SYSTEMS FOR THE CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS IN DEVELOPED COUNTRIES

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"We're all tackling the same problems of economic and social change... of family disintegration, of community breakdown and of social exclusion... and many of the solutions that will be adopted will be similar.... What I think is sensible is to throw it open to ideas and say let's talk about it and learn from one another." **(Rt. Hon. Tony Blair MP, *The Guardian* interview, 15 May 1998).**

1. EXECUTIVE SUMMARY

What is the report about?

This **report looks at how other countries provide care for people with mental health problems.** The report is concerned with the boundary problems that arise in providing care across various agencies. **It examines how the UK can learn from models of excellence in other countries.**

Why was the report commissioned?

Three main reasons. First, **services for people with mental health problems are not working as well as they should.** Second, the numbers of people with mental health problems in the UK are increasing. Third, **the cost of chronic care is likely to increase in real terms,** fuelled by increasing labour costs, more expensive medicines/technology and rising health expectations.

Despite a high, and rising, level of spending on mental health, there is a feeling that significant structural problems remain. **Much more needs to be done to provide seamless care and to devise financing systems that encourage and reward innovation and good care practices.**

What are the main findings?

The report describes the findings of a **nine-month Study Fellowship** examining mental health care in the United States of America, New Zealand, Australia and Singapore.

The **key issues covered** include:

the trend towards **the provision of 'person-centred' care;**

resolving **the challenges around funding,** means-testing and inheritance;

how to improve quality in the health service, social care and housing.

The **main political and policy dangers** in this area lie in:

the *potentially high public expenditure costs* from improving access to care as people substitute formal for informal care;

targeting issues - ie the need to balance greater expenditure on the genuinely needy with a need to improve existing services for the bulk of the population;

the growing *difficulty of recruiting and retaining staff* in the caring professions.

The **report's findings** can be summarised under three broad headings:

(1) **The 'modernising government' agenda.** The report looks at ideas of how to improve inter-agency working in order to improve and modernise the way government works;

(2) **How to provide 'seamless' mental health services.** It analyses models of cross-boundary working in other countries, examines ideas of how to achieve better integrated care and draws lessons to help improve UK services on the ground, thereby securing better value for money;

(3) **Examples of good practice at the health and social care boundary.** The report documents specific examples of best practice from around the world.

A. LESSONS FOR THE UK'S 'MODERNISING GOVERNMENT' AGENDA

This research shows that no country in the world has a blueprint for cross-boundary working which we can import unaltered, but there are some positive findings:

The need for a strategy

In countries, eg New Zealand and Australia, where an effort has been made to draw up a **single strategy document setting out the goals and plans** to deliver high quality mental health care, they have been able to set a clear agenda and deliver improvements. Important elements in implementing such a strategy are:

involve key agents and service users in drawing up services;

provide *dedicated funding* for service developments over a realistic time scale;

draw up a *detailed implementation plan,* backed by proper monitoring.

The watchwords for good care are flexibility, dedication and creativity. A broad strategy for integrated care should ensure that: care is person and family-centred, with multidisciplinary needs assessment; accessible and adapted housing is available; there are transparent and flexible funding streams; care is provided by properly trained staff and people are assertively followed up and monitored with a focus on outcomes.

Integrating funding

For people such as mental health users, who need to access multiple services, the consensus is that **health, housing and social services budgets need to be more integrated to deliver high quality care.** There are various ways to do this, including:

- blended or pooled funds;
- increasing the scope for home and community care agencies to work across departmental or organisational boundaries;
- instituting formal coordinated care pilots.

The UK has already passed legislation that addresses the first two options. The question is whether progress will be fast enough without further policy action.

Ultimately, without a **single funding source for chronic care,** it will be hard to deliver truly integrated care. Countries with systems of social insurance, and the Scandinavian countries with comprehensive public health and social care systems get closest (but not very close) to unitary funding. However, even in these countries there are still significant operational boundaries between agencies at local level.

B. DELIVERING 'SEAMLESS' CARE

Broad observations

Over the next 30 years, several factors mean that **a larger share of public spending is likely to go to those who need chronic, as opposed to acute, care:**

continued aging of the population, with *many more people living past 80;*

older people, the disabled and people with mental health problems tend to have multiple, *interrelated and often complex health needs;*

the *trend towards much shorter hospital lengths of stay* due to modern medical and surgical techniques.

In order to deliver seamless care, 'person-centred care' is required. With increasingly complex service delivery mechanisms, good outcomes are associated with making services revolve around people, *not* the other way round. **Holistic care is likely to be both more efficient and more effective,** consuming fewer total resources for a given output as well as yielding a better outcome for given inputs.

Much evidence points to the fact that multidisciplinary teams are worthwhile. In the UK, needs are mainly assessed by social workers. For people with high needs, multidisciplinary assessment (involving various professionals) helps to identify all the client's needs at the outset. It avoids the costly and time-consuming problems arising from undetected and unexpected complexity at a later stage in treatment. The challenge is that multidisciplinary teams are hard to run given different professional work cultures and the fact that specialist staff input is scarce.

This philosphical shift may mean that the era of **'vertical' care delivery systems may be waning.** Organisations which deliver care 'in one place' with vertical 'chains of command' - eg hospitals and social services departments - have led to large health and welfare gains, but these hierarchical organisations may have reached a natural limit in delivering better care (see section 2 of Issues Chapter for further details).

'Horizontal' forms of care delivery are better at providing integrated care. Examples of such models include: one-stop advice centres in Germany, 'Community Options' programmes in the USA, coordinated care agencies, home and community care programmes in Australia and multidisciplinary mental health care in New Zealand.

There are difficult hurdles to overcome in implementing 'horizontal' care. These include: the steep learning curve associated with fund pooling; the challenges of multidisciplinary team working; the difficulty of accurately targeting home health care on those who would otherwise be institutionalised; the shortage of unpaid carers and respite facilities.

Seamless care clearly requires better information sharing. Care planners and co-ordinators, social care agencies, GPs, hospital wards and pharmacies ought to be IT-linked and work to common protocols and administration forms.

Prevention and rehabilitation are also areas where existing practices can be inefficient. **Prevention advice should be clearly targeted** at changing or reinforcing particular behaviours. International best practice in geriatric care stresses the **importance of starting rehabilitation at the point of hospital admittance,** so as to prevent deterioration which requires costly bed stays to reverse.

Organisational issues

Major changes to the UK's organisational boundaries are unlikely in the near future. The Royal Commission's preferred approach of expanding services provided free at the point of use by the health service (eg personal care) would be costly and, without service reorganisation, would not directly improve quality - a key policy goal. Nevertheless, it is clear that some action is needed to reduce boundary problems.

Less radical options include either **giving a lead to the newly created Primary Care Groups to coordinate community care,** *or* **enhancing local government's role in organising and managing long-term care,** for example by giving control and responsibility over community nursing and rehabilitation to social services authorities. Both options pose dilemmas and difficulties, explored in this report.

