monitoring systems at the health district level.

The implementation of policies and program across the health districts and local communities are registered by several national institutes. The Trimbos Institute registers prevention programs provided by mental health services across the country. The Netherlands Institute for Health Promotion and Disease Prevention maintains a national database on health promotion and prevention activities in other health sectors, which may also include activities targeted at mental health. The current national QUI-project, in which several national institutes are collaborating, aims to integrate the available databases of several national institutes into one comprehensive national monitoring system for the implementation of health promotion and prevention programs.

The Netherlands Organization for Health Research and Development coordinates quality assessment, efficacy and effectiveness studies of health promotion and prevention policies and programs as part of a national prevention research program funded by the Ministry of Health, Welfare and Sport. In the first planning period, 1998-2002, approximately 30% of the research budget was spent on projects that targeted mental health.

United Kingdom, England


Policies and Plans

In 1999, the national government released the 10-year National Service Framework for Mental Health which aims to improve quality and increase the uniformity of mental health provision in England. This document outlines the Government’s vision for mental health services, treatment, care and promotion. It followed a Government commitment to making mental health a priority, increasing budgets, supporting workforce development, enhancing the mental health sector and ensuring appropriate public and patient involvement in mental health care and programs. It also aims to contribute to broader Government objectives such as reducing health inequalities, providing equality of opportunity, enhanced choice in health and improved access.
The National Service Framework for Mental Health (NSFMH) focuses on the mental health needs of working age adults up to 65. While it touches on the mental health needs of the population across the life course, then specific needs of children, young people and older adults are addressed through the National Service Framework for Children, Young People and Maternity Services (2004) and the National Service Framework for Older People (2001). The NSFMH sets national standards and defines service models for promoting mental health and treating mental illness, puts in place underpinning program to support local delivery, and establishes milestones and a specific group of high-level performance indicators against which to measure progress within agreed timeframes. It covers health promotion, assessment and diagnosis, treatment, rehabilitation and care, and encompasses primary and specialist care and the roles of partner agencies.

The national standards are based on the available evidence and knowledge base and supported by service models and examples of good practice. Standard one addresses mental health promotion and the discrimination and social exclusion associated with mental health problems. Standards two and three cover primary care and access to services for anyone who may have a mental health problem. Standards four and five cover effective services for people with severe mental illness. Standard six relates to individuals who care for people with mental health problems. Standard seven draws together the action necessary to achieve the target to reduce suicides.

The Mental Health Taskforce is the most senior group of mental health stakeholders advising Government. This external reference group provides advice on mental health policy development and implementation. Public mental health promotion expertise is represented on the taskforce. In 2005, the National Institute for Mental Health in England (NIMHE) published a national framework for improving mental health and mental well-being. The framework informs the next stages in the design, delivery and evaluation of mental health promotion at all levels among a range of statutory and voluntary sector providers.

National government programs, such as Neighbourhood Renewal, Urban Regeneration and Social Inclusion, all highlight mental health improvement as a target and approved outcome for programs at the local level, particularly in the most deprived areas. The Local Government Act 2000 gives local authorities the power to promote well-being among local communities.

Broader public health policy, including that set out in the Government white paper, Choosing Health: Making Healthy Choices Easier (2004), also highlights improved mental health as a key deliverable. As a result of this report, it is hoped that local delivery plans will include more detail on the assessment, development, delivery and evaluation of public mental health programs. There are also an increasing number of programs considering the development of indicators and measures for mental health and an increasing number of national and regional networks which support those tasked with the delivery of mental health improvement.

Although a number of policies state the importance of promoting public mental health, budgets for mental health promotion at all levels are limited in comparison with other target health improvement areas, such as smoking or obesity, and other mental health advances, such as assertive outreach or home treatment and crisis support teams. It is hoped that the increased commitment to public health will lead to an increased commitment to public mental health in time. There has also been a call to set local targets related to mental health promotion to encourage commitment and delivery.
Supporting policies, plans and programs

There are a range of policies and programs to support mental health promotion and mental illness prevention throughout the lifecycle and across settings. For early childhood, there have been large investments in parent training and early childhood development through the Sure Start program, the Early Years Development and Childcare Partnerships, as well as programs supported by the Children’s Fund and the newly appointed Children’s Commissioner.

In schools, investments have been made in the Healthy Schools program and Connexions services supporting young people through periods of transition, as well as in the development and implementation of policies such as Every Child Matters. The New Deal program supporting people back to work and the Pathways to Work program have also demonstrated mental health outcomes.

There are also programs supporting work-life balance and enhanced interest in programs that support healthy workplaces and broader corporate responsibility. In local communities, the Neighbourhood Renewal and Urban Regeneration programs aim to improve health through enhanced community participation, civic engagement and improved physical and social environments. Community strategies and the work of Local Strategic Partnerships support enhanced well-being within localities. There is also increasing support for the health impacts of culture and the arts, physical activity and leisure and improved safety and security in communities.

