THE WINDOWS OF OPPORTUNITY
for Mental Health Reform in Ontario

Canadian Mental Health Association (CMHA), Ontario

March 2010

Executive Summary

As part of the response to the Ministry of Health and Long-Term Care discussion paper, "Every Door is the Right Door", the Canadian Mental Health Association (CMHA) Ontario has prepared a review of recent strategies for mental health reform released by:

- The government of Australia: *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009- 2014* (November 2009)
- The state of Victoria, Australia: *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009- 2019* (February 2009)
- The government of England: *New Horizons: A Shared vision for mental health* (December 2009)
- The Future Vision Coalition of the National Health Service, England*: A Future Vision for Mental Health* (July 2009)
- Judge McKee's report to the province of New Brunswick: *Together into the Future: A transformed mental health system for New Brunswick* (February 2009)
- The government of Scotland: *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 – 2011* (April 2009)

These strategies have been compared using the framework presented by the Mental Health Commission of Canada (MHCC), in their document "Towards Recovery & Well-Being" under the goals: Recovery and Well-Being; Promotion and Prevention; Diversity; Families and Carers; Effective, Seamless, User-determined Services; Research and Outcome Measures; and Stigma and Discrimination. In addition, this report has included sections comparing Vision, Governance and Workforce Issues.

This review will show that there are many similarities in core elements amongst the reviewed strategies, however the actual approach to system and service change varied widely depending on local factors such as the current state of mental health reform, cultural differences and the preparedness for change.

The vision contained in all the strategies stressed the necessity for system reform that is predicated on a recovery-based or person-centred approach. Believing that the best outcomes for those with mental illness are contingent on a partnership between providers and consumers, all jurisdictions addressed the barriers and opportunities for shifting control from the system into the hands of people with lived experience.

Social determinants have long been seen as primary factors in physical well-being. Reform strategies have recognized that these determinants are equally beneficial, or detrimental, to mental well-being and as such, are recommending action to coordinate cross-sectoral portfolios. Public health, child and family

services, education, housing and employment are examples of departments that are now being considered as part of a "whole of government" approach.

The reviewed strategies were also in agreement that the social, economic and moral impacts of mental illness are so substantive that money spent on mental health promotion and the prevention of mental illness (the upstream costs) pose significant cost-benefits when compared to the downstream costs of illness. As a result, reforms in the reviewed reports detailed a variety of actions that cultivate healthy families, good starts in early childhood, mentally health workplaces and the reduction of risk factors. Early identification and early intervention were also seen as clinically effective and cost-beneficial in mitigating the effects of mental illness.

The challenges related to increasingly diverse communities were also addressed in this review. Diversity takes many forms. The damaging effects of social isolation resulting from linguistic and cultural differences, gender, living with a co-occurring disability and life in rural or remote communities are discussed.

In the past, the main focal point for mental health reform was on the consumer and the delivery system. Attention has now broadened to include the informal networks that surround a person with lived experience, such as family and other carers. Strategies now recognize the vital role that these individuals play in recovery and have developed recommendations to "support the supporters."

The importance of community was also recognized as another essential element to mental well-being. Vibrant, inclusive communities that build mental resilience were seen as absolutely pivotal in the development of population mental health. In that same context, the provision of mental health services within the community to facilitate early identification, early intervention and treatment when mental illness does arise was consistently seen as vital to efficiency, effectiveness and a recovery orientation. Resource considerations to expand community services were evident throughout all strategies.

Enhanced resources were also recommended for research. Whereas investigations have primarily been related to drug interventions in the past, governments are encouraging research that will bring more science to the field and drive evidence-based practice. The development of performance indicators and the inclusion of consumer experience measures were also part of the trend to monitor the effectiveness of system and service changes.

Strategies to combat stigma and discrimination were addressed by all jurisdictions. The discrimination that exists towards people with mental illness, their families and carers, and that which is both levied and experienced by the mental health workforce itself, were topics of discussion.

Finally, reformation of many aspects of the mental health workforce was seen as a prerequisite to successful system change. The challenges relating to service culture, shortages, moral, education, ongoing professional development and career opportunity were recognized and plans to remedy these issues were reviewed.

The Canadian Mental Health Association (CMHA), Ontario has prepared this review to offer insights into strategies and action plans of other jurisdictions' activities in mental health reform. The similarities in core elements reflect the growing recognition of factors that influence mental health and support the journey of recovery. The differences in implementation reflect the variations that arise from local context. Nonetheless, the degree of consensus in the need and direction of reform is illuminating.

CMHA, Ontario congratulates the Ministry of Health and Long Term Care (MOHLTC) on its discussion paper, "*Every Door is the Right Door*". We hope this review will further inform your deliberations and ultimately lead to mental health reforms that nurture mentally healthy people in a healthy society.

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Introduction

If Every Door Is The Right Door, What Are The Windows of Opportunity?

CMHA, Ontario is a not-for-profit, charitable organization whose vision is "mentally healthy people in a healthy society". As a core responsibility, CMHA, Ontario develops and provides public policy advice that promotes mental health and improves the lives of people living with mental illness.

In July 2009 the MOHLTC released its discussion paper "*Every Door is the Right Door: A 10-Year Mental Health and Addictions Strategy*". To inform the discussion, CMHA, Ontario has conducted a review of six of the most current mental health strategies released by:

- The government of Australia (November 2009)
- The state of Victoria, Australia (February 2009)
- The government of England (December 2009)
- The Future Vision Coalition of the National Health Service Confederation (July 2009)
- The province of New Brunswick, Canada (February 2009)
- The government of Scotland (April 2009)

The review has included and compared these strategies to those outlined by the Mental Health Commission of Canada (MHCC) in its 2009 paper "Toward Recovery and Well-Being". Using the goals articulated in the MHCC's paper as the framework for this review, as well as additional sections on Vision, Governance and Workforce, CMHA, Ontario has identified strategies and approaches that may prove thought-provoking for discussions on mental health reform in Ontario. While local context provided variations in system reformation and delivery approach amongst the various jurisdictions, there was a significant amount of consensus in core elements throughout the reviewed strategies.

CMHA, Ontario appreciates the opportunity to contribute to the discussion on mental health and addictions reform in Ontario. As the MOHLTC deliberates on responses to its discussion paper, it is hoped that this jurisdictional review will provide insights to the question, "If every door is the right door, what are the windows of opportunity?"

Visions of the Future

The visions for mental health system reform offered succinct insights into the priorities, directions and principles of the reviewed jurisdictions.

Australia
"….a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community" [1]

The National Mental Health Policy articulated the vision for the Australian mental health system in 2008. It not only enshrined a recovery-based approach to care, but it also embraced the requirement for "whole of government" action to fully address the spectrum of influences and needs that determine mental well-being. "The Fourth Plan" released in late 2009 also emphasized the need to develop and monitor "robust" performance indicators as well as public accountability and reporting of results.

The state of Victoria, Australia
"By 2019, all Victorians have the opportunities they need to maintain good mental health and well-being, while those experiencing mental health problems can access timely, high quality care and support to live successfully in the community" [2]

The Victorian vision is built around four core elements: prevention, early intervention, recovery and social inclusion. In keeping with the national strategy, these elements draw on a cross-sectoral approach to achieve success.

The Mental Health Commission of Canada (MHCC)
"All people in Canada have the opportunity to achieve the best possible mental health and well-being" [3]

A deceivingly simple statement; an incredibly complex challenge. Behind the MHCC's vision is the belief that there should not be any distinctions between those who are currently suffering from mental health problems and those who are mentally healthy. In spite of progress that has been made over the years, the MHCC observed that there is still much work to be done in the areas of promotion and prevention; early identification; comprehensive service provision; a recovery-based approach and user involvement in all levels of system change;

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[1] Australian Government. <u>Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009- 2014</u> (November 2009) pii
[2] State Government of Victoria. Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009- 2019 (February 2009) p19
[3] Mental Health Commission of Canada. <u>Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada</u> (November 2009)

the social determinants influencing mental health and the need for a cross-sectoral approach to coordinating these factors.

England
While a pithy statement was not available, excerpts from the "New Horizons" document provided a sense of the vision seen by government. Elements deemed important to this country included the need for partnerships that encompassed central and local government as well as the Third Sector and the professions. Government at the highest levels endorsed a "whole of government" approach and stressed that physical health and mental health are now to be regarded on an equal footing. England also recognized the importance of a recovery and person-centred approach, observing that people with mental health problems can contribute to family, community and the economy just as those with physical health problems. In that regard, this country also framed mental health and well-being as more than a health concern; it now regards mental health as a major social issue requiring major attention.