Funding systems

The **major distinctive area of weakness for the UK is the financial borderline between health and social services.** The UK borderline between privately paid-for and means-tested social services on the one hand and a free at the point of use NHS is unhelpful. Tinkering with means-testing tapers would almost certainly raise expenditure, but is still unlikely to completely resolve the underlying political issues about generational inheritance.

It is widely accepted that integration of funding would help to deliver more integrated care services on the ground. **Pooled budgets will help,** but **more uniformity in charging and co-payments** as well as **pushing take-up of direct payments should also be explored,** in return for better or guaranteed access to services.

The type of care that needs to be provided depends on the state of health of someone with mental health problems. Blanket care coordination or integration is unwise and costly. But people still spend too long in acute care, though lengths of stay are falling. 'Revolving door' admissions are also still too common. International evidence suggests that **people can be effectively and adequately cared for in homely settings.** For this to work well, there needs to be:

overall management by someone skilled in care for older people. This could be, but need not necessarily be, a geriatrician;

comprehensive assessment systems. For clients with multiple complex care needs, it is vital that a care manager oversees their care;

good links between the client, GP and other care professionals. Family doctors play a particularly crucial role;

a full range of community support options, including carefully targeted respite care, for those who need more than family-based care.

Careful thought needs to be given to current organisational and financial incentives to remove any biases towards institutional care, eg charging rules which make residential care cheaper than domiciliary care. Experiments with providing case-managed community care showed that it might postpone entry to institutional care for about two years.

In housing, the main gain, aside from better central government coordination in supporting local initiatives, is likely to come about by **ensuring that people live in safe and suitable environments.** This is the long-term care equivalent of the environmental gains from home insulation.

C. LESSONS FROM INTERNATIONAL EXPERIENCE

Where can the UK improve and share its own existing good practice?

In some areas, the UK is already at or around the leading edge and should do what it is already doing and disseminate good practice. Some examples are:

- **building capacity in the community to enable people to help themselves.** UK Health Action Zones are encouraging people from deprived communities to take more active roles in the community, although the benefit system still makes it hard to combine work and other interests;

- **encouraging PCGs/GPs to be more involved in coordinated care.** However, international experience suggests GPs should not directly coordinate care (as they would need special training to carry out this function), but instead be kept fully involved in their patients' care arrangements;

- **helping consumers to become more informed users of health care.** Capitated funding sets the right framework, but it is vital to help consumers become informed users of health and social care. The US Foundation for Accountability and the UK Audit Commission are doing much useful work in this area. The UK could also use its innovative 'NHS Direct' telephone advice service to provide pro-active ill-health prevention advice;

- **consolidating successful initiatives by incorporating one-off monies into mainstream funding.** An example is 'winter pressures' money where it has been used constructively to address structural issues, eg through funding joint teams for care for the elderly. The benefit of this funding will be lost if it is not incorporated into recurring funding;

- **reducing wasteful structures and practices.** The UK has cut average hospital lengths of stay markedly in the last ten years, but more methodical triage and pre-admission procedures could reduce stays further. More action could also be taken to reduce the over-medication of some older people.

Where can the UK improve and share its own existing good practice?

The key messages are:

- bolster moves to **a population and public health focus,** which provides a common framework for discussion;
- **engage everyone** in drawing up a strategy - especially users and carers;
- **flexible resources** will be needed in the future to continue innovation;
- **better information systems** are required;
- **partnerships** with primary care, substance misuse teams et al will be key;
- there is a clear need to **develop quality tools** - guidelines, outcomes and report cards.

Organisational issues

Separate local mental health authorities, reporting to either health or local authorities, might help to deliver more integrated care. Initially they could commission care, monitor policy delivery and encourage joint working.

There is near-universal consensus that **care is best delivered for the vast majority in the community.** Important aspects of integrated community-based care are:

- enough **intensive (acute) care must be available for people in crisis;**
- **clients not in crisis *can* be managed in community and primary care settings** (by a combination of GPs, CPNs, trained social workers, etc);
- importantly, a range of supported residential care needs to exist;
- an **employment-oriented programme** to develop skills and provide vocational training.

The link with the world of work and housing is vital. Without those components, support arrangements collapse, thus increasing the need for expensive acute beds.

Funding issues

There is widespread agreement from people administering or working in mental health services globally that the **mental health budget within the Ministry or Department of Health needs to be ring-fenced.** This view has gained currency in the UK and is adhered to elsewhere, eg in Australia.

Drawing up outcome measures is hard, in this area as in others. There is little international consensus on appropriate measures, eg suicide rates. Some agencies are using **improving access and the quality of services for hard-to-reach clients** (perhaps using a levelling-up approach), such as those from ethnic minorities, as proxies for outcome measures.

Where can the UK learn from other countries?

There is an urgent need to pay more attention to the needs, aspirations and desires of users. It is still all too commonly assumed that the professional knows best. The New Zealand mental health system has made real strides in including the views of users and family members in policy planning and delivery.

Encouraging a philosophy of *recovery* not *treatment*. Decent, safe and affordable housing, the opportunity to earn income and be free from physical addictions is just as important as mental health care per se.

Three other aspects are also seen to be key:

the **promotion** of **self-determination** and quality of life as objectives;

the **emphasis on prevention and early intervention** to deal with targeted mental disorders.

A **wider choice of housing options is necessary** to help people make the transition between hospital, sheltered housing and their own home (see, for example, the NZ Accommodation for Mental Health Best Practice example).

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2. INTRODUCTION

> *"All too often when people have complex needs spanning both health and social care good quality services are sacrificed for sterile arguments about boundaries. When this happens, people, often the most frail and vulnerable in our society - the frail elderly, the mentally ill - and those who care for them find themselves in a no man's land between health and social services. This is not what people want or need. It places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers' money - it is unacceptable."*

(Extract from Foreword of *Partnership in Action,* UK Department of Health Discussion Document, September 1998)

Aims and objectives of the report

The health policy debate has tended to be dominated by issues raised by acute and emergency services: discussion of the relative priority between preventive, chronic and acute health care and the boundaries within and between these services has often been given low priority.

But the rapid increases in the numbers of those over 65 and 85 years of age, combined with the rapidly increasing prevalence of chronic disease and disability are stimulating much greater attention in developed countries on issues of disabilities and the need to provide appropriate and contiguous services for the elderly and disabled groups.

Comparative analyses of international long-term care systems have been carried out by the OECD (for example, *Caring for the Frail Elderly: Policies in Evolution,* 1996 and *Health Care Reform: The Will to Change,* 1996). This report does not attempt to replicate these comparative studies, but instead focuses specifically on the way the boundaries between acute, post-acute medical care, long-term or chronic care, housing and social care are managed in developed countries.

This report aims to:

- document mental health systems in use in other developed countries;
- compare and contrast problems and practice elsewhere with those in the UK;
- provide some lessons and pointers to how care boundaries for the elderly and users of mental health services might be better managed in the UK.