Resources for Implementation

Infrastructure

In England, the policy lead for mental health is the Department of Health. The implementation lead for mental health is the National Institute for Mental Health in England (NIMHE), which has recently become part of the Care Services Improvement Partnership (CSIP) within the Department of Health. NIMHE has a national advisory group for mental health promotion which brings together representatives from mental health and public health organizations to advise and support effective implementation.

CSIP has eight regional development centres (RDC) throughout the country supporting NIMHE programs. In each RDC there is an individual responsible for mental health promotion and anti-stigma and discrimination work. In most areas there are co-ordinated regional networks to inform, develop and support individuals working in localities. Regional health structures supporting public health implementation also include central government offices which host the Regional Directors of Public Health and their teams who are responsible for Regional Public Health Strategies, as well as Public Health Observatories which monitor and evaluate public health targets within regions. NIMHE has pooled resources with the North East Public Health Observatory to establish a Public Mental Health Observatory.

There are many national public health organizations with an increasing interest in mental health. These include the United Kingdom Public Health Association, the Institute of Health Promotion and Education, the Royal Institute of Public Health, the Royal Society for the Promotion of Health, the National Institute for Health and Clinical Excellence and the Faculty of Public Health. The Faculty has recently established a working group on mental health which will include a focus on mental health promotion and signed a Memorandum of Understanding with NIMHE. Nationally, there are a number of professional bodies and voluntary organizations who deliver mental health promotion and mental illness prevention.
Workforce

The mental health workforce in England is a varied one. Those in mental health promotion and mental illness prevention are generally drawn from public health, health promotion or mental health backgrounds. The broader networks of mental health promotion implementers at the local level include health visitors, primary care professionals, teachers, councillors, housing officers, community development workers, transport co-ordinators, leisure workers, social workers, police, probation officers, prison staff and colleagues in mental health services.

There are an increasing number of academic organizations that are including mental health promotion and mental illness prevention in more generic training, such as for mental health nurses or occupational therapists. The Open University is also including mental health promotion in broader mental health training program for distance learning. However, this advancement is relatively ad-hoc and although national training has been piloted and delivered through some NIMHE regions, there is no commitment to continue to train and support those tasked with delivery.

Monitoring and Evaluation

In The National Service Framework for Mental Health – Five Years On, Appleby (2004) noted that mental health services have become increasingly responsive to the needs and wishes of the people who use them. Specialist community mental health teams have been set up across the country, offering home treatment, early intervention or intensive support for people with complex needs. Staff numbers have substantially increased. Modern treatments are in widespread use. Most users of services report that their experience of mental health care has been positive. Suicide rates are at their lowest recorded level.

Appleby identified key areas for action over the next five years (2005-2010), including the move towards greater patient choice, improved access to specific services, and a broadening of focus from specialist mental health services to the mental health of whole communities. He pointed to the need for improved in-patient care – particularly ward environments – and better services for people with a dual diagnosis of mental illness and substance dependence. He also noted the need to tackle social exclusion of people with mental health problems by improving their employment prospects and opposing stigma and discrimination; improving services for ethnic minorities by abolishing inequalities in care and earning the confidence of people from minority communities; enhancing the care of long term mental disorders by setting out a new model of mental health care in primary care; and increasing the availability of psychological therapies.

Underlying these developments will be the need for better information, information systems and workforce redesign. Appleby emphasized the critical importance of the Government’s continuing commitment to mental health as one of the priorities of the National Health Services, and the cooperation of the rest of the health and social care system to respond to the Government’s commitment, thereby keeping mental health in the mainstream of reform and investment.

United Kingdom, Scotland

**Policies and Plans**

In Scotland, government policy on mental health integrates mental health improvement and treatment under the auspices of the Mental Health Division within the Scottish Executive Health Department. Mental health improvement includes mental health promotion and mental illness prevention. Treatment includes the implementation of mental health legislation and mental health services for people with mental disorders. The current mental health policy in Scotland provides a template for comprehensive local mental health services and places a duty on local authorities and their partners to provide services designed to promote the well-being and social development of people with mental disorders.

The National Program for Improving Mental Health and Well Being (the National Program) was launched in October 2001 to raise the profile and support action in promoting mental health and well-being, eliminating the stigma of mental ill-health, recovery from mental illness, and suicide prevention. The work of the National Program is at the heart of the Scottish Executive’s efforts to improve health and achieve greater social justice. As such, it is structured within the context of other relevant policy areas: health improvement, social justice and social inclusion, education and young people, and enterprise, lifelong learning and community regeneration. The National Program has four key aims, six priority areas and six areas of supporting activity.