The Future Vision Coalition (FVC) of the National Health Service, England
While a vision statement was not included in their document, the FVC did highly endorse the need for a "whole of government" approach. It also endorsed a recovery-based, person-centred approach, highlighting the role that employment plays in mental health and well-being. The FVC supported the concept that a person with mental ill health should be given the choice of what supports will best suit them in their recovery journey, with service providers acting as partners rather than directors in care. Family and carers should also be included in the partnership, as decided by the consumer. Early intervention was recommended to minimize the impact of mental ill health.

The province of New Brunswick, Canada
"Mental health for all people is a government priority and mental illness is accepted, understood and treated as any other illness rather than the poor second cousin" [4]

In his report to the government of New Brunswick, Judge McKee saw components of an effective system working together seamlessly without regard to service silos; a network of integrated connections where "bridges, not walls"[5] exist; single points of accountability and protected service envelopes; evidence-based services; and supports for all ages and all degrees of severity.

Scotland
The Introduction summarized the essence of the 2009 Scottish policy and action plan:

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[4] The Honourable Judge Michael McKee. Together into the Future: A transformed mental health system for New Brunswick (February 2009) p4
[5] McKee p4

"There is no health without mental health. The Scottish Government is committed to working to improve the mental health of Scotland's people through ensuring that appropriate services are in place, but also by working through social policy and health improvement activity to reduce the burden of mental health problems and mental illness and to promote good mental well-being" [6]

Scotland's plan outlined strategies to support communities in their efforts to help people look after their own mental well-being through a combination of cross-governmental activity; policy and program collaboration in poverty reduction, anti-discrimination projects; equality and equity initiatives; economic regeneration; education and early years development.

Common Vision Elements:
√ Service is recovery-based and person-centred
√ People with lived experience should be involved in system change
√ The prevention of mental illness and promotion of mental well-being are important health, social and economic issues
√ Engaged communities are essential for building mental health and effective mental health service delivery
√ Early identification and early intervention are extremely important in mitigating the effects of mental illness
√ Social determinants are essential to mental health and necessitate the need for a "whole of government" approach beyond the traditional boundaries of mental health service provision
√ Physical health and mental health are of equal importance
√ Service delivery must be best practice and evidence-based

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[6] Scottish Government. Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 – 2011 (April 2009) p5

Governance, Funding and Accountability

While all strategies embraced a "whole of government" approach to achieve population mental health, the manner in which the philosophy is implemented varies. Some strategies called for policy integration; others looked to incentivize action through funding while others recommended structural changes to support mental health reform.

The MHCC advocated that mental health policy must be more broadly integrated into public health and social policy at all levels of government and within all departments, including the activities at the regional level. There must also be a complete blanket of service available to those who suffer from mental health problems, enabled by policies that are complementary and comprehensive. These services and their related policies should include primary care, specialized hospital and community care, as well as housing, employment, education, recreation, and family and community development in order to achieve an effective mental health system.

The government of Australia acknowledged that governance arrangements between all the components of health and social delivery systems must be structured around the needs of the individual, rather than those of the service. To that end, government is not only reviewing policy impacts on mental health within all government portfolios; it is also considering new governance and funding models at the local delivery level. For example, integrated care centres may be established and funded for a holistic service response, as might expanded use of existing community health centres. To accommodate this, regional health authorities will be funded in such a way as to encourage partnering between health and social service providers.

In addition, the government is considering the use of flexible funding models that support service substitution to meet targets in a manner that is best suited to the local environment, the resources of the community and the needs of the individual. These funding models will be developed in conjunction with the national service planning framework that targets the mix and levels of the full range of mental health services.

The Australian Health Ministers' Advisory Council will both lead implementation and measure the success of "The Fourth Plan" by establishing or finalizing cross-sectoral performance indicators and reporting on progress annually. With the collaboration of all Health Ministers as well as those Ministers outside of Health Australia is committed to system change.

The state of Victoria, Australia believes collaborative governance structures and common accountability frameworks are key to the transformation of the mental health system. A Mental Health Reform Council will be created to bring together all sectors responsible for advancing mental health reform in Victoria. The

Council will be composed of government and non-government stakeholders with the mandate of guiding and reporting on the progress of change; it has a term of five years and reports to the Minister for Mental Health.

At a local level, government is working to establish local Mental Health Boards (MHBs) that will operate under existing regional Health Service Boards. The MHBs will be responsible for Community Mental Health Plans that oversee the planning of clinical, psychological and primary health services related to mental health services. As part of the plans, MHBs will also:

- Facilitate the joint management of primary and specialist mental health care services
- Bring Child and Youth, and Adult and Aged specialist mental health under common governance arrangements to facilitate seamless transition in service throughout the life journey
- Negotiate agreements on the operation of mental health coordinated care arrangements
- Oversee initiatives on clinical care governance, workforce development and deployment, discharge planning information systems, client outcome measurements and consumer/carer participation in the overall system

Victoria is committed to defining progress against an established set of indicators, regular monitoring of same and an accountability structure that is responsible for achieving the outcomes. Regular reporting in the form of a scorecard will be used for benchmarking using indicators that measure health, social and community outcomes, the determinants of mental health and performance of the service system. The local MHBs will be accountable for delivering on the scorecard outcomes while the Department of Health Services will oversee progress across the state.

The National Health Service, England established a Mental Health Ministerial Board to oversee high level progress of the "New Horizons" (NH) agenda and a NH Ministerial Advisory Group for Inequalities and Mental Health to advise on implementation and monitor progress of its mental health strategies.

Through a mixture of publications, policy frameworks, impact assessments, public consultation sessions, performance indicators such as Public Service Agreements (PSAs) and Local Area Agreements (LAAs), the national government is encouraging a cross-sectoral approach to mental health.

The national government believes that local governments are the key to developing responsive and "value for money" cross-sectoral services, thus it will introduce a "Payment by Results" funding system by 2011 that will be based on case mix-adjusted activity. Administered by Primary Care Trusts and their Mental Health services trusts, the incentives for sector cooperation and collaboration are financial rather than structural.

The Future Vision Coalition (FVC) of the National Health Services Coalition, England agreed with the strategies laid out in "New Horizons" but also encouraged a more vigorous approach than that laid out by the government. The Coaliton recommended that a Cabinet Minister post be created specifically to champion mental health and well-being, as well as oversee all government activities with a view to determining their impact on mental health. The FVS also recommended that an Interdepartmental Coordinating Committee be established to support linked policies and integrated services across government. This is based upon the recognition that a pre-requisite for system transformation is the elimination of ministerial and departmental silos.

In addition, the FVS advocated for a new Public Service Agreement (PSA) for mental health and well-being that would specify expected actions and outcomes at the local level. The new PSA would incentivize the collaborative efforts of local health and social care agencies. As well, the FVC suggested that funding for local health and social services be pooled to permit flexible determinations of resources across a range of services. Similar in concept to the Australian proposal, the FVS saw local decision-making and flexible resource allocations as important in the delivery of holistic, effective mental health services.

The report from the Honourable Judge McKee in the province of New Brunswick, Canada also took a "whole of government" approach on mental health strategy by recommending an Interdepartmental Committee of Ministries as the point of accountability for the province's mental health strategy. Chaired by the Minister of Health with membership from Ministers of other key departments, this committee would lend structure and increase cooperation in cross-governmental action. In addition, Judge McKee also recommended that an Interdepartmental Coordinating Committee be established to support linked policy development and ensure that ministries are not inadvertently creating polices and strategies that operate at cross-purposes.

Accountability for ensuring interdepartmental collaboration would be built into Ministry staff performance appraisals that place an emphasis on partnerships and client outcomes that reflect joint efforts.

The government of Scotland set the direction, policy and outcomes for mental health and left the specifics to regional NHS Health Boards in cooperation with established local Community Planning Partnerships (CPP) and Community Health Partnerships (CHP). CPPs were established by law to manage community planning processes and bring together public, private and third sector organizations; CHPs are subdivisions of Health Boards and oversee local physical health, mental health and social services. Government does intend to support overall mental health strategy by creating a National Mental Health Improvement Planning and Delivery Coordination Group.

In recent years the government has been moving towards a more outcomes based approach to public sector accountability. The Scottish Public Health Observatory will report annually on national mental health well-being outcomes using indicators to track progress and measure achievements. The indicators have been developed within the context of the National Performance Framework.