The methodology

The report has emerged from a process of formulation, consultation and feedback involving six stages. First, a study proposal was formulated in consultation with the health policy team in HM Treasury and economic experts in the UK Department of Health.

Having clarified the precise area of study - the boundary between health care and social care for the elderly and users of mental health services - and drawn up a list of key issues (see Annex B attached) which needed to be addressed in the UK, the second stage involved 'road testing' these key issues with various people in the UK who have a clear stake in the UK system of long-term care and mental health.

The aim of this process was to ensure that I had a clear idea of current UK practices and problems before going to examine systems and practice overseas. I am very grateful to a number of individuals (see Annex A) for taking part at an initial stage in drawing up the questions and issues to be addressed in the report.

The third, international, stage of the work involved travel to the USA, New Zealand, Australia, Singapore, Sweden, the Netherlands and Germany to interview and discuss issues with leading academics, policymakers, lobbyists and care deliverers/ practitioners in each country. Since there was not time to see everyone in the field in each country, a key individual or first point of contact was selected in each country, usually a key adviser in the Department of Health, who then suggested further contacts.

The most interesting of the interviews and the most pertinent observations, combined with relevant material and publications where this had been supplied to me, form the basis for the country chapters and thematic review sections of the report. The documentary material supplied by my contacts, which comprises a sizeable number of publications, articles and programme documentation collected during the research, is available for reference and consultation.

The next two stages of the Fellowship involved peer review of the emerging findings. In the fourth stage, the first draft of the country chapters were sent to several key contacts in each of the countries visited for their comments. These comments were incorporated into an improved second draft of the report. The fifth stage involved discussion of the findings from the non-European countries visited - the USA, New Zealand, Australia and Singapore - with the UK-based individuals who were consulted at the earlier second stage. I gave a series of presentations and seminars in spring and summer 1999, explaining the emerging themes and findings. The issues, questions and comments raised in this round of discussions were used to further review the material collected and informed the conduct of European visits.

In the sixth and final stage, a draft of the final report was circulated to the Treasury and Department of Health and two key contacts in each country visited, before being written up and finally circulated to the sponsoring departments.

Report structure

Besides an Executive Summary, which draws out the main findings and lessons, the report is structured into three broad sections:

(i) an **account of health and social care systems, problems and practices** in the seven key developed countries visited;

(ii) an **account of innovative or useful care services and practices** in the countries visited, which have lessons for UK and other policymakers;

(iii) a **cross-cutting/cross-country examination of the main policy issues** (strategic, service delivery and financing) affecting health and long-term care for the elderly and mentally ill.

Sections (i) and (ii) are incorporated in the country chapters, while section (iii) forms a free-standing (issues) chapter.

ANNEX A

The individuals consulted at the outset of the project were:

UK Civil Service

- Robert Culpin, Director of Spending in HM Treasury, and Gill Noble, Deputy Director with responsibility for health spending, HM Treasury;
- Andrew Hudson, Sue Catchpole and Mike Evershed in HM Treasury's health team;
- John Aldridge, Gavin Anderson and Gill Otley in the Scottish Office Health Department;
- Alan Davey and Patrick Hennessy, Secretariat, Royal Commission on Long Term Care, Department of Health;

Academics and commentators

- Professors John Hills and Howard Glennester, LSE and CASE;
- Professors Bleddyn Davies and Martin Knapp, PSSRU and LSE;
- Professor Gerald Wistow and Brian Hardy, Nuffield Institute, Leeds;
- Janice Robinson, King's Fund;
- David Browning, Audit Commission;

Practitioners

- Anne Windiate, Director, Riverside Mental Health Trust;
- Cath Cunningham, Local Government Association;
- Chris Bull, Southwark Social Services;
- Philip King and Naomi Landau, Soho Community Mental Health Team;
- Dr Geraldine Strathdee, Oxleas Mental Health Trust.

ANNEX B

ISSUES/QUESTIONS

This note sets out the main questions to be explored in research undertaken as part of a 1998/99 UK Government Study Fellowship. The research will look at and report experience of dealing with the boundary between health and social care in the United States, New Zealand, Australia, the Far East and Europe. The issues addressed by the Fellowship have been chosen because of their importance for Government policy in the United Kingdom. The issues and questions have been deliberately cast in fairly broad terms so as to stimulate a wide range of ideas and unearth innovations and good practice.

Interest in the issues listed below will vary by country and between states/Provinces within countries. In each country or state, discussions will concentrate on those issues of most local relevance. It is therefore not the intention to address all the issues in all countries or with every interlocuter.

There are four main areas of interest:

1. The strategic framework for delivering care

2. The roles and responsibilities of the relevant agencies

3. The delivery of services and accountability mechanisms

4. Financial issues, incentives and rewards

The strategic framework for delivering care

What is the strategic framework for delivering health and social care to the elderly and mental health populations?

Is an overall strategy or vision shared by the key agencies? If so, how is it manifested and expressed?

Is there consensus between relevant agencies about how care should be delivered?

The roles and responsibilities of the relevant agencies

Have the roles and responsibilities of the relevant agencies/professionals been clearly defined? Are these roles accepted and understood? Where are the boundaries?

Is 'seamless' care an objective? What boundary or programme cross-working issues remain to be resolved? How might they be overcome?

Are there lessons for general government from the experience of dealing with clients with long-term care or mental health needs?

The delivery of services and accountability mechanisms

How are elderly/mental health services provided? What is the balance between country/federal, state/provincial, profit/not-for-profit and family provision?

Does a unified organisational structure exist? Is there a unified care budget? Are services formally planned or commissioned? How do current organisational structures promote or impede collaboration?

In what ways are agencies and professionals held to account? Is value for money an explicit objective? How is monitoring and performance management used to review strategy and care responsibilities?

Financial issues, incentives and rewards

Are services charged for? If so, how and for which client groups? How is the line drawn between charged and non-charged services? Is public sector-funded coverage expanding or contracting? Is there consensus on charging?

What financial incentives and rewards are perceived to exist? Do these promote or damage collaboration in delivering care? If so, how?

Does cost-shifting take place? If so, to whom? How are the resulting problems and conflicts managed?

Mark Minford
HM Treasury
United Kingdom
August 1998

3. COUNTRY CHAPTERS

A. UNITED STATES

Summary and Overview

In mental health, as in other areas, it is impossible to speak of a single US system - rather, there are 50 different mental health systems which have arisen in response to local philosophies, legislation and service pressures. This section highlights some of the features of US mental health systems in a few particular states visited, some important debates and a couple of examples of best practice.

The most recent data suggests that around 8.2 million adult Americans under 70 have a mental and/or emotional disorder (5% of the US population) and 3.3 million have a severe mental disorder.

Transition from institutional to community care

Until relatively recently, the goal of US mental health systems was to provide humane custodial care. It was assumed that people would need lifelong services. This is in contrast to long-term care, where it was traditionally assumed that people could be cared for out of institutions. However, in recent years there has been a questioning in the USA - and not just in the field of mental health - of the ability of government to address deep-rooted social problems, as well as an increasing demand for accountability in the use of taxpayer funds.