The four key aims are:

- raising awareness and promoting mental health and well-being
- eliminating stigma and discrimination
- preventing suicide
- promoting and supporting recovery

The six priority areas are:

- improving infant mental health
- improving the mental health of children and young people
- improving mental health and well-being in employment and working life
- improving mental health and well-being in later life
- improving community mental health and well-being
- improving mental health promotion and prevention in local services

The six areas of supporting activity are:

- evidence into practice
- research
- evaluation
- indicators for mental health and well-being
- keeping people informed
- sharing and learning
The Scottish Executive invested £24 million (€34.3 million) in the National Program Action Plan 2003-2006 and £18 million (€25.7 million) in the National Program Action Plan 2006-2008 through the Health Improvement Fund. This equates to £1.78 /€2.54 per capita per year for 2006/07 and 2007/08.

Scotland, as part of the United Kingdom, endorses the WHO Declaration and Action Plan for Mental Health in Europe. The Declaration establishes a solid framework for the further development of mental health policy in Scotland.

**Resources for Implementation**

**Infrastructure**

The mental health infrastructure in Scotland consists of the Scottish Executive and other statutory bodies, non-governmental organizations, professional bodies and academic institutes that all play a part in the development and delivery of public mental health and mental health improvement.

The National Program’s National Advisory Group, chaired by the Deputy Minister for Health, is comprised of stakeholders from the public, private and voluntary sectors and representatives from a variety of different settings, life stages and issues. The National Program also has an Executive Group which consists of the key national agencies responsible for supporting the implementation of public mental health policy.

Health Scotland is the key implementation body for the National Program. As a special health board within the National Health Service Scotland, Health Scotland is sponsored by the Directorate of Health Improvement within the Scottish Executive Health Department and is well positioned to move the National Program forward.

Infrastructures have recently been established to implement specific components of the National Program. A national implementation support team and local co-ordinators have been established to implement the national suicide prevention strategy and action plan. Other infrastructures include: implementation support for the national anti-stigma campaign, a national recovery network to promote and support recovery for people who experience long term mental health problems, and a national project aimed at achieving an integrated approach to the promotion of good mental health, prevention, care and treatment of mental health problems among children and young people.

**Workforce**

In Scotland, the workforce involved in mental health promotion and mental disorder prevention is drawn from diverse settings and sectors, including the National Health Service, local authorities and the wider public and voluntary sector. Scotland also has a number of Health Improvement Officers with a specific responsibility for mental health improvement at the local level and 32 ‘Choose Life’ Coordinators who oversee local implementation of the national suicide prevention strategy and action plan.

Professional development and community-based training cover a wide variety of topics, such as mental health literacy, healthy workplace practices for employers and managers, mental health promotion, and suicide prevention. Training has also been developed to support the use of evidence in practice and the evaluation of mental health improvement. A postgraduate qualification in public mental health and mental health improvement is currently being debated in Scotland.
Monitoring and Evaluation

Scotland uses the standard measures GHQ12 and SF12 to monitor the mental health of the population. The GHQ12 is used in several national surveys, such as the Scottish House Condition Survey, which looks at the physical condition of Scotland’s homes and experiences of householders, and the Health Education Population Survey, which collects data on priority health topics, including information on knowledge, attitudes and behaviour/health status. Well? What do you think, a biennial national survey of public attitudes to a range of mental health issues, also uses the GHQ12, along with questions to establish the presence or absence of factors likely to affect respondents’ mental health and well-being. The SF12 is used in the Scottish Health Survey, which gathers information about the physical and mental health of the population of Scotland.

Health Scotland has undertaken the development of a core set of sustainable mental health and well-being indicators for Scotland in support of the National Program.

Approximately 10% of National Program resources are invested in research and evaluation. This includes funding for national research and evaluation work and support for local action research through an innovative annual small grants award scheme. Several independent evaluations of national initiatives relevant to mental health promotion and prevention of mental disorders have been commissioned, including the evaluation of a depression project, Doing Well by People with Depression, which examines the changes required in local service systems to enhance responses to people with depression.

The implementation of Choose Life, the first phase of the national strategy and action plan for preventing suicide, has been evaluated with an emphasis on the assessment of infrastructure and early impacts. This evaluation will inform the next phase of the strategy. Plans are underway to evaluate other key elements of the implementation and results of the National Program.

United States


Policies and Plans

In 1999, the Surgeon General of the United States issued Mental Health: A Report of the Surgeon General which engaged the American public in a discussion about the importance of mental health and the status of research on services. In 2002, the President of the United States signed an Executive Order creating the New Freedom Commission on Mental Health and charged it with issuing a report describing obstacles to care within the mental health system, examples of successful community-based care models, and ways to address deficiencies in the system.

In July 2003, the Commission released Achieving the Promise: Transforming Mental Health Care in America. The vision is to create a future when everyone with mental illness will recover, mental illnesses are detected early, and everyone with a mental illness -- at any stage of life -- has access to effective treatment and supports. The goals are to ensure that:

- the public understands mental health is essential to overall health
- mental health care is consumer and family driven
- disparities in mental health services are eliminated
• early mental health screening, assessment and referral to services are common practice
• excellent mental health care is delivered
• research is accelerated
• technology is used to access mental health care and information

In 2004, the US Center for Mental Health Services (CMHS) began working closely with the States to implement the six goals of this report. Currently, CMHS programs are being transformed to address the recommendations of the President’s New Freedom Commission on Mental Health.