Achieving a "Whole of Government" Approach

	Australia	Victoria	Mental Health Comm. Canada*	England	Future Vision Coalition	New Brunswick	Scotland
Policy integration throughout gov't	√	√	√	√	√	√	√
Incentivizing cross sectoral collaboration through funding or performance targets	√	√		√	√	√	√
Interministerial Council (High Level)	√	√		√	√	√	
Cross Sectoral Implementation and Monitoring Cttee	√	√		√	√	√	√
Local Mental Health Boards	√	√					
Flexible funding models for health and social services locally	√	√			√		

*As noted previously, the Mental Health Commission of Canada (MHCC) strongly supported a "whole of government" approach for mental well-being for the population. The MHCC report focused primarily on the goals needed in mental health system reform rather than actual tools for governance and government infrastructure.

Goal #1
People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being

All strategies are moving towards a philosophy of recovery or person-centred care in their support of people with mental health problems and their families/carers. Some reports took a stronger position on the recovery principle, while others advocated person-centred care which incorporated the recovery principle.

Recovery and Well-Being
As the Mental Health Commission of Canada (MHCC) pointed out, "There is no single, comprehensive definition of recovery and well-being that is shared by everyone"[7].

There were however, a number of shared beliefs that appeared across the reviewed strategies as follows:
- Positive outcomes (clinically and financially) are linked to services where people with lived experience are supported in managing their own journey
- A new service paradigm is required which is based on consumer empowerment, self-determination and partnership with service providers
- Everyone's journey is unique, therefore services must be personalized to meet the needs of each individual and must include the broader social determinants of health
- There may be occasions where advance directives must be incorporated but substitute decision-makers are determined by the individual affected when competency is not a concern

Consumer and Carer Involvement: Self-Determination
The recovery principle applies to all levels of the mental health system, from service delivery to system planning, implementation, evaluation and governance. As a result, the trend to include consumers and carers in every aspect of change was evident in all reports. Equality of voice and partnership in decision-making were important themes, reflected in recommendations for personalized care plans; involvement by consumers on local Mental Health Boards; development of measurements to monitor adherence to recovery approaches by people with lived experience; seats on system planning committees and government oversight committees; and workforce recruitment and training.

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[7] MHCC pg 27

Examples of specific actions:

In **Australia**, the Recovery focus has been championed by non-government and community groups for some time, however "The Fourth Plan" announced government's intention to extend this approach to clinical staff in the private and public sectors, both for bed-based and community-based environments.

The **state of Victoria, Australia** is considering creating "consumer and carer peer worker roles" to assist others in navigating the complexities of the mental health system. Employing people with lived experience, the peer worker or navigator roles would provide assistance in both primary and specialist care settings.

The Office for Disability Issues in **England** has developed a new legal right, "The Right to Control." This right confers disabled people (of which those with mental health problems are included) greater choice and control over the support and services they receive. This right, coupled with England's "Independent Living Strategy" will provide both a legal basis and financial support to user determination of services.

The **Future Vision Coalition (FVC) of the National Health Service, England** recommended that "Quality of Life" packages be offered to people with ongoing and severe mental health problems. Based upon personal health budgets, these packages would give people the flexibility to choose from a range of services that allows them to achieve recovery on their own terms,

In **New Brunswick,** Judge McKee urged government to establish formal structures such as Community Advisory Groups to participate in all levels of system planning. These committees would include people with lived experience. Judge McKee also recommended that people with mental illness be included in the provision of workforce training, hiring and evaluation.

Scotland has been a leader in the recovery approach. Government funds the Scottish Recovery Network (SRN), an organization established to promote recovery-based service delivery. The SRN provides training, learning materials for the workforce as well as for people with mental illness, and supports the development of peer and employee support networks. Government also supports Voices of Experience (VOX), a user-led, volunteer organization that is dedicated to ensuring user involvement in service development and actions to create positive environments for those with mental illness.

Goal #2
Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.

There is increasing evidence that shows the prevention of mental illness and the effects of early intervention are clinically significant, cost effective and socially beneficial. As such, there was a high degree of consensus on the benefits of preventative measures through mental health promotion, early identification and early intervention.

Social Determinants of Mental Well-Being

All of the strategies reviewed agreed that social determinants play a significant role in mental well-being or the development of mental illness. These include employment, adequate income, appropriate and affordable housing, education and other aspects of social inclusion. As a result, all reports addressed social factors that enhanced population health and community mental well-being.

By including social determinants in their approach to mental health, all governments were also obliged to take a "whole of government" approach to effectively encompass portfolios outside the traditional jurisdiction of health. It was recognized that cross-sectoral collaboration is a necessity to decrease the risk factors of mental illness (eg. family violence, sexual abuse, poverty and homelessness) and increase protective factors that enhance mental well-being (eg. employment initiatives, adequate housing, "vibrant communities" including the arts and socio-recreational facilities).

Mental Health Promotion and Prevention Activities

The reviewed strategies all agreed that biological, economic, social, situational and psychological factors combust to produce mental well-being or mental health problems. Typically no one factor is the sole contributor to the onset or severity of an illness. As a result, governments are focusing more attention on the benefits, both morally and financially, of improving "upstream" social and environmental factors that promote mental health and prevent illness.

Workplaces can either be places that promote mental health or be the cause of significant mental and emotional distress. Jurisdictions have equated the financial impact of workplace absence due to mental health problems in the millions of dollars annually. Recognizing the important economic benefits to society and companies, many governments have embarked on initiatives that encourage public and private enterprise to become good "quality of life" employers.

Examples of Types of Mental Health Promotion Activities:
√ Broad, generalized public campaigns to increase mental health literacy and acceptance of people with mental illness
√ Social marketing campaigns to promote healthy pregnancies, good parenting and positive family relationships
√ Public Health initiatives, pre and post-natal, to support new parents
√ Targeted campaigns using peer-run programs aimed at groups that are high-risk for mental illness and substance abuse
√ Development of social policies that reduce risk factors (such as family violence, poverty and unemployment
√ Legislation that imposes a legal duty of care on employers to ensure that employees' mental health in taken into account in the workplace

Early Identification and Early Intervention Throughout Life

Australia defined early intervention initiatives in three ways: "early in life, early in illness and early in episode."[8] It recognized that childhood identification of mental disorders, relapse prevention and rapid action at the onset of recurring illness are very effective in reducing distress for the individual as well as their family/carers. All jurisdictions recognized that early intervention initiatives can have downstream cost-savings by reducing the social and economic impacts of mental illness.

Even though the statistics varied to some degree, research in Canada, Australia and Scotland illustrated that one of the greatest opportunities to mitigate the effects of mental illness are in children and youth. Early identification of emerging mental illness and intervention in these years reduces long-term problems both in severity, recidivism and cost. Thus training activities for staff in day care, the school system, Maternal Child services and Child Youth services are becoming increasingly prevalent in an effort to identify early signs of mental disorder and secure treatment for these children.

Youth interventions were also seen as critical in minimizing and even preventing the development of mental illness. All strategies addressed the need for targeted youth services to address early psychosis and the potential for addictions, suicide and self-harm and homelessness.

That is not to say that advantages to early intervention exist only in the young; there are opportunities in other age groups as well. This is particularly true for older people, where the effects of isolation, loneliness and poor housing can lead to undetected depression and suicide. Training that enables staff and volunteers who are involved in service to older people, to identify the early signs of depression, dementia, anxiety or other mental disorders will provide early warning and treatment opportunities.

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[8] Australia p 33

Intervention early in the episode of illness was also seen as important. The role of family and other carers was recognized as they can be bellwethers for recurring chronic illness. Training and support for these individuals was seen as important both from the perspective as caregivers and as people who need support as well.

The co-occurrence of substance abuse and mental health problems are well-known. Both as a precursor or a consequence, those suffering from mental illness often suffer from addiction to alcohol and/or drugs and those who have an addiction may also develop mental illness. Many of the strategies are acting on this knowledge by recommending that mental health staff be trained to be aware of the potential for substance abuse and early detection. Likewise, addictions staff are being trained to detect early signs of mental illness and provide treatment opportunities.

Early Intervention in the Justice System
The approach to mental well-being and early intervention goes beyond considerations of age; it also includes efforts that reach into the justice system and the workplace.

All jurisdictions were considering, or have implemented, diversion strategies within the justice system to identify individuals who are suffering from mental health problems. As Judge McKee stated in his report to the provincial government of New Brunswick, "We need a justice system where being sick is not a crime."[9]

Ministries and departments responsible for health and justice are cooperating and developing training programmes for the workforce that permit identification of those needing treatment and diverting them to programs suited to their needs. They are also investigating opportunities to provide faster access to treatment for mental illness and addictions for those already in prison, as well as pre and post discharge adjustment programs to assist people in adapting to life outside of prison.