In this climate, as noted by the Wisconsin Blue Ribbon Commission, difficult questions have been raised about the appropriateness of providing caring services that accept lifelong dependence on mental health services and professionals. Similar changes have occurred in the approach to services for children and adolescents. Alternative models are being sought which promote improvement, recovery and full integration into the community.

In certain parts of the country, eg Wisconsin, mental health customers have begun assuming responsibilities for overseeing the policies and practices of mental health services. This has created a paradigm shift with profound implications for the mental health field and a new philosophy of thinking - the Assertive Community Treatment (ACT) model which, alongside radical models developed elsewhere by Laing and others, has had increasing influence on traditional care models.

Best practice in consumer-directed care

The premise of the ACT model is that systems should be consumer-directed, family-supporting, outcome-oriented and cost-effective. Best practice suggests that there are three essential constituents of successful community mental health care:

- an **integrated multidisciplinary team;**
- oversight and funding of teams by a **locally-based mental health authority,** who would concentrate on planning, commissioning and monitoring care;
- **effective medical and social care interventions.**

Insights from the US system

US insights for the development of adult MH services include:

- an *emphasis on a high degree of flexibility and responsiveness* to individual needs and environments, coupled with a view that people with mental disorders can and should have the major voice about the services offered;
- the *need for services oriented to risk reduction,* including an emphasis on rehabilitation as well as adequate housing, employment and education;
- the *importance of a single point of authority and accountability,* both at state and county levels, which should be responsible for funding and monitoring a comprehensive set of services; managing single stream funding for hospital and community services and appropriate information services.
- for children and adolescents, *collaboration among child-serving agencies, local inter-agency service planning and delivery structures* and *returning young people to their families and communities* are seen as the way forward.

A1 Strategic Framework

A1.1 Historical background

Until the enactment of the Medicare and Medicaid programmes in the mid-1960s, state mental hospitals were the mainstay of mental health care. But a number of medical, financial and ideological changes converged in the two decades after the Second World War to effect the start of a major shift from inpatient to community care. These changes included:

- a social ideology favouring individual rights, which led to new national community mental health legislation;

- new medications which seemed able to effectively control symptoms of mental illness;

- federal programmes that gave incentives to serve people in non-institutional (state mental hospital) settings.

The national shift from inpatient to community care - the deinstitutionalisation movement of the 1960s and 1970s - with its effect on the location of mental health care meant that the responsibility of care gradually shifted from the states to the Federal Government, and federal funding support has become increasingly important for people with chronic mental illness.

This new service ideology was stimulated by a growing movement among families, advocates and consumers of mental health services who were pressing for high quality community services and more accountability in mental health care. In retrospect, this movement was a halfway house to full deinstitutionalisation, that is beginning to occur in some parts of the country today (see examples of good practice in Baltimore and Wisconsin detailed in section 3 below).

In the 1960s and 1970s, community programmes were developed that included group homes, sheltered workshops and day treatment programmes. They provided 24-hour care and supervision, but allowed few opportunities to interact with community members or assume valued community roles. As in the UK, two decades later, these programmes were more willing to cater for the less impaired members of ex-state hospitals. Hence, many persons left hospitals but never entered community mental health programmes. Again, parallelling the UK, as institutional settings were closed, funds to pay for services in community settings were not transferred.

In the 1980s the community support system was applied to the elderly through an initiative led by the National Institute for Mental Health. This involved the use of mobile outreach teams to senior citizens ('seniors') that focused on establishing trusting relationships and home-based services and services through aging networks.

But major barriers to community integration still existed: homelessness among people with mental disorders; poverty; disincentives to work built into the funding and benefit system (Social Security Disability Insurance and Supplemental Security Income) as well as limitations in private health insurance coverage of mental health services.

In the late 1980s and 1990s consumers, advocates and policymakers began to question the excessive reliance on professionally developed and controlled solutions to community integration. There was a growing demand by persons with disabilities for full community membership. The federal Americans with Disabilities Act was a major landmark civil rights law and included persons with disabilities for the first time.

A1.2 Roles and responsibilities of US agencies

In the 1970s, states began to address the need to develop local mental health services. As federal funding to community mental health centres began to decline, states began to assume leadership for all mental health services in their jurisdiction.

The substantial increase in the number of private psychiatric hospitals and non-Federal general hospital, psychiatric hospital and residential services during the 1980s generated a rationalisation of hospitals and a decrease in the number of hospitals and beds. States are struggling to reduce their budgets by eliminating costly hospital and residential programmes, stressing community care and preventing admission to psychiatric beds whenever possible.

Innovations began to take place, such as making counties or local mental health agencies responsible for mental health services in their own areas. The community support system that grew up in this period suggested that living in the community rather than in a protected, supervised environment was possible.

The way that mental health services are currently delivered is as follows:

- state mental hospitals take referrals from Emergency Departments of medical hospitals for those who have little or no income, or the police for those picked up off the street;

- private hospital, clinics and private psychiatrists exist for those who are insured or who have sufficient means to self-pay;

- in recent years, a third route has grown up, where Medicare and Medicaid funding is available to fund stays in private hospitals.

The public MH system is changing in the USA. Medicaid, which pays for the treatment of the mentally disabled and non-workers is increasingly being transformed into managed care. But a substantial population is needed to make managed care work. Hence, in many states (eg Wisconsin and

Maryland), city or county authorities are natural levels to which to devolve managed care. These authorities in turn contract with managed care organisations to run services for them. In other states, eg Tennessee and Iowa, there is a state-wide MH services contract.

Practical risk-spreading considerations, together with the new thinking on how to deliver mental health services, meant that state mental health Departments are now starting to:

- create local mental health authorities while retaining the functions of defining target populations and planning a statewide service system;

- give financial incentives to serve people in communities, not in institutions;

- evaluate the performance of local (county) authorities.

The Baltimore model

An interesting example of this new pattern of service delivery and new way of thinking is in Maryland, where State MH programmes have been devolved to an organisation - Baltimore MH Systems Inc - which runs a City-wide programme (see Best Practice Example 1 in Section 3 for more details).

Baltimore City systems comprise a hospital clinic, a small centre run on an ACT model and case management systems, which operate within each operational unit. The state provides a grant, and Medicare/Medicaid fees are also used. The budget is therefore the total cost, less the fee and grant income.

Wisconsin

In another state visited - Wisconsin - mental health responsibilities are attached to (elected) County Boards of Supervisors. In this state, counties have always had responsibility for care of the elderly, substance abuse, learning or developmental disabilities and mental health. There have never been huge state hospitals, but there are 2 state hospitals with 100 adult beds, 130 child and adolescent beds and 400 forensic beds whose care is paid by statutory boards.