The key national organizations involved in the funding, delivery and/or oversight of mental health services are the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH), National Institutes of Health (NIH). The Public Health Service Act (2000) defines the functions of the NIMH and CMHS. In 2002, the Children’s Health Act (2000) authorized the SAMHSA to carry out children and adolescent focused mental health programs.

**Resources for Implementation**

**Investment**

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. It is estimated that approximately one sixth of the population is without any health insurance.

The federal government spends 6% of the total health budget on mental health. The primary sources of mental health financing in descending order are private insurances, tax-based funding, out of pocket expenditure by the patient or family. In the 1980s, mental health care was included in federal employees’ insurance. In the 1990’s, the focus of federal programs, such as Medicaid and Social Security Disability Insurance was on managed care, which separated out mental health benefits from other medical benefits. Today, the combination of public and private managed care plans has resulted in ‘dumping’ from one level to another (e.g. when private insurance benefits are exhausted, the consumer moves from the private to the public sector). Such dumping has the effect of keeping private sector insurance costs artificially low, while encouraging the development of a large public safety net of mental health services.
Infrastructure

Mental health services are provided by a variety of practitioners who work in diverse, relatively independent, and loosely coordinated facilities and settings. These services exist at every level of government and throughout the private sector and have varying missions, settings, and financing. These services are referred to, collectively, as the de facto mental health service system. The system is usually described as having four major components or sectors:

- **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
- **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
- **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
- **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 and to services financed with government resources. 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.

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.

The general hospital psychiatric units, outpatient clinics and halfway houses of the 1950’s gave way to comprehensive treatment informed by a philosophy of the least restrictive alternative. There was a gradual consolidation of service treatment for drug users, children and people living in impoverished areas. In the 1970’s, case management and assertive community treatment took hold, leading to an emphasis in the 1980’s on improving community services for people with mental disorders. In the 1990s, there was a shift back to containment prompted by perceived link between recidivism and community care. The last decade has been characterized by increased attention to the relationship between mental illness, homelessness, and addiction, which has led to the development of a recovery philosophy and greater consumer choice and control.

**Workforce**

Currently, mental health care is provided by mental health and substance abuse providers, primary care physicians, and social service providers or self-help groups. There are approximately 4300 mental health organizations in the country, of which over one-fifth are state, county or private mental hospitals and residential treatment centres for emotionally disturbed children. Mental health
service organizations employ about 680,000 people, with over three-fourth being patient care staff and nearly half qualifying as mental health professionals. NGOs are mainly involved in advocacy, promotion and prevention.

Monitoring and Evaluation

The National Health Interview Survey conducted by the National Centre for Health Statistics collects information on mental disorders in adults and children. The mental health data collection system is currently funded by NIMH. The CMHS is responsible for statistical information on mental health populations and services through the National Reporting System.

IV. LESSONS LEARNED

Why Develop Mental Health Policy?

Mental health policy, when well conceptualized, can define a vision for improving mental health and reducing the burden of mental disorders in a population. It allows the expression of an organized and coherent set of values, principles and objectives to achieve the vision and to establish a model for action. Without policy direction, lack of coordination, fragmentation and inefficiencies in the system will weaken the impact of any mental health intervention (Funk et al, 2007).

The WHO Declaration and Action Plan on Mental Health in Europe makes the case that having a national policy on mental health is fundamental to the task of raising awareness and securing resources, which, in turn, are necessary to deliver effective, equitable and affordable treatments. A national policy can provide the framework within which to coordinate actions across the multiple agencies and sectors that must be in place to respond to the complex needs of people with mental health problems.

In the 2005 Mental Health Atlas, the World Health Organization argues that a substance use policy is vital to facilitate the planning and improvement of services for people at risk of and experiencing substance use problems, including substance dependence. The existence of a policy helps to prioritize issues related to substance use and provide common direction to governmental and non-governmental organizations in reducing the harms associated with substance use and improving services and resources for people negatively impacted by substance use.

Characteristics of Effective Mental Health Policy

Those jurisdictions with successful mental health policies have embraced their leadership responsibilities and assumed a unifying role with stakeholders, working with them to develop agreement on targets and priority activities. The successful evolution of a national mental health policy is predicated on the active involvement of the national government, an emphasis on mental health promotion, increased research, appropriate indicators or targets and robust surveillance systems.

In the United Kingdom, the 10-year National Service Framework for Mental Health (1999), set standards with benchmarks and accompanying strategies to achieve them in five key areas: mental health promotion, mental health care within primary care, needs of the severely mentally ill, services and supports for caregivers to the mentally ill, and suicide prevention. To facilitate oversight and ensure effective implementation, the government established the National Institute for Mental Health in England. A recently completed five year review of the plan noted major improvements in the
country’s record of care and prevention, including a drop in the suicide rate to its lowest recorded levels.