Early Intervention in Suicide and Self-Harm
Suicide prevention initiatives are the last leg of early intervention in the sense that the desperation leading to suicide can be mitigated by staff who are able to identify early warning signs and undertake strategies to prevent the ultimate act. Thus, many governments included in this review are reviewing or undertaking projects that train a broad spectrum of public service staff (such as police, emergency measures, schools, social work, housing, welfare, primary health

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[9] The Honourable Judge Michael McKee. Together into the Future: A transformed mental health system for New Brunswick (February 2009) p14

care professionals, hospital emergency room staff) in the early warning signs of suicide. Targeted action by government to improve media handling of suicide has also been useful in modifying social perceptions and reducing the stigma associated with seeking help.

Examples of Early Identification and Early Intervention projects:
Australia:
√   Implemented a national model for early intervention for youth psychosis
√   Provided funding for tailored mental health response for children who have been exposed to physical, sexual or emotional abuse
√   Developing a national suicide prevention framework to coordinate activities across the country and improve identification and support of at-risk individuals

State of Victoria, Australia:
√   Established "youth service hubs" that co-locate specialist mental health support, addictions services and other youth support and general health services in the community
√   Implemented tailored interventions for abused children and included children who are involved in the Youth Justice system, Children's Court, Child Protection Agencies and Youth Homelessness services.

England:
√   Developed the "Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society (2008)" that addresses older persons' housing, income and social needs to enable them to live independently yet safely in their own homes
√   Implemented the "Targeted Mental Health in Schools" program which helps clusters of schools utilize best-practice early intervention work for at-risk children5 – 13 years of age
√   Established "Sure Start" children's centres in every community to deliver early education, childcare and family support to families with children under 5 years
√   Approved funding for the IAPT (Improving Access to Psychological Therapy) program to increase access to low and high intensity therapy teams for people with mild to moderate mental health problems.

Future Vision Coalition of the National Health Services Coalition, England:
√   Recommended that early identification training be provided for teachers as well as police, emergency service workers and social care staff

New Brunswick, Canada:
√   Judge McKee recommended that government establish school-based mental health teams as well as Youth Concurrent Disorders teams

Scotland:
√   Developing a public awareness campaign targeted at older people who will be encouraged to recognize signs of early dementia and seek help

Goal #3
The mental health system responds to the diverse needs of all people in Canada

The ever-increasing diversity of national populations requires an equally diverse approach to mental health promotion and the prevention of mental illness if they are to be effective. In keeping with a recovery-based and person-directed approach, reviewed strategies agreed that the needs of diverse communities must be considered when transforming their mental health systems.

The MHCC stated that "there is good evidence to affirm that ignoring the diversity of needs and experience can hinder access to valuable services and contribute to disparities in health outcomes."[10] This is equally true for mental health as well as services related to social determinants such as housing, education and employment.

If good mental health outcomes are to be achieved, jurisdictions agreed that services must be culturally safe and culturally competent. Practices must respect the traditions, outlooks, experiences, language and religion of the people being served if they are to be relevant.

Government policy is a major lever in assuring that the needs of diverse communities are met. For example, Scotland now requires an "Equality Impact Assessment" on all policies, initiatives and implementations funded under their mental health strategy.

Aboriginal Peoples
Aboriginal mental health issues are often linked to grief, loss and trauma and frequently include substance abuse problems.[11] This can result in high rates of unemployment, poverty, lower levels of education and shortened life expectancy compared to non-aboriginals. The reviewed strategies are committed to providing more culturally competent services to indigenous peoples and in many cases have recommended that aboriginal peoples be trained to deliver mental health services to their own community.

Linguistic and Cultural Diversity
For those whose first language is not English, the obstacles in asking for help and receiving it are doubly challenging. As a result, many French-speaking Canadians are disadvantaged in receiving the mental health services that are more readily accessed by those who speak English. In spite of the fact that English and French are both official languages of Canada, French mental health services and materials are not as available as those in English.

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[10] MHCC p49
[11] Victoria p49

Beyond the concerns over French services the MHCC also pointed out that "...12% of people living in Canada most often speak a language other than English or French at home."[12] This is true not just in Canada, but in the other reviewed jurisdictions as well.

Refugees and immigrants have been arriving in increasing numbers in many jurisdictions, many with no language skills in English. This creates barriers for them in almost every area that would facilitate their integration into the social fabric of their new communities. The support and sense of connectedness to others is cut off and isolation can set in.

Australia has observed that the experience of trauma in their home of origin, dislocation, discrimination and isolation due to language and cultural barriers are creating higher levels of psychotic disorders and involuntary admission in their refugee communities[13]. To address this, Victoria will implement mental health reforms that require professional interpreter services; increased workforce sensitivity to religion, culture and gender; and support networks for multi-cultural community groups. England has committed to a national action plan "Delivering Racial Equality" to tackle the issues of earlier intervention and improved access for people from black and ethnic minority groups.

Rural and Remote Communities
In rural and remote communities, there exists a higher risk of mental health problems and substance abuse issues due to limited specialist care access; inadequate, affordable housing; lack of public transportation and fuel poverty. Primary care may be the only service available and practitioners have little or no access to specialists for advice on assessment and treatment. In Australia**,** government has recognized these needs and is working on solutions such as ehealth, enhancing the mental health skills of the primary care team, increasing the use of nurse practitioners and mental health nurses and training aboriginal peoples to become mental health workers.

Gender Differences
Victoria, Australia is doing some interesting work on gender differences in mental health problems and the impact of aging on these differences. Where previously there was an assumption that results of studies done on white, middle-aged males could be extrapolated to all male age categories and to all women, recent evidence has shown that this is not the case. The diversity of gender and age make a tremendous difference on mental health treatment and support.

Acquired Brain Injury, Autism and the Developmentally Delayed
For those who have ABI, autism or are developmentally delayed, the risk of developing mental health problems can be three to five times more common than

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[12] MHCC p53
[13] Victoria p50

in the general population.[14] The action plan for Victoria, Australia has therefore included strategies that will bolster the capabilities across government portfolios to enhance awareness of this potential at both primary health and disability service levels. Government will also create co-existing portfolio roles within adult mental health services so that specialist assessment, treatment and care are available to those suffering from a severe mental illness and another disability such as ABI.

Responding to Diversity:
√ **Government Policy:**
  o Apply an equality impact lens to all mental health policy
√ **Aboriginal Peoples:**
  o Recognize the history of grief and loss related to the people
  o Train the workforce to provide culturally safe and competent services
  o Train aboriginal peoples to provide mental health services
√ **Linguistic and Cultural Diversity:**
  o Provide services and materials in French as well as English, as well as other languages
  o Provide interpreters
  o Train workforce to enhance sensitivity to different cultures and language
  o Support multi-cultural community networks
√ **Rural and Remote Communities:**
  o Strengthen primary care capacity
  o Expand use of nurse practitioners
  o Utilize technology such as ehealth, teleconferencing
√ **Gender Differences:**
  o Support research into gender differences in mental illness and treatment
√ **Acquired Brain Injury, Autism and Developmentally Delayed**
  o Recognize the prevalence of mental illness in these groups
  o Build skills in primary care and disability services to identify mental illness and provide treatment in conjunction with specialist care

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[14] Victoria p51

Goal #4
The role of families in promoting well-being and providing care is recognized and their needs are supported.

There is an increasing amount of recognition and attention being directed towards the informal support network of family and other "carers" of people with mental health problems. In fact, many of the strategies made family and carers a focus in their mental health action plans because of the key role they play and their potential contribution for system transformation. The following mental health strategies are being considered and/or implemented around those roles.

As Crucibles for the development of young children
Families are critical to the development of a child's mental well-being and future resilience in life. Recognizing that, many strategies focused on public health programmes that encourage healthy pregnancies, pre and post-natal support programmes, education on parenting skills and visiting nurses for first-time families.

Programs are also being implemented to support the children of families where one parent suffers from mental illness. For example in England, the National Health Service has been funding the "Think Family" program since April 2009. "Think Family" is a cross-departmental program involving the Departments of Children, Schools and Families; Justice; Health; Communities and Local Government. The objective of the program is to provide early identification and coordinated service responses to children who are at risk before problems fulminate into mental illness.