In the 1970s the philosophy of Assertive Community Treatment (ACT) took hold. Today, the state is going beyond ACT as the new philosophy prioritises recovery over treatment. Wisconsin (along with California) has enthusiastically embraced managed care over Medicaid fee-for-service funding for two reasons. First, they believe Medicaid tends to favour institutional care and managed care can lead to greater flexibility, more community-oriented solutions and is amenable to contracting for an outcomes approach. Second, risk can be devolved downwards onto providers (who conversely fear they may be disadvantaged by a move away from the fee-for-service system).

A1.3 Financing arrangements and accountability mechanisms

In recent years, Federal administration and service delivery has been largely transferred to states. In the 1980s and 1990s, there has been massive restructuring of mental health policy and financing. The increasing prevalence of block grants has increased the role of local governments and states.

Funding mechanisms

There are three major funding sources for mental health - county funds, state community aids and Medicaid. At their inception, neither Medicare nor Medicaid would pay for services provided in an Institution for Mental Diseases (IMD). The law simply stated that no Medicaid benefits would be available to an IMD resident. IMD exclusion was embodied in Medicaid (as it had been in the predecessor Kerr-Mills legislation) as a means of ensuring that states did not use newly available Medicaid matching funds to refinance their state mental hospitals.

This exclusion was premised on the belief that mental health was separate from physical health and its treatment could be compartmentalised. This view that mental health care is not part of mainstream health care continues to be Medicaid policy, though it is increasingly challenged.

The gradual release of people from state hospitals resulted in an increase in people admitted to nursing homes. Congress immediately suspected that states were gaming the IMD exclusion to get federal matching funds and as a means of running down hospitals for the mentally retarded. In response to this trend, the 1987 Omnibus Budget Reconciliation Act initiated a review of the numbers of people placed in nursing homes at Medicaid's expense. Unfortunately for federal policymakers, the programme found that most people with mental disorders did indeed need skilled nursing care. Partly as a result of this experience, language was added in 1990 to the Medicaid statute requiring that mental health services be part of nursing home services.

There are unintentional, but nevertheless harmful, interactions between employment, benefit receipt and the mental health system. For example, if someone earns more than $500 per month, then they lose entitlement to assistance with drug costs. Without access to medication, some people with mental disorders are likely to be unable to carry on working, or work at their previous intensity. The loss of their prescribed drugs may also worsen their physical and psychological health.

A2 Broad Policy Debates

In the USA, mental health care has well-defined boundaries, but many different agencies. One Director of mental health care stated that the system was "regulated, but totally disorganised". The US faces many of the same issues that exist in the UK, namely: separate streams of money for health and social services; the difficulty of integrating medical treatment, housing, income support, employment and rehabilitation; problems of people with mental health problems ending up in prison.

A2.1 The balance between hospital and community-based services

As the number of hospitals and bed-days in state mental hospitals has continued to decline, policymakers are confronted with big decisions regarding state mental hospitals. How should a balance be struck between community-based agencies and state mental hospitals? Should these facilities be closed? The policy tide has turned against institutional facilities, but the fact that there is a need for an asylum of the last resort when community facilities do not work and practical arguments for employment in local communities provide countervailing pressures.

On the whole, state mental health agencies favour the expansion of community-based services, and Federal legislation promotes community-based services through the block grant distribution mechanism. Nevertheless, in the mid-1990s, state mental hospitals still consumed over half the total spending by state mental health agencies.

A2.2 How do you create good practice in mental health care?

There is still an incentive under Medicaid rules to treat people in a hospital setting, although all the evidence suggests that the increased use of managed care and other cost-saving mechanisms are reducing the length of hospital stays. However, if services are to revolve around the patient (particularly for high-end users), rather than the other way round, this requires more flexible models of care. In particular, an inter-disciplinary team approach is needed so that individuals get the services they need, rather than being forced to access particular services.

There is a need to move from medical 'cottage industries' (which are fiercely defended by specialist groups of doctors) to a world where primary care physicians, cardiologists and psychiatrists liaise and work to a common goal. The key question is how do you get this inter-disciplinary approach and understanding. Two answers were suggested: through training programmes and manuals for professionals.

At least three separate models of integrated care can be identified:

(i) a capitation model. This should be capable of using money flexibly and should be monitored according to outcome performance measures. Evidence to date shows, however, the benefits of accessing a single pot of money are not often being realised;

(ii) Assertive Community Treatment (ACT). This is the most intensive method of treatment and works on the (correct) premise that service integration works best if you can determine what is best for the client and then access appropriate care.

But there are two problems with ACT models:

it is difficult to replicate small programmes and experiments. A mechanism to get top-down implementation is lacking - in contrast, for example, to the Victoria Mental Health system in Australia;

programmes are very costly and so are probably best confined to high-end users, whose treatment is anyway likely to be expensive in a conventional acute-care setting. A better, and cheaper, approach might be through a 'Cash & Counselling' programme (see Section 1.5.1 in LTC part of the report), where individuals themselves (or their representatives) handle money directly.

In both of these models, it is possible for nurses or psychiatric social workers, rather than doctors or psychiatrists, to lead teams

A problem in the USA is that there is a plethora of different agencies, each of which is keen to maximise its business. Not only does this make it difficult for an individual to receive seamless care, it also means that there is a lot of unnecessary administration. The existence of a set of non-nested bureaucracies contrasts unfavourably with the situation, for example, in the UK where one Ministry of Health plans, coordinates, monitors and enforces policies through regional offices and health authorities.

The key to improving services seems to be to incorporate good practice from a wide variety of areas and put them together, as no one state has a monopoly of best practice. Clinical protocols are useful, but they need to be flexible enough to cope with different locations of care. The real problem is that whilst there may be many micro examples of good practice, it is hard to get a multi-layered service to work well. Training and exchange programmes are vital so that people can see, and learn from, what happens elsewhere.

One model of good practice can be summed up in the acronym T-PETROL. The ingredients of this model are as follows:

T - targeting: project participants need to be clear who can receive care;
P - payment: providers must be adequately paid;
E - evaluation: the care model and practices need to be carefully evaluated;
T - training: people running MH projects must be properly trained;
R - risk sharing: risks are spread and there are good financial

incentives;

- O - outcomes: there must be a focus on outcomes, not outputs or inputs;
- L - a limited number of clients.

A2.3 How to remedy the fragmentation of services?

There is a widespread view that poor mentally ill people fall through the cracks in current service delivery arrangements. With the privatisation of the MH system, companies have contracted with the state to provide medical care only, and gaps have been left in the provision of social services. The result is that agencies - shelters, missions, social service agencies, drop-in centres, etc - have been overwhelmed.

Over the past 3 decades (1960s to 1990s), the decentralisation of services has become so extreme that care has been poorly coordinated and fragmented among a large number of providers. This took a number of forms:

- fragmentation between MH service agencies;

- between MH and other agencies in the social welfare system;

- there were few city or county-wide services;

- community MH centres had little or no connection with public hospitals.

Several policies have been advocated as ways of reducing fragmentation, including financial integration, service structure reorganisation and addressing non-health issues.