Australia is recognized as a world leader for its innovations in mental health care reform. Australia’s national mental health strategy, initiated in 1992 and implemented and renewed through a series of five-year plans, commits all state, territorial and Commonwealth governments to improve the mental health of the population and improve the lives of people with mental illness. Central to Australia’s success with mental health policy reform has been the development of longitudinal data for tracking expenditures and measuring progress. Regular national mental health reports have been an integral part of the country’s planning.

In New Zealand, the 1998, Blueprint for Mental Health Services has provided the main framework for action in reforming the country’s mental health system. The primary objective of the Blueprint is to provide access to services for people with severe mental illness who represent approximately three percent of the population. An important feature of the Blueprint has been its base analysis of the number of resources, including beds and health professionals, required to properly service targeted populations. The actual resources are regularly measured against the recommended resources with strategies and funds deployed to close specifically identified gaps. In 2005, the government expanded its focus to include the positive mental health of the general population. The renewed 10-year plan identifies clear, measurable outcomes for people and services, as well as leading challenges to overcome to achieve the outcomes.

The characteristics of an effective mental health policy include the following elements: shared vision with guiding principles that are based on notions of equity, uphold human rights standards and are reflected in all actions and interventions; clear objectives with supporting strategies that address the broad determinants of health and mental ill health; and, actions that are based on reliable information about available mental health resources, incidence and prevalence of mental disorders, burden of disease, economic and social costs of mental disorders, and evidence of the effectiveness and relevance of specific interventions. To remain effective, mental health policies must be revisited and updated regularly to address emerging epidemiological trends, new knowledge and evidence of effectiveness, and changing social norms (Funk et al, 2007).

It is not easy to achieve a common vision among stakeholders from diverse backgrounds. Part of the difficulty is that different stakeholders interpret the population’s mental health needs in different ways. Autonomy may be the most pressing issue for consumers. While families may emphasize the need for adequate information, financial and social support, mental health professionals look towards efficiency and resources, and policy makers seek cost-effectiveness. However, the process of establishing a vision allows discussion and the sharing of ideas among different stakeholders and helps to negotiate boundaries and define a general image of the future of mental health. This shared vision can provide direction to activities and improve collaboration. A common vision will be underpinned by a number of values and principles. If debated and made explicit, the values and principles will improve the coherence of strategies to implement the vision (Funk et al, 2007).

Once the vision, values and principles are defined, a number of objectives and strategies can be formulated to improve the health of the population, respond to people’s expectations and provide financial protection against the cost of ill health (World Health Organization, 2001). Effective national policy frameworks must extend beyond the confines of the health system to include concerted action in the areas of housing, education, employment, social services, and criminal justice (Knapp et al, 2007). Strategies that simultaneously address a number of areas for action need to be identified in order to take these objectives forward. These areas include: financing, legislation and
human rights, organization of services, human resources and training, promotion, prevention, treatment and rehabilitation, advocacy, quality improvement, information systems, research and evaluation (Funk et al, 2007).

Legislative instruments have obvious roles to play to address human rights violations, stigma, discrimination and social exclusion. There are already human rights instruments drawn up by the United Nations, the principles of which should underpin the development of supporting legislation. However, any such legislation can only be effective if implemented and monitored, with adequate sanctions to effect change (Knapp et al, 2007).

In the area of service organization, there is now general acknowledgement that a ‘balanced care’ approach is required, where front-line services are based in the community but hospitals and other congregate care settings play important roles as specialist providers (Thornicroft & Tansella 2004). Where they are required, hospital stays should be as brief as possible, and should be offered in ‘normalized’ integrated facilities rather than in specialized, isolated locations. Accompanying the move away from hospital-centred services across much of the European continent, particularly in higher-income countries, has been a gradual ‘reconceptualization’ of need, with more emphasis on human rights and social inclusion (Knapp et al, 2007).

A robust mental health policy requires a funding base that is adequate, equitable and efficient. Some funding mechanisms can create incentives to better practice, while others erect barriers to the achievement of better individual and population health outcomes. As jurisdictions move away from mental health systems dominated by institutional management to systems focused on community management, the balance of funding must also shift from a near exclusive reliance on health systems to a more mixed economy of resources. As community models develop, services and supports from outside the health system will be called upon to help people to access appropriate housing, employment, education, recreation, social support and other determinants that greatly influence mental health and quality of life (Knapp et al, 2007).

Challenges for Mental Health Policy Development

In developed countries, deinstitutionalization has not been accompanied by sufficient provision of community-based residential and occupational facilities. The detection and treatment of mental disorders in primary care settings remains poor and there remain tensions between the competing demands for general versus specialist services. The larger social and economic factors impacting on mental health need to be addressed as part of the effort to narrow the gap between evidence and policy, and between policy and practice. Poverty reduction and the social and economic integration of people with mental disorders can contribute to reducing the burden of disease and associated costs. In the end, it will be the political commitment of governments to address mental health problems, the strength of consumer and family movements to ensure that mental health does not disappear from the agenda, the support provided by international and multilateral organizations, NGOs and the international community at large that will ensure continued progress in the area of mental health (Funk et al, 2007).