As Decision-makers for children
When children are young, parents must make decisions on their behalf. All strategies agreed that parents must be regarded as equal partners in the decisions around their child and as such, must be provided with all available information and support that will support that role.

Canada, Australia, England and Scotland have observed that family members occasionally experience discrimination from members of the public services, including mental health workers. In these cases they are regarded as the cause of their child' mental illness and are blamed for the family's troubles. This acts as a deterrent to families seeking help as well as being engaged in the care plan. Workforce training and overall social marketing campaigns have been implemented to relieve the stigma associated with having a child with mental health problems and eliminate these negative behaviours.

As Partners in decision-making for treatment for youth and adults
Family and other carers can play a valuable role in early detection, intervention and follow-up for their loved one. While balancing confidentiality and privacy, all jurisdictions are taking measures to include carers as partners in decision-

making for treatment plans when desired by the person with mental illness. If agreed, carers must have access to information, education and guidance so that they are supported in their efforts to help.

To that end, the MHCC urged the creation of "Family Navigators" to assist families in their role as mental health partners. These "Navigators", along with other providers, would help families through the maze of services and decisions that present themselves when confronted with the problems posed by mental illness. The state of Victoria, Australia is considering the implementation of Care Coordinators to assist consumers and their carers in performing this exact function, crossing all portfolios (eg. housing, employment, education, mental health, social work) necessary for recovery.

As Caregivers who also need care
The task of caring for a loved one with mental illness can be demanding and without respite. As a result, research shows that the rates of mental health problems are higher in family members caring for someone with mental illness.[15] For that reason, all strategies recognized that the physical and mental health of the carers must be a priority.

The MHCC recommended that family needs should be met by providing.[16]
• Respite services
• Assistance with day-to-day caregiving responsibilities
• Support for the family members (including emotional support)
• Income support when family members cannot work due to caregiver responsibilities

England is already taking measures through their "Carers at the heart of 21st century families and communities" strategy released in June 2008. This is a 10-year, cross-government strategy that commits funding to respite for carers, support for employment (initial or re-entering), improved support for young carers, annual health checks and training for General Practitioner's to recognize and support carers.

In his report to the province of New Brunswick, Judge McKee recommended that support networks such as "First Episode Families" be recognized and assisted in their efforts to build support networks for people caring for those with mental ill health. He also urged government to work with the MHCCto design and pilot a "Mental Health Family Link" project. This peer support network and the knowledge gained from it will become part of the "Knowledge Exchange Centre" project.

As Governors, System Planners and Evaluators

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[15] England p59
[16] MHCC p 62

There is widespread agreement that consumers and carers must be a part of the governance, planning, implementation and evaluation of mental health services at all levels of the system.

This included representation at government committees for planning and oversight (eg. England: NH Ministerial Advisory Group for Inequalities and Mental Health), seats on governing bodies that oversee mental health services (eg. Victoria: Mental Health Boards), service planning and implementation at the local level (New Brunswick: McKee Report) and as participants in the development of performance indicators that reflect the quality of services (eg. England: National Service Framework)

As Researchers
Some jurisdictions, such as the state of Victoria, also saw a role for carers as researchers. In keeping with that, the state is considering the creation of a "Centre of Excellence for Consumers and Carers" that will support and develop the skills of carers to conduct research into mental health.

As Members of the mental health system workforce
All strategies believe that people with lived experience, such as family members and carers, should become part of the mental health system workforce. Thus governments are undertaking reviews to determine how carers and consumers can be incorporated into the workforce as trainers, participants on recruitment panels, and peer support workers. Australia is also establishing standards to guide the minimum amount of hours that should be provided by consumer and carer staff in both the community and bed-based environments.

Supporting Families and Carers:
√   Public health programs to ensure "good starts" in life
√   Identify "at-risk" children in families with a parent with mental illness and provide early multi-service response for emerging disorders
√   Regard parents of young children as decision-makers and partners in service provision and end discrimination against these parents
        o   Train workforce in anti-discrimination and to engage parents as service partners
√   Consider the use of cross-sectoral Family Navigators and Care Coordinators
√   Utilize strategies to support families and other carers in their needs for respite, employment, mental and physical health and emotional support
√   Include families and carers at all levels of system change and service delivery for governance, implementation, development of performance measures and evaluation as well as research
√   Employ family and carers of those with lived experience in the mental health workforce

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Goal #5
People have equitable and timely access to appropriate and effective programs, treatments and services and supports that are seamlessly integrated around their needs.

Providing user-defined services
Positive clinical and fiscal benefits have been found to be related to providing care that is geared towards user-identified needs and supports rather than the service needs of the providers.[17] In fact, a study conducted in Australia revealed that **"**clinical outcomes have been shown to improve engagement and outcome when those with lived experience are involved in the recovery process.**[18]"**

Because the goals of a transformed mental health system are tightly interlinked, other sections have already addressed the need for a recovery-based, person-centred approach to treatment and support (Goal #1).

There is some variation in the degree to which all strategies embraced the concept of recovery, partly due to a lack of congruity over the definition and because of its limitations when addressing the needs of children[19]. However, there is good support for many of the principles behind the approach, as noted in the section on Goal #1.

Seamless integration of Services across Government
To achieve seamless integration of services, strategies agreed that a "whole of government" approach is needed to influence and coordinate the social determinants impacting mental well-being and mental health problems (Goal #2). The confluences of family relationships, poverty, housing, addictions, joblessness, income and education have long been recognized for their effect on physical health. Now governments are recognizing and acting on these "upstream" factors because of their effects on mental health and the subsequent moral, societal, clinical and economic consequences.

A cross-sectoral approach is a complex task at all levels of planning and delivery. Our section on "Governance" illustrated varying strategies for achieving a "whole of government" approach. Some jurisdictions are establishing infrastructure enablers such as inter-ministerial committees for high level system change, reform councils with staff and stakeholder membership for monitoring and implementation.

When employed these committees and councils are responsible for activities such as:

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[17] Judge McKee, p19
[18] Australia p51
[19] MHCC p27

- Monitoring progress in mental health reform as outlined in policy and action plans across all portfolios
- Mental health policy development
- Mental health impact assessments of all government policy
- Legislation to support and enable the rights of those with mental health problems
- Development of planning, implementation and funding priorities that will achieve the objectives of good mental health for the population
- Ensuring that policy development in one ministry or departmental portfolio is not counter-productive to mental health objectives

Regional and Local Integration

Governments in all reviewed jurisdictions agreed that the success of seamless, cross-sectoral service depends on integration at the regional and local levels. As the MHCC stated, "For too long, these services have been organized to meet the requirements of administrative and funding arrangements, and have contributed to sustaining silos that separated mental health from other health and social services."[20]

To remedy that, reforms in most of the strategies included governance and funding changes that incentivize local combination of traditional physical health, mental health and social services into a more responsive delivery model.

Examples of Local Strategies:
- √ Flexible funding pools that enable service substitution by local authorities for the provision of supports best suited to their communities and the client's needs in any of the bio-psycho-social domains
- √ Individual health budgets that permit the consumer to select services and supports best suited to their needs
- √ Mental health councils/boards with membership composed of mental health and social services stakeholders as well as consumers and carers
- √ Integrated social and mental health service performance indicators and scorecards
- √ Agreements or contracts between government and local authorities that target integrated mental health and social services and incentivize collaborative efforts
- √ Staff performance appraisals that include collaborative service partnerships between mental health and social services as part of the evaluation
- √ The use of Care Coordinators and Family Navigators to assist people with lived experience in accessing needed bio-psycho-social services

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Community is the Cornerstone to Mental Health

All strategies agreed that the community is critical in mental health promotion, mental illness prevention and mental illness treatment. The community is the place where the confluences of biopsychosocial factors interact to create healthy,

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[20] MHCC p74

well-balanced and resilient citizens of good mental health, or individuals who are at high-risk for developing addictions and mental health problems.

Scotland's action plan stated that "the actions of individuals and communities are central to their agenda" [21] for mental well-being in the population. It pointed out that the mental health of individuals and healthy, vibrant communities are reciprocal states. When communities are socially inclusive with good quality physical spaces, adequate and affordable housing, employment and educational opportunities, individuals have less risk of developing mental health problems. Conversely, if community environments impoverish their citizens, placing them at higher risk for the development of mental illness, the communities are at-risk for social dysfunction such as higher rates of crime, homelessness and addictions.