Financial integration

Various ideas have been floated in this area:

- merging the major funding sources (Medicaid, state and county monies) might allow more comprehensive services for mental health treatment, recovery and prevention to occur and help ensure that 'money follows the patient';

- integrating funding for institutional and community services could encourage the development of community-based service alternatives, as would more incentives to encourage counties to reduce inpatient and nursing home care;

- develop improved data systems, including collecting information on: the per person cost of services funded (where they exist) by community aids, county tax funds and Medicaid, as well as performance contract details and consumer outcomes.

Service structure reorganisation

In service terms, there is no single solution to the problem of service fragmentation and diffusion of responsibility. A variety of models have been cited as the 'solution' to this fragmentation, including reversion to community MH centres; a 'core' service agency and an MH authority or board. The latter model was chosen by the Robert Wood Johnson (RWJ) Foundation in the Program on Chronic Mental Illness (PCMI) project.

The linchpin of PCMI was the idea of one central MH authority per city or county. It planned, funded and coordinated care and ran its own admin, fiscal and clinical systems. The system in Baltimore is an example of such a system operating today (see Best Practice Example 1), although experience suggests that an MH authority might be necessary, but not sufficient, to create a comprehensive set of services.

The unique feature of PCMI was its emphasis on developing housing. Each site created a housing development corporation as an outgrowth of the local MH Authority. In this process, hundreds of units were developed and acquired for use by individuals.

Addressing non-health issues

There is a pretty clear consensus that housing, income and rehabilitation to the workplace are all crucial to mental health. For example, experience shows that homeless people do not attend clinics and hence do not address their mental health problems. If someone has housing on the private rental market, it is likely to be low quality, since they only have SSI or SSDI levels of income. If there are long intervals between outpatient appointments, they will need more continuous support. People also need to be helped to get work, so as to improve their self-esteem and get some additional income.

A3 Best Practice Examples

Example 1: Baltimore Mental Health Services Inc.

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In 1986, the Baltimore City Health Department received a 5 year ($2.5 million) grant from the Robert Wood Johnson Foundation to develop a local mental health authority that would develop a coordinated and comprehensive network of services responsive to the needs of clients. The grant established a non-profit entity called Baltimore Mental Health Systems Inc (BMHS) as the local mental health authority for Baltimore City with accountability to the state government.

BMHS has a catchment area of 636,000 of whom 28,000 (under 5%) were authorised to receive mental health care. In the last fiscal year, about 16,000 individuals - half adults and half children - received services through the city's publicly funded MH system.

The state establishes the fee schedule for fee-for-service treatments.There is then a three-tier structure to mental health provision. At the top, utilisation and claims authorisation is sanctioned by an organisation called Maryland Health Partners. BMHS then acts as the health authority and manages, funds and coordinates mental health services in Baltimore City. It focuses on improving care continuity, creating new financing initiatives, developing new affordable housing opportunities, expanding the range of services offered and public education. At the bottom layer are direct service providers to whom BMHS aims to pass service risk.

One of the interesting features of Baltimore's system is that it is relatively integrated. Many social services tasks are subsumed within the health system. While welfare payments, food stamps, etc, are provided by the Social Services Department, the Health Department's case management unit provides social work services.

Furthermore, recognising that adequate housing is crucial to someone's chances of improving their mental health, this organisation has set their own non-profit housing organisation called Community Housing Association to provide affordable housing. CHA uses the city's rental subsidy scheme (section 8 vouchers) to keep rents down. Tenants can use the vouchers to pay for whatever housing services they like and contribute around 30% on top of their benefit income.

Example 2: Wisconsin Blue Ribbon Commission

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The Wisconsin Blue Ribbon Commission Report includes a wealth of information on how to deliver an empowering and community-based MH system. Its methodology is a model of how to consult on changes in care delivery systems.

The Commission tackled key and difficult issues in a fully inclusive and consultative manner within a short time frame. Its work paralleled Wisconsin's Department of Health and Family Services (DHFS) Long Term Care Redesign Initiative and included a strong commitment to coordinate long-term care and mental health services.

The Wisconsin state Governor's Blue Ribbon Commission on Mental Health was appointed in May 1996 and reported in April 1997. The committee met monthly until February 1997 and received input from over 700 persons. The full report can be downloaded from the Wisconsin DHFS website: www.dhfs.state.wi.us, located under programmes/mental health/Blue Ribbon Commission.

Aims and objectives of the Commission

The Commission was appointed to examine three main areas:

- the configuration of the mental health delivery system, in particular looking at state/county partnerships;

- elderly, adults, adolescents and children's mental health services;

- the impact of stigma on perceptions and current mental health policies.

The Executive Order creating the Commission specifically asked it to recommend:

- model mental health delivery systems;

- ways that federal, state and county governments can cooperate to gain fiscal efficiencies and greater service capacity;

- a service system targeted at prevention, early intervention, treatment and recovery, and positive consumer outcomes;

- ways to reduce stigma in Wisconsin's mental health policies and programs.

Innovatory working methods

In some ways, what was most unusual about this Commission was not the subject matter - which concerns all mental health authorities worldwide - but the way the Commission set about its business.

The Commission's membership included all key Wisconsin stakeholder groups interested in mental health services: representatives of public and private providers, county and state elected officials, recipients of mental health services, family members, advocates, the judicial community and insurance and hospital groups. It is striking that the letter to the Governor from the Chair of the Commission remarked: "Above all, the consumers' outcomes must drive the system".

Outcome - a vision statement, a mission and a detailed action plan

The product of the Commission is a vision, mission statement and principles and proposals for a redesigned mental health system in Wisconsin to inform and guide policymakers and practitioners over the next 20 years. This vision fully takes into account the views of 'consumers' of mental health services, their families, carers and advocates. The **vision statement** aims to convey a sense of hope:

> *"All persons in need of mental health services ... have equal access to resources that strengthen self-determination and self-sufficiency by promoting health and wellness, improvement and recovery, quality of life and dignity."*

The **mission statement** has 5 elements:

- creating partnerships that develop, coordinate and provide a full range of resources;

- emphasising hope and optimism in all interactions;

- implementing a strategy to eliminate stigma and discrimination;

- involving consumers, families and communities as equal stakeholders in all aspects of governance, planning and delivery;

- acknowledging the extent and limits of available resources and committing to responsible stewardship of these resources.

Various interesting **recommendations,** which are more widely applicable, were made by the Commission. These included: the identification of a target population; specification of consumer outcomes; prevention and early intervention services; treatment and recovery services; the stigma attached to mental disorders as well as practical changes to the way services are organised and funded in Wisconsin (not discussed here).

Identification of a target population

The Commission recognised a need to identify groups of individuals to be served by the mental health system, based on the level of a person's service needs. Five target populations were defined in two groups:

(i) those in need of *treatment and recovery services:*

persons in need of ongoing, high intensity, comprehensive services;

persons in need of ongoing, low intensity, comprehensive services;

persons in need of short-term situational services.

(ii) groups in need *of prevention and early intervention services:*

persons at risk;

people with an acceptable level of mental health.