Stigma and Discrimination

Stigma distinguishes mental health disorders from most other health problems and is the major reason for discrimination and social exclusion. The stigma attached to mental illness is the main obstacle to the provision of care. It creates a vicious cycle of alienation and discrimination and can become the main impediment to recovery, causing social isolation, unemployment, homelessness, and institutionalization. Sartorius (2007) notes that stigma does not stop at illness: it marks those
who are ill, their families across generations, institutions that provide treatment, availability of psychotropic drugs, and mental health workers. Stigma makes community and health decision makers see people with mental illness with low regard, resulting in reluctance to invest resources in mental health care. Tackling this discrimination remains a key policy challenge (Thornicroft, 2006).

Stigma and discrimination have a long history and are not easily resolved, therefore undertaking action against stigma should be seen as a major, long term commitment. In 1996, the World Psychiatric Association (WPA) embarked on a worldwide program to fight stigma and discrimination because of schizophrenia called “Open the Doors”. The objectives of the program are to increase the awareness and knowledge of the nature of schizophrenia and treatment options, improve public attitudes to those who have or have had schizophrenia and their families, and generate action to prevent or eliminate stigma and discrimination. Open the Doors is an international network involving over twenty countries. The original program was piloted in Alberta.

Experience over the past two decades has identified the main parts of successful action against stigma: consultation of people with mental illness and their families about targets for action against stigma and their involvement in relevant programs; conception of the fight against stigma as a long term endeavour that is incorporated into health and other social services; involvement of all stakeholders, including government, health service personnel, and the media; and, a focus on specific problems that result from stigma (e.g. discrimination against people with mental illness) rather than generic approaches to change people’s attitudes (Sartorius, 2007).

**Consumer and Family Involvement**

The mental health system exists largely for persons with mental disorders and their families and both groups make important contributions to defining what works and how to improve the mental health system. In addition, families assume a great part of the responsibility for caring for a family member who has a mental disorder, and this is likely to increase with the movement towards deinstitutionalization and community care. Families’ understanding, knowledge and skills can significantly influence the quality of care and support provided to a person experiencing mental illness. At times, there are notable tensions between the viewpoints of consumer and family groups, especially in the area of involuntary admission and treatment. However, it is imperative that both persons with mental disorders and family members be included in the development and renewal of policy, legislation, services and standards.

**Choice and Control**

The overarching policy challenge will be to continue moving mental health systems from an era of containment to a future of opportunity and choice. In Europe, the WHO Declaration and Action Plan for Mental Health have provided the impetus to create new opportunities for the social and economic inclusion of people with mental disorders. In moving away from confinement to a focus on lifestyle opportunities, policy makers will need to find a balance between keeping vulnerable people connected with services and interfering too assertively in their lives. Policy makers will also need to develop measures that balance the need to protect individuals and communities from harm (including self-harm) against the risk of denying people their right to freedom and self determination (Knapp et al, 2007).

**Evidence-based Decision Making**

There is a growing evidence base of evidence of the effectiveness and cost effectiveness of mental health interventions, from mental health promotion to mental illness prevention, treatment and recovery. There are also valid tools for measuring well-being and evaluating mental health outcomes.
The challenge is to ensure that the available information is what policy makers actually need, that it reaches them in a form that they can understand and employ. More needs to be done to improve channels of communication between policy makers, front-line workers, researchers and other stakeholders. Decision makers must continually ask whether the evidence is robust enough to allow mental health services to compete with other claims for scarce health or wider resources (Knapp et al, 2007).

Commitment to Quality

Quality is a measure of whether services increase the likelihood of achieving desired outcomes and are consistent with current evidence-based practice. Quality is an essential requirement of any mental health service whether the service is in its infancy, with minimal resources, or well established, with plentiful resources. A focus on quality helps to ensure that scarce resources are used in an efficient and effective way. Poor quality services are likely to be ineffective and result in a waste of already scarce resources. Despite this, access to the latest developments in mental health care and the capacity to implement quality standards is a considerable challenge in settings with few human and financial resources. Policy makers need to implement simple strategies to improve quality, such as building quality standards into policy and legislation, defining professional standards of the mental health workforce and their training, establishing and monitoring services through established standards and accreditation procedures, and ensuring the availability of clinical guidelines based on evidence-based practice (Funk et al, 2007).

Service Organization

In order to deliver a high standard of mental health care, WHO emphasizes the adoption of an integrated system of service delivery, which attempts to comprehensively address the full range of psychosocial needs of people with mental disorders. A number of policy recommendations for service organization have been highlighted in the World Health Report 2001, and elaborated upon in the WHO Mental Health Policy and Service Guidance Package (2003). They include shifting care away from large psychiatric hospitals, developing community mental health services, and integrating mental health care into general health services.