Communities are also the place where people with mental illness seek their treatment and work on their journey of recovery. Thus governments have identified that integrated delivery of community services must be focal points of activity if they are to achieve their aims of system reform. Examples of effective community-based programmes and services in England and the state of Victoria, Australia are provided in the table at the end of this section.

The pivotal role of primary care in mental health promotion and mental illness prevention is also a recurring theme in all reports. This is particularly true as it pertains to early identification of emerging mental illness or addictions, support for carers, the management of chronic physical disease that often leads to anxiety and depression, and the early detection of suicidal proclivity. In rural and remote areas primary care, if available at all, may be the only service available to the community.

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[21] Scotland p7

Examples of Community-Based Care (planned or established):

State of Victoria, Australia:
√ Community Mental Health Services:
- o Expanded availability of community mental health clinics
- o Specialist services in community-based settings, including centralized psychiatric triage and consult
- o 24 x 7 public telephone line for mental health help and service referral

√ Alternatives in to Acute Care:
- o Emergency departments with increased resources for mental health professionals to avoid admission and enable community support
- o Short stay units for those in mental health crisis with rapid, supported discharge to appropriate community services

√ Vibrant Communities
- o Neighbourhood renewal projects

√ Justice System Alternatives
- o Pre and Post-discharge Transition community programmes for prisoners leaving the penal system and re-entering mainstream society
- o Enhanced supervision and assistance to divert those with a mental illness from the penal system to an environment that includes community-based orders

England:
√ Community Mental Health
- o Early intervention for psychosis, at-risk young people and conduct disorders in children in community-based settings
- o Improved access to psychological treatments (IAPT programme)
- o Improved identification and treatment of depression by providing training and support to primary care professionals
- o Alcohol-reduction and other addictions-related programs
- o Support for volunteer and Third Sectors to build their capacity and leverage their contributions to mentally healthy communities

√ Acute Care Alternatives
- o Community-based teams, including crisis intervention and home treatment teams, to avoid hospital admissions
- o Improved hospital discharge processes utilizing community services and supported accommodation rather than extended hospital stays

√ Justice System Alternatives
- o Diversion of clients from the Justice System to community-based mental health service teams

Goal #6
Actions are informed by the best evidence, based on multiple sources of knowledge; outcomes are measured and research is advanced.

While mental health system transformation has been an ongoing process for all concerned, more attention is being placed on research, evidence-based practice and performance indicators for more effective interventions, measurement and evaluation of changes at the service and system levels.

Shaping the research agenda
In the past, mental health research has primarily been focused on pharmaceutical interventions.[22] Most of the reviewed strategies recommended an expansion of research beyond that to include investigations into the biopsychosocial factors of mental health and well-being. This includes genetic and physiological precursors as well as the effects of childhood development, school, co-existing physical problems, employment, addictions and housing. In addition, the expeditious translation of knowledge "from the bench to the bedside" was recognized as a necessity in order to bring the use of effective, evidence-based practice to the field in a more timely fashion.

To accomplish these objectives, more research funding was recommended in all strategies. For example, the MHCC recommended that "the Canadian Institutes of Health Research (CIHR) and other federal, provincial and local research funding agencies …increase the funding that is available for the full range of mental health research.[23]"

Australia is developing a Mental Health Research Strategy to focus and coordinate research across the country as well as increase research activity in the community and non-governmental sectors. The Department of Health in England will also influence the overall direction of researchers by increasing funding to areas identified as gaps in knowledge. Funding for mental health research in general will also be increased both in range and amount to levels that are more reflective of the proportion of national budget spent on mental health.

As another illustration, the state of Victoria is working in collaboration with the national agenda to encourage mental health research in research institutes, research fellowships and jointly funded academic positions. Government will also encourage participation by consumers and carers in the development and process of planned investigations. To support this, Victoria is considering the creation of a "Centre of Excellence for Consumers and Carers" to build the necessary research skills.

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[22] MHCC p81
[23] MHCC p81

Outcome measures and performance indicators

In the recent past, the use of performance indicators in mental health service provision has not been as prevalent as those in other areas of health[24] and participation by consumers and carers was not considered to be informative to the evaluation process. A review of the strategies showed that there has been a trend to change this.

For example, Australia established the "National Mental Health Performance and Benchmarking Framework" in 2006. From this, "Key Performance Indicators" (KPI) were developed for services provided across the age spectrum in the public sector. Future plans intend to extend the KPIs to include the private sector and non-governmental organizations.

In concert with the national project, the state of Victoria has also developed a "Mental Health Outcomes Framework" for use in evaluating health and community outcomes; the determinants of mental health and eventually, service performance at the delivery level. The evaluation of local service will include client outcome measures as they relate to quality of life, perception of the service experience, effectiveness, appropriateness and access.

The National Health Service (NHS) of England has already developed a number of national indicator sets measuring different facets of mental health and well-being in the population as well as service indicators. England has also developed measures to evaluate the extent to which a recovery approach is used by mental health services. These include DREEM (Developing Recovery Enhancing Environments Measures) and the Recovery Star.[25] This country has also developed PROMs (Patient-Reported Outcome Measures) as an analytical tool for incorporating client evaluations in general healthcare as well as mental health.

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[24] MHCC p83
[25] England p79

Scotland has turned its attention increasingly to public sector accountability and "tangible, measurable actions."[26] In keeping with the "National Performance Framework", evaluation tools are being developed that will be "evidence-informed, logical and achievable ….for short, medium and long-term outcomes."[27] Another example is that of the collaboration between the government, NHS Scotland and the Scottish Centre for Healthy Working Lives to develop an outcomes framework for mental well-being in the workplace.

Public accountability will be addressed by releasing the results of the mental health indicators (both for well-being as well as illness) through the annual publication of the Scottish Public Health Observatory (SPHO). Along with other performance indicators on health, the SPHO will provide information to the public as well as stakeholder organizations that will lend public health intelligence to policy development, decision-making and strategic planning processes.

	Examples of Mental Health Performance Indicators
Australia	2006 National Mental Health Performance Indicators: • Key Performance Indicators for mental health services
Victoria	Mental Health Outcomes Framework to measure: • Health and community outcomes • Social determinants of mental health • Local service delivery performance
England	National Health Service Indicator Sets for population mental health and service performance Measuring the shift to Recovery-Based Service Delivery: • DREEM (Developing Recovery Enhancing Environments Measures) • Recovery Star • PROMs (Patient Reported Outcome Measures)
Scotland	National Performance Framework which will include mental health indicators. Also,developing outcomes framework for workplace mental well-being

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[26] Scotland p3
[27] Scotland p10

Goal #7
People living with mental health problems and illnesses are fully included as valued members of society.

Putting a Stop to Stigma and Discrimination
"Stigma and discrimination frequently have as great an effect on people as does their mental health problems or illness itself.[28]"

All action plans are undertaking strategies to end stigma and eliminate discrimination against those with mental illness. Discrimination against people with lived experience, whether it is conscious or unconscious, is present in the public at large, within the mental health workforce itself and other public service and private sectors.

a) Self-Stigma
Stigma emanating from external sources can be devastating, however when it is internalized, the consequences to the individual are even more damaging. Fear of suffering from discrimination obstructs a person's willingness to seek help early on in their illness and generates feelings of shame and hopelessness. This is also true for families and carers, who may hesitate to reach out for themselves or for their loved one because of fears that they have "caused" the problem. Stigma and discrimination must be stopped before a person with mental illness, or their family, suffers the additional burden of self-stigma.

b) The Public
Governments are approaching this work with a variety of tools including broad and targeted social media campaigns, targeted education for school age children and legislation. In addition, specific efforts are being made in the employment and housing sectors to provide new opportunities and support for people who suffer from mental health problems.

For example early in 2010, England will conduct a public attitude survey and based on the results, launch a "Tackling Stigma" campaign in the media. Government will also partner with the "Time to Change" national anti-stigma campaign led by two national mental health advocacy charities, MIND and RETHINK to combat discrimination. The state of Victoria, Australia has introduced education for school-age children on mental health literacy and well-being as well as anti-discrimination. Scotland will include mental illness under the Disability Discrimination Act and will raise levels of awareness of its application as well as remind employers of their obligations to provide equitable job opportunities to those with physical and mental illnesses.

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[28] MHCC p90

c) Service Providers
Those who work within mental health and in other areas of public service can be a source of discrimination. In an interesting twist, the mental health workforce can also be a victim of discrimination.