Specification of consumer outcomes

The Commission stated that consideration of people's unique needs required the definition of specific outcomes, services and indicators that are sensitive to the needs of persons at different life stages. Specific performance indicators and tools for measuring outcomes should form the basis for contracts in the redesigned mental health system.

They identified 15 desirable outcomes, grouped into three categories of 'energising' (personal) outcomes, 'clinical' outcomes and 'community living':

Energising outcomes	*Community living outcomes*	*Clinical outcomes*
consumer satisfaction	social relations and support	symptom relief
access	meaningful activities & occupations	psychological well-being
awareness	goal attainment	physical health
personal safety	basic survival and housing	
equal opportunity	freedom from substance abuse	
empowerment & self-esteem	daily living skills	

Prevention and early intervention services

The Commission believe that research on prevention strategies for three diagnoses was particularly compelling and recommended that they be priority targets for specific prevention and early intervention activities:

- conduct disorder in children;
- depression in all age groups;
- post-traumatic stress disorder in all age groups.

Treatment and recovery services

The Commission identified four broad groups of services that ought to be available to help consumers achieve desired outcomes:

- 'core' mental health services (assessment, crisis intervention, case management, etc);
- self-help, peer support and natural supports;
- community supportive services;
- in-residence services.

In a redesigned mental health system, all consumers should:

- participate in comprehensive assessment;
- receive highly individualised services based on that assessment and the consumer's chosen way of life;
- have a service plan designed to achieve positive consumer outcomes, including self-sufficiency;
- be served with dignity, respect and the least restrictive interventions necessary to achieve consumer outcomes;
- receive services that meet an applicable standard of care.

Addressing the stigma of mental disorders

The Commission identified a range of problems associated with the stigma attaching to receipt of mental health services. It recognised that the key remedy for stigma lies in education and society's ability to recognise mental disorders as analogous to other long-term health conditions, such as diabetes or high blood pressure.

ANNEX 1: A BRIEF DESCRIPTION OF THE US HEALTH-CARE SYSTEM

Care settings

As in other countries, most older Americans are free from disability and do not need long-term care. The majority of those who are frail live at home and the numbers of the elderly in all settings are growing fast. In the mid-1990s, around 20% of the 33 million people over 65 (7 million) were disabled. Of these, almost <u>three-quarters lived at home</u>, usually receiving unpaid care from relatives and friends. A growing number of the home-dwelling disabled are receiving home care services through Medicare and Medicaid.

About one quarter of the disabled elderly lived in institutional settings in the mid-1990s. A greater number - about 2 out of the 5 people who live to 65 years of age - will spend <u>some</u> time in a nursing home before they die.

The system and services

The US system for meeting the health and social needs of the elderly is bureaucratic and convoluted. There are multiple funding sources, which means that service delivery and funding for a particular type of care, eg home-based care is very fragmented. Given the US system of statutory rather than common law, there are highly detailed and prescriptive Federal rules for care of the elderly. But constricting Federal requirements does not prevent significant geographical inequity, since each state has different Medicaid practices and eligibility criteria.

The major funding sources for health and social care for the elderly are Medicare and 'Medicaid. Besides these major Federal programmes, other Federal support is available through Title III of the Older Americans Act (OAA), the Social Services Block Grant, Veteran Administration (VA) programmes, and Home and Community Services Waiver schemes.

The Federal Government has also approved various 'Partnership' (Insurance) programmes, tax deductions for health care insurance premiums and cash-for-care programmes. On top of these Federal programmes, the states also run their own long-term care programmes.

Medicare provides pretty universal medical insurance coverage for the elderly, defined as those aged over 65, at least for hospital care and skilled nursing facilities. **Medicaid** pays for nursing home care and most long-term care outside hospitals and skilled nursing facilities.

Medicare coverage is divided into 2 parts: Part A, which covers hospital care, the first 20 days of nursing home care and skilled nursing care at home, and Part B, which covers physician services, outpatient services and most home health care.

Part A Medicare services are provided free, while Part B services require beneficiaries to pay a monthly premium, although around 75% of the costs are met by federal subsidy out of tax revenues. There is also a deductible of $500-$700 for hospital care and co-payments (of around $95 a day) for nursing home services, for which most people take out 'Medi-Gap insurance. There are also day limits on hospital use, but because of shortening lengths of stay, few people hit these limits. Medicare also has a home health benefit, which began life as a parallel to the skilled nursing benefit. The number of visits limit was removed in 1980 and no co-payments are required.

Public spending on medical and long-term care

Public funding for Medicare comes from payroll taxes, currently 2.9%, split evenly between employers and employees, with no cap. Medicare long-term care coverage is limited to some home health agency services and short-term post hospital skilled nursing care.

Medicaid is the dominant source of public funding for long-term care, as opposed to acute medical care. In 1997/98, a total of $56.1 billion was spent on long-term care by Medicaid representing a third of total Medicaid spending. Out of this total $13.5 billion was spent on home care services and $8.1 billion on waiver programmes. Spending on the elderly within this total accounted for the majority of this spending (around $30 billion). Put differently, while about 10% of Medicaid beneficiaries in that year were elderly, spending on that group accounted for over a quarter of total Medicaid spending.

Three quarters of Medicaid spending on the elderly was for long-term care. There has been a clear shift in spending patterns for LTC services. Medicaid spending on institutional (nursing homes and intermediate care facilities for the mentally retarded has fallen from 90% in 1987 to 75.8% in 1997. Conversely, home care spending has doubled to nearly a quarter of all spending over the same period.

The pattern and extent of Medicaid long-term care expenditure varies widely across the USA. In 1995, spending per beneficiary varied from a low of nearly $3,600 in Mississippi to over $19,000 in Washington DC. The proportion spent in nursing facilities and home care respectively varied from a low of 58% and a high of 39% in Oregon, to a high of over 98% and a low of under 1% in Mississippi.

3. COUNTRY CHAPTERS

B. NEW ZEALAND

B1 The Strategic Framework

Mental Health (MH) services in New Zealand, as elsewhere, have been a 'Cinderella' service - marginalised, in poor buildings and expected to deliver care 'on the cheap'.

B1.1 A brief history of mental health services

The history of New Zealand mental health services parallels the UK's very closely. Legislation in the 19th century established a network of psychiatric hospitals, evolving into the framework common until recently in the UK of hospitals with 'villas' of twenty to forty 'patients' set up on former farmland. Recent policy and service developments parallel the UK fairly closely, in particular, by a marked trend towards de-institutionalisation in the 1980s and 1990s.

In recognition of the parlous state of services in the early 1990s, a clear policy focus, strategic frameworks and resources have been developed over the last five years. New Zealand Mental Health (MH) services now have a good strategic framework, benchmarked against international practice, as a result of policy development over the last five years. The Ministry of Health took over responsibility for community residential services from the Department of Social Welfare in 1995.