There is now a clear expectation that mental health service organization will enhance the accessibility and acceptability of services, strongly contribute to improved mental and physical health outcomes, and achieve a better rationalization of resources. As mentioned earlier in this report, a large part of mental health care can be self-managed and/or managed by informal community mental health services in the community. Where additional expertise and support is needed, a more formalized network of services is required which include, in order of increasing intensity and specialization, primary care services, formal community mental health services, psychiatric services in general hospitals, and specialist and long-stay mental health services.

In some countries, the shift away from institutional care has been slowed by the use of long-stay care homes. In other countries, a process of re-institutionalization is occurring where individuals who were once accommodated in psychiatric hospitals are now housed in prisons, secure forensic units or care homes (Priebe et al, 2005). For policy makers, the challenge is how to foster better community-based systems of treatment and support. This will mean more than simply replacing institutional care with outpatient services. Policy makers must assess what people need, what they are actually prepared to use, and identify the appropriate configuration of community services and supports to meet those needs (Knapp et al, 2007).
Financing
The case for investment in mental health is strong. There is now substantial evidence that greater expenditure in many areas of mental health is not only justified on the grounds of individual health, but also because it represents a more efficient use of health and other sector resources. The challenge for policy makers is to understand the widely ranging costs associated with mental health problems and create the right funding environment and structure of incentives to mobilize appropriate resources in order for people to access the services they need across relevant life domains (Knapp et al, 2007).

Financing is not only a major driver of a mental health system, but is also a powerful tool with which policy makers can develop and shape mental health services and their impact. Financing can be used to address equity issues by allocating specific resources to certain disadvantaged population groups or groups at high risk of developing mental disorders, and to ensure that persons who meet certain income criteria do not have to pay user fees for services or that they pay in accordance with their incomes. Financing can be used to enhance efficiency by basing resource allocation decisions on data about effectiveness and cost-effectiveness, and linking them to priorities specified in a progressive policy (Funk et al, 2007).

Implementation
The successful implementation of mental health policies requires well-resourced and highly coordinated action across different sectors and organizations. The challenge for policy makers is to develop funding mechanisms that facilitate the movement of resources between different sector budgets and institutional arrangements that remove barriers created by multiple and conflicting organizational and professional mandates. In this way, policy makers can overcome some of the disincentives (or perverse incentives) that distort or inhibit appropriate action (Knapp et al, 2007).

Workforce Development
A mental health system relies on the skill and motivation of its workforce to promote mental health, prevent disorders and provide care for people with mental disorders. Yet major difficulties are frequently encountered in the planning and training of mental health human resources. In many jurisdictions there are too few trained and available personnel. Where available, personnel are often distributed inefficiently or inequitably within a given jurisdiction. In many cases, human resources are not used appropriately and people feel unproductive or demoralized (Funk et al, 2007).

For policy makers the challenge is to ensure the best fit between the level of knowledge and skills required of mental health workers at different levels of service delivery and service needs. Planning needs to address practical details about the numbers of mental health professionals required at different levels of service delivery and the required skill mix and competencies. Continuing education, training and supervision are fundamental to providing evidence-based care and need to be reviewed periodically and improved, in keeping with the mental health needs of the population. Ongoing education and opportunities for skills development, along with the provision of specialist training, can also act as an incentive to retain individuals who may otherwise be tempted to seek employment opportunities elsewhere. Finally, management strategies need to enhance leadership, motivation, recruitment and the deployment of often scarce personnel (Funk et al, 2007).
V. RECOMMENDATIONS FOR BRITISH COLUMBIA

In order to achieve population-level mental health and substance use outcomes, and reorient health and other systems to fully support the achievement of these outcomes, a 10 Year Mental Health and Substance Use Framework for British Columbia would benefit from having the following elements:

**Shared Vision**

**Determinants of health approach:** clear understanding of the influence of broad social, economic and environmental factors, such as income, housing, employment, education and social support, on the mental health of the general population and diverse population groups.

**Whole systems approach:** clear understanding that multiple sectors and systems must be mobilized to achieve optimum population mental health; these sectors include health, education, social services, housing, employment, transportation, enforcement and justice.

**Broad mental health focus:** goes beyond the needs of people with severe/persistent mental illness, substance dependence and/or concurrent disorders to also include the mental health of the whole population and diverse groups, specifically:

- promotion of positive mental health across the life course
- prevention of mental health problems and substance use problems across the life course
- equitable access to evidence-based services for emerging, mild and moderate mental health problems as part of primary health care
- equitable access to specialized psychiatric services and formal health care settings for those most in need

**Population lens approach:** clearly acknowledge the differences in mental health and substance use, vulnerability to mental ill-health and harms from substance use, burden of mental illness and substance-related harm, and effectiveness of interventions on the basis of age, gender, ethnicity, culture, socioeconomic status, sexual orientation, history of violence/trauma, citizenship status, risk conditions, risk behaviours and co-occurring conditions.