Sadly, people with mental illness are sometimes regarded as "incurable, incompetent or incapable" by members of the public and private sectors. Service providers with that attitude can become obstacles to recovery and a culture that is person-centred. The inclusion of workforce training aimed at raising awareness and reducing discrimination is an essential element in eliminating behaviours that are counter-productive to good client outcomes. Some jurisdictions are also developing workforce qualifications based on core competencies in addition to education, to ensure new entrants to the workforce have the personal attributes necessary to support a recovery-based philosophy of service. More detail is included in the Workforce section.

The mental health workforce has also been a target of discrimination, being regarded by some as a low growth, low opportunity and low reward job. The shortage of staff in this sector is in part, a reflection of the regard in which it is held. Realizing this, jurisdictions such as the state of Victoria, are increasing opportunities for research, professional development and university training in the mental health field.

Employment and Housing
All jurisdictions recognized the importance of a job, decent income and affordable housing as essential elements in mental health. For persons recovering from an episode of mental illness, their ability to achieve quality of life is also reliant on employment and a place to live, however discrimination often bars them from finding suitable work and decent housing.

a) Employment
For that reason, jurisdictions are developing approaches such as Australia's "National Mental Health and Employment Strategy" and England's "Working Our Way to Better Mental Health Framework" to address barriers to employment faced by people living with any kind of disability, be they mental or physical.

The state of Victoria is taking it a step further by creating "Individual Placement and Support" staff to support their mental health clients in their search for appropriate employment. Staff also work with clients and employers after a job is secured, for as long as required, to help the client adjust to the work environment. The Canadian Mental Health Association (CMHA) of Fredericton, New Brunswick also provides a program that supports employment for people with mental illness.

Scotland's government not only supports the Scottish Mental Health and Employment Network, it is also working with the Scottish Development Centre for Mental Health, trade unions and mental health foundations to explore areas where unions can offer support to those with mental illness in the workplace.

b) Housing
To address the issues around discriminatory practices that exclude those with mental illness from adequate housing, a number of different approaches are being taken.

The state of Victoria is explicitly planning and allocating housing for people with mental illness as part of their state-wide housing plans. Government will also review current public housing allocation policy and improve access to those with mental illness as well as plan for growth in supported accommodation.

England is increasing housing access by building performance indicators in their PSAs, Primary Care Trusts and other funding agreements that will reflect the housing status for people with mental illness. Government is also focusing on the plight of older people by developing a cross-governmental strategy "Lifetime Homes" to assist seniors to continue to live in their homes as they age.

Judge McKee's report to New Brunswick urged government to increase the number of rent supplements as another alternative for people living with mental illness. He also recommended that a range of affordable housing options be developed to help people live independently.

Strategies to End Stigma and Discrimination

Public:
- √ Public attitude surveys to determine levels, causes, targeted action
- √ National anti-stigma campaign using information gathered from survey
- √ Education at school-age levels to introduce mental literacy and anti-stigma concepts
- √ Inclusion of mental illness under legislation aimed at reducing discrimination against those with disabilities, particularly in employment opportunities

Service Providers (see Section on Workforce for more detail):
- √ Workforce training for all public sector staff to reduce their discriminatory behaviour and nurture a culture that is recovery-oriented (see Section on Workforce)
- √ Emphasize core competencies required for service provision that are person-centred
- √ Increased opportunities for professional development and research for workforce

Strategies for Employment and Housing

Employment:
- √ Develop national employment strategies that identify and address obstacles which prevent people with lived experience from finding suitable employment
- √ Establish employment support workers in mental health services to support consumers in finding and maintaining work
- √ Explore opportunities with unions on their role in supporting members with mental illness in the workplace

Housing:
- √ Allocate public housing and supported accommodation spaces specifically for those with mental illness
- √ Increase available supported accommodation
- √ Establish performance indicators that measure housing status for those with mental illness
- √ Develop housing strategies for older people with mental illness to enable them to continue to live in their chosen communities as they age
- √ Consider the use of rent supplements to increase the number of available housing opportunities for those with lived experience

<u>Workforce</u>

The reviewed strategies recognized that workforce challenges must be addressed if transformation of the mental health system is to be achieved. Paternalistic and discriminatory service delivery was a major area of concern as was the exclusion of people with lived experience from most partnership roles from system development to care planning. Many services did not appear to be geared towards cultural or linguistic considerations and the workforce is not sufficiently diverse to adequately reflect the ethnicity of their clients. Finally, the stigma that surrounds work in the mental health field as unrewarding and lacking in both educational and career opportunities was noted, as was the shortage of professional people in the field.

To address some of these challenges, the MHCC urged an expansion of the existing workforce and the introduction of new provider roles to complement and supplement current shortages.

In Australia, government is establishing a National Mental Health Workforce Strategy that will define standardized workforce competencies and roles for use in clinical, community and peer support settings. A shortage of psychiatrists has prompted the government to consider a review of the role of these specialists in private practice and the use of nurse practitioners and mental health nurses in primary care settings. It will also look at the use of technology (such as tele-health and web-based interventions) in remote areas to enhance the availability of specialist services for client consultation as well as staff training.

To monitor the integration of consumer and carer employment in the mental health workforce, Australia is developing specific, reportable participation rates. Government will also incorporate qualitative and quantitative measures of client experience to monitor and encourage development towards a recovery-oriented service culture.

The state of Victoria will pursue recruitment strategies that attract students, re-entry and retired workers, rural students and international mental health workers. Retention strategies by government include the support of post-graduate studies and the active encouragement of joint academic/service appointments. The state government will also explore the creation of an "Institute for Mental Health Workforce Development and Innovation" to support the necessary changes in the workforce as well as establish a "Centre of Excellence for Consumers and Carers" to provide opportunities for research and skills development.

The province of New Brunswick has received a recommendation from Judge McKee to improve the integration of psychiatrists into community health centre team environments to improve access and facilitate a single point of entry for clients. He has also recommended a review of existing policies on the

deployment and future recruitment of psychologists and psychiatrists to maximize available human resources.

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Workforce Strategies:
- √ Encourage a philosophical shift to recovery-based service delivery
- √ Redesign workforce qualifications based on core competencies
- √ Recruit people with lived experience (both consumers and carers) into the mental health workforce and establish expected participatory rates
- √ Training to reduce the stigmatizing attitudes and discriminatory behavior of those working in the field towards consumers and carers
- √ Encourage services that are evidence-based and best-practice
- √ Increase educational opportunities using technology
- √ Increase the availability of university-based research and training opportunities for mental health
- √ Support recruitment and retention strategies to attract new personnel and retain existing workforce
- √ Evaluate the opportunities for increased use of nurse practitioners and psychologists
- √ Create a more diverse workforce that is representative of the populations being served
- √ Extend basic mental health training and assessment to all frontline public services (such as substance abuse workers, police, ambulance, teachers and social service agencies)

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Conclusion

The strategies for mental health and addictions reform varied from jurisdiction to jurisdiction. System adaptation and service delivery took on many different forms which reflected the culture, the evolution of reform, progress to date, national frameworks and preparedness for change. In spite of the variations, there were many core areas of consensus. This review has illustrated the similarities that exist at a high level while illustrating the differences in approach that presented at cascading levels.

There was a consensus around a number of themes. First, all strategies addressed the need to change the fundamental relationship between people with lived experience and the mental health system. In future, consumers will be partners with those who drive the system as well as those who provide the service. A recovery-based or person-centred orientation is becoming the focal point for mental health reform.

In addition, the importance of mental health promotion and the prevention of mental illness are gaining momentum. All strategies recognized the social, economic and moral consequences of mental illness and are preparing to allocate funding that will reduce risk factors and promote population mental health. Early identification of problems and early intervention have been seen as clinically effective and cost-beneficial in mitigating the effects of mental illness.

Increasingly diverse communities in all the jurisdictions have precipitated the need to become more responsive to the needs of aboriginal peoples, immigrants and refugees. There was wide-spread agreement that mental health reforms must be culturally safe and culturally competent. Diversity comes in many different forms and strategies also addressed the issues that arise when considering rural communities, gender differences, and people with co-occurring disabilities such as ABI, autism and developmental delay.

Families and other carers of those with mental illness have become a focal point in many strategies. While previously the formal structures supporting a person with mental illness were the main concern, there was growing recognition that the informal network of friends and family are critical to recovery and ongoing well-being. In conjunction with that was the realization that support and respite are required for carers to enable them to sustain their supportive roles and their own mental health.

The provision of effective, seamless and user-determined services – where every door is the right door – is reliant on a definition of service provision that is broader than the traditional boundaries of mental health. All strategies agreed that the social determinants of health apply to mental health as well, and as such necessitate a "whole of government" approach to system and service change. As a result, there must be collaboration between portfolios such as Child and Family

Services, Education, Housing and Employment; they must be integrated into mental health system reform and coordinated at local service delivery levels.