B1.2 Formulating a national Mental Health Strategy

A national Mental Health Strategy *(Looking Forward: Strategic Directions for the Mental Health Services)* was launched and published in 1994. This outlines the goals, principles and strategic directions for the development of MH services over the next ten years. The Strategy's seven key directions are:

more mental health services;
more and better services for Maori;
better mental health services;
balancing personal rights with protection of the public;
developing and implementing the National Drug Policy;
developing the mental health services infrastructure;
strengthening promotion and prevention.

In November 1995, an inquiry was set up to look at the availability and delivery of acute and semi-acute services. The inquiry, carried out by Judge

Mason, reported very quickly - by May 1996 - and made five recommendations. The main ones were:

- expenditure on Mental Health services, including alcohol and drug services, should be ring-fenced at prevailing RHA and CHE levels;

- funding be increased by not less than $125-$140 million over five years;

- a Mental Health Commission be set up and prepare a blueprint for the development of mental health services.

The Government accepted all the main findings of the Inquiry and in 1996 set aside an amount increasing over 5 years to $144 million per annum (by 2000). Specifically, a national plan 'Moving Forward' was devised and published in 1997, which provides specific national objectives and targets in line with the 'Looking Forward' framework. This set of objectives has been backed up by:

a five-year national funding plan, with specific targets and milestones;

the setting up of a new Mental Health Commission as a 'watchdog' to monitor implementation of the National Mental Health Strategy;

the production of a service Blueprint by the new Commission.

Vigorous implementation is now needed with attention in particular to the chronic, rehabilitative nature of most mental health problems. The MH Commission states that considerable service growth is indicated. One of the Government's key strategic targets is to provide MH services to 3% of adults and 5% of children. However, services currently fall far short (see Broad Policy Debates section). The current figures for the whole of New Zealand are 1.5% of adults and 0.7% of children. The HFA believes that with additional funding allocated, the numbers able to be served will rise to 2.2% of adults and 1.6% of children by mid-2002.

There is, nevertheless, a risk that policy set in terms of specific volume goals creates a possibility of 'supply creating its own demand'. However, service levels are comparatively low by international standards, and there is evident under-servicing of the population, especially of the young, as evidenced by youth suicide rates. This risk is therefore small, and volume targets might work in levering up service delivery. Encouragingly, the Commission notes that more does not always mean better.

B1.3 Future service needs

The Commission states that effective provision requires services which are:

staffed by people with the right skills;
based on appropriate values and principles;
responsive to the needs of all consumers;

deliver therapies and programmes of proven effectiveness.

Policy is currently putting a major focus on workforce development and anti-discrimination, developing Integrated Care proposals (see Section 2 - Broad Policy Debates), putting emphasis and training on clinical risk assessment and management in all services and using 'evidence-based' approaches.

B1.4 Roles and responsibilities of different agencies

A key feature of the current New Zealand system is that the funding for both mainstream health services (called personal health) and social services (disability support services) are funded from the health vote. At first sight, this would seem to solve the problems which exist in the UK and allow the HFA to coordinate services across the social/health services boundary, prevent cost-shifting and make efficient purchasing decisions.

However, given the split of purchasing responsibility within the HFA, organisational boundaries still exist between personal health, disability services and mental health - in particular, there is no consistency in the funding of MH services for older people (see Broad Policy Debates below).

B1.5 Financing arrangements and accountability mechanisms

These arrangements are broadly the same as those described for long-term care (see Long Term Care report), ie the HFA draws up a contract with the Ministry of Health to deliver mental health care and is directly accountable to the Minister.

B1.6 Service delivery models

The structure of mental health services in New Zealand is as follows:

- a 38-bed National Secure Unit at Lake Alice, with 25 of the inmates requiring long-term secure care;
- around 64 beds in medium/minimum Secure facilities at the Mason Clinic near Auckland;
- acute hospital and psychiatric wards, backed up by a variety of facilities in the community.

Two broad models of care in New Zealand coexist uneasily side by side:

- the consumer empowerment model, which is largely a US import;
- the acute ward-driven model, which sees services as crisis-led and with medication playing a vital part.

An interesting service model has been set up for people with dual dependency (drugs, eg marijuana and alcohol). A person with an alcohol or drug abuse problem is seen by a Mental Health Outreach/Crisis team. They then admit to an acute psychiatric ward and examine the symptoms to determine the primary problem. People are then discharged to a community MH team, who in turn refer to a D&A team based in community clinics. Proponents of this model acknowledge it would be even more effective if the Community MH team had the skills to do a D&A diagnosis or if there was a dedicated D&A team.

B2 Broad Policy Debates

B2.1 Resource issues

The Mental Health Commission notes in an end-1998 report that the Mental Health Strategy is not linked to a clear implementation pathway. It says "the HFA mental health plan ... indicates that the National Mental Health Strategy's objectives and targets will only be partially achieved." *(The Funding Needed for Mental Health Services in New Zealand,* Mental Health Commission, December 1998). They state that mental health resources in many service areas are well below what is required to fully realise the National MH Strategy targets.

At the end of the 1990s the Commission believe that funding is about 60% of that required. They further believe that full implementation of the National MH strategy by 2004 would require mental health funding to be increased from NZ $490 million in 1997/98 to around NZ$845 million in 2004.

The further 'Mason' money is forecast to meet around 15 per cent of this gap, but the Commission believe an additional annual allocation reaching NZ$355 million in 2004, including $35 million simply to meet the expected demographic increase, is needed. They acknowledge that this resource gap cannot be closed quickly given the present workforce and infrastructure constraints.

Four key areas where services for people with mental health problems are currently inadequate include:

- inter-agency cooperation and collaboration, especially regarding housing, training & employment and income generation;

- outreach services backed up by staffed/supported accommodation in the community, especially including residential options post-rehabilitation;

- 'dual diagnosis' (drug and alcohol/MH) services

- services for children and young people, where provision is estimated to be only one quarter of the guideline level.

The challenges that remain are:

- to remedy the great pressure on acute and secure beds;
- to rectify the lack of psychosocial interventions and an increased 'illness' focus in some services;
- to reduce the numbers of mental health users who abuse alcohol and drugs;
- to listen to many more of the families of mental health service users.

B2.2 Boundary issues

Psycho-geriatric services

One of the problems in New Zealand, which also comes up regularly elsewhere in the world, is the unclear responsibility for mental health services for older people. Practice differs across HFA regions. In some parts of the country, MH services for older people are funded through the HFA's mental health division and in other areas funding for these (psycho-geriatric) services is handled through the DSS division. There is not therefore a coherent overview of the total amount of resources going into mental health, as DSS figures do not separate out the population served with mental health.

People's ability to stay mentally well and to achieve the highest levels of recovery from mental illness are highly dependent on their access to adequate and appropriate housing, income, meaningful activity and preferably paid employment.

Employment and education services

Another problem (cf *Mental Health Commission Funding Report,* 1998) is that there appear to be many gaps in the provision of services to support access to education and employment for people with mental illness. Where employment services exist for people with mental illness, they have usually