*Good Example: Australia, New Zealand*

**Guiding Principles**

An effective and humane mental health and substance use policy framework must be consonant with human rights (e.g. respect, protect and remedy any violations of basic human rights), and be explicitly underpinned by the principles enshrined in the United Nations Convention on the Rights of Persons with Disabilities. In particular, the policy framework and any supporting legislation, plans and programs must address stigma and discrimination. The stigma attached to mental illness and addiction is one of the main obstacles to improving mental health and reducing substance-related harm. The elimination or reduction of stigma and the specific problems that result from stigma, such as discrimination in the provision of care and low uptake of services by those who need them most, will require long term, co-operative and concrete action at the individual, organizational, system and societal level.
Good Example: Australia, Finland

Policies and Plans

- Strong and sustained political commitment
- Clear performance targets to mobilize health and other systems
- Evidence-based actions that are feasible, relevant to British Columbians and cost effective
- Meaningful consumer and community engagement
- Collaborative action and partnerships
- Capacity for effective, efficient and equitable implementation that ensures timely access to services for all who need them, while taking into account local and regional conditions
- Organizational arrangements that support implementation across settings, disciplines, systems and jurisdictions
- Clear indicators of progress
- Trusted accountability mechanisms

Good Example: United Kingdom, New Zealand

Investment

An effective mental health and substance use policy framework requires adequate resources that are distributed equitably and used efficiently by key actors. Investment in mental health must be proportionate to the burden of mental illness and substance-related harms and the availability of cost-effective and affordable interventions. Public spending on mental health must ensure that populations with the greatest need for services and supports have the greatest access to them. Stigma about mental illness cannot be allowed to constrain the use of available resources. Governments must also strive for optimum allocative and technical efficiency in its funding mechanisms and interventions, and avoid the over-concentration of resources in large institutions at the expense of community infrastructure. It is critical for the health system and its community partners to be well-resourced during this period of transition to become "implementation ready", thereby making the most efficient, effective and humane use of available resources to improve population mental health.

Good Example: New Zealand

Service System

Continuum of interventions: comprehensive continuum of services and supports that is matched to client and community need, seamlessly integrated, easily accessible and based on the best available knowledge and evidence, including:

- individual and community mental health promotion
- prevention of mental health problems and substance use problems
- early identification of problems, diagnosis and early intervention
• harm reduction, stigma reduction and anti-discrimination
• pharmacological treatment, psychosocial treatment and assertive case management
• supportive recovery
• day and residential treatment
• recovery and relapse prevention
• supportive housing
• social integration and economic participation

**Integrated service delivery:** mental health and substance use services integrated into general health promotion, public health and primary health care services and settings

**Decentralized service delivery:** mental health and substance use managed largely through self care and informal community support and, when needed, through formal community-based and hospital-based mental health and substance use services, including specialist care and facilities

**Shared care models:** interdisciplinary teams of service providers working to overcome professional and institutional barriers to consumer access, service quality and achievement of health outcomes

**Infrastructure:** service system is well supported by research, surveillance, systematic evaluation, and knowledge translation and exchange

**Good Example: Australia, Finland, Chile, Spain**

**Workforce Development**

The complexity of mental health and substance use, coupled with advances in prevention and treatment knowledge, mean that workforce development is critical to the sustainability of the service system and, ultimately, to achieving population health outcomes. Comprehensive workforce development must include the following elements:

• Interprofessional education at the undergraduate, postgraduate and residency level
• Competency-based professional accreditation
• Continuing education and training
• Recruitment and retention of people from multiple disciplines and sectors
• Recruitment/retention of people living with mental health problems and substance use problems
• Job supervision and supports
• Safeguards to prevent burn-out
• Performance evaluations
• Performance incentives
Good Example: The Netherlands

**Monitoring and Evaluation**

In its stewardship role, government is responsible for the careful management of the health and well-being of the population. For government to hold itself and key partners accountable for the achievement of population-level mental health and substance use outcomes, an effective policy framework must contain the following elements:

- Clear and unambiguous indicators of progress in achieving population-level mental health and substance use outcomes, such as measures of:
  - positive mental health across the life course and diverse populations
  - incidence and prevalence of mental health problems and substance use problems across the life course and diverse populations
  - treatment gap for mental health problems and substance use problems across the life course and diverse populations (e.g. proportion of people in need of care who are not receiving appropriate care)
  - illness, injury and death associated with mental health problems and substance use problems across the life course and diverse populations
  - social integration and economic participation across the life course and diverse populations
  - system-level costs of untreated mental health problems and substance use problems
  - Valid and reliable mechanisms and transparent processes for monitoring progress and reporting progress to consumers, key stakeholders and the public
  - Capacity to disaggregate performance data on the basis of age, gender, culture, ethnicity, socioeconomic status and other factors
  - Feedback mechanisms to incorporate monitoring and evaluation data into policy development, planning and programming on an ongoing basis with opportunities for course correction
  - Supportive environments to foster informed public discourse on mental health, substance use and the effectiveness of public policy responses

Good Example: Australia, United Kingdom
VI. REFERENCES