The vital role of community was emphasized in all strategies. As part of the movement towards mental health promotion and the prevention of mental illness, vibrant communities were recognized as essential to the well-being and resilience of the population. Community services were also seen to be an essential part of early identification, intervention and treatment and as such, received increased attention and support to enable greater roles in the delivery of mental health and addiction services.

Increased funding for research is being considered in all strategies to facilitate the provision of evidence-based practice. As with promotion and prevention, the up-front costs related to research were ultimately seen as cost-savings when compared to the consequences of less effective interventions and prolonged mental illness. Performance indicators were also an increasing area of focus as jurisdictions sought ways to measure outcomes and provide greater public accountability.

The disabling effects of stigma were points of concern in all strategies. Jurisdictions may have been separated by many miles geographically, but philosophically they were in close proximity on the need to eliminate discrimination against those with mental illness. It was noted that discrimination was also leveled against the family and other carers of those who are ill, as well as the mental health workforce itself. A great deal of anti-discrimination activity is occurring broadly at the public level in addition to targeted initiatives that are geared towards specific sectors to nurture environments that are socially inclusive.

Finally, reformation of the mental health system was often quoted as contingent upon reformation of the workforce. Challenges such as a shortage of professionals, low morale, insufficient opportunities for professional development and career advancement, and a service philosophy that is control-based rather than recovery-oriented are cited throughout the strategies. Concerted efforts are being applied in all jurisdictions to revive the workforce and channel personnel into competencies and opportunities that will more closely align with the directions off mental health reform.

In closing, a review of mental health reform in seven different jurisdictions showed that there were many common elements in their strategies. On the other hand, actual implementation of these strategies was as varied as the prevailing culture, current state of reform and readiness for change. Local context set the background for local solutions.

As the Ontario Ministry of Health and Long-Term Care (MOHLTC) deliberates on its final strategy to ensure that "*Every Door is the Right Door*", CMHA, Ontario is

pleased to provide this review as another input to the process. It is hoped that this scan will serve to inform the discussion and contribute to the insights that may ultimately open the windows of opportunity for mental health reform in Ontario.

Appendix A

Glossary of terms [i]

Acquired Brain Injury (ABI)
A permanent brain injury that results in impairment to an individual's physical, cognitive, behavioural and/or emotional functioning. The injury may be caused by accident, assault, infection, disease, overuse of alcohol, stroke, brain tumour or other medical illnesses. Acquired Brain Injury is not in itself a mental illness, however, people with Acquired Brain Injury can also suffer from a mental illness.

Autism Spectrum Disorders
Autism Spectrum Disorders are a range of neurological disorders that most markedly involve some degree of difficulty with communication and interpersonal relationships, as well as obsessions and repetitive behaviours. Those at the lower-functioning end of the spectrum may be profoundly unable to break out of their own world. Those at the higher-functioning end, sometimes diagnosed as Asperger Syndrome, may be able to lead independent lives but still be awkward in their social interactions.

Carer
The term carer is used to describe someone who is actively caring for a person with a mental illness with whom they have an ongoing relationship. The carer need not necessarily live with the person with a mental illness. A carer may be a family member, friend or other person who has a significant role in the life of the person with a mental illness. Carers are at higher risk of developing physical and mental health problems themselves as a result of their caring role.

Co-existing disability
The co-existence in an individual of a mental health problem and a mental impairment resulting from intellectual disability, Acquired Brain Injury or Autism Spectrum Disorder.

Community Treatment Order (CTO)
Community Treatment Orders can be issued under the *Mental Health Act 1986*. They enable involuntary patients to receive treatment for their mental illness in the community. CTOs are made by an authorized psychiatrist and offer a less restrictive treatment option than involuntary admission to a psychiatric inpatient service.

Consumer
A term chiefly used to describe a person who is a client of specialist mental health services. However, the designation 'consumer' has been adopted by some people with a mental health problem whether or not they are current clients of the

mental health system, and is used in the context of a 'consumer movement' and 'consumer advocacy'.

Dementia

A group of brain disorders that most commonly occur in old age, although sometimes develop earlier. They are the result of brain tissue deterioration. Common features include decline in the ability to recall recent and past events, decline in mental functioning (for example, the ability to make simple calculations or organize a routine task) and the person behaving in ways considered out of character.

Depression

A lowering of mood which includes feelings of sadness, despair and discouragement, which range from mild to severe and is sustained over a period of time. Mild depression is an emotional state that many people experience during their life. Severe depression is a severe mental illness producing symptoms such as slowness of movement, loss of interest or pleasure in most activities, sleep and appetite changes, and agitation. People experiencing severe depression will have intense feelings of worthlessness and may experience delusions; for example, a person may believe they are the cause of the world's problems. Severe depression can lead to suicidal ideas and actual suicidal actions.

Dual diagnosis

The co-occurrence of mental health problems and drug and alcohol misuse problems.

Inpatient services

Bed-based publicly funded hospital psychiatric services that require either a voluntary or involuntary hospital admission for the treatment and management of a person who has a severe mental illness.

Intellectual disability

People with intellectual disabilities have learning difficulties and develop at a slower rate than normal. The condition is usually identified at birth or in early childhood. Intellectual disability is not a mental illness and requires very different specialist skills from those offered by mental health services. However, people with intellectual disabilities can also suffer from mental illness. Mental illness can be more difficult to identify in people with intellectual disability.

Mental health promotion

Any action taken to maximize mental health and wellbeing among populations and individuals by addressing potentially modifiable determinants of mental health. This encompasses actions that strengthen the understanding and the skills of individuals in ways that support their efforts to achieve and maintain mental health; and influencing the social and economic factors that determine

mental health, such as income, social status, education, employment, working conditions, access to appropriate health services and the physical environment.

Outreach services
Refers to the delivery of support to individual clients outside of formal service settings, for example in people's homes, or to homeless people on the streets or in transitional accommodation.

Personality disorder
A group of disorders characterized by patterns of disruptive and dysfunctional behaviour, well established by early adulthood and continuing through out a person's life. The person with a personality disorder typically has marked problems and frequent crises in personal and social relationships including threatened or actual self injury.

Primary health services
A term used to describe services that are usually the first point or level of contact with the health system for individuals, the family and community. Primary health services bring health care as close as possible to where people live and work, and constitute the first element of a continuing health care process. In the context of this review 'primary health services' refers mainly to general practice and community health services.

Problematic substance use
Problematic substance use may be used to refer to any pattern or type of drug use (including alcohol, legal and illegal drugs) that impacts negatively on an individual, their family or the community more generally. Problems experienced may be social, financial, psychological, physical and/or legal.

Protective factors vs. Risk factors
Protective factors reduce the likelihood that a particular individual or identifiable group of people will develop an illness or problem. These differ from **Risk factors** which increase the likelihood that a particular individual or identifiable group of people will develop an illness or problem

Psychiatric crisis
Psychiatric crisis describes the situation where a person with a mental illness or severe mental disorder experiences thoughts, feelings or behaviours which cause severe distress to themselves or those around them, requiring immediate psychiatric treatment to assess and manage risk and alleviate distress. This may be the person's first experience of mental illness, a repeat episode or the worsening of symptoms of an often continuing mental illness.

Psychosocial support
Support provided to people with mental illness and psychiatric disability. Such services could include housing support, day programs, prevocational training,

residential services and respite care, aimed at improving a person's abilities to live independently, their domestic and social functioning, and that assists in improving a client's personal, domestic and social functioning, so that they can live independently in the community.

Recovery
Recovery "is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness."[ii]

Screening
Screening is a strategy used in a population to detect an illness or condition in individuals without signs or symptoms of that disease.

Secondary consultation
The provision by specialists of advice and support to professionals in a more generic

Severe mental illness
A mental illness in which a person's ability to think, communicate and behave appropriately is so impaired that it interferes with the person's ability to deal with ordinary demands of life. Without effective treatment and support, the outcome for the person may be significant impairment, disability and/or disadvantage.

Social Housing
Social housing means housing which is owned or regulated by the government to assist people on low incomes.

Social support services
This term is used broadly to encompass those services, such as housing, homelessness, employment, that, while not directly providing care, can significantly contribute to reinforcing the protective factors and reducing the risk factors for mental health.

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[i] Glossary of terms, edited, Victoria pp 157-163
[ii] MHCC p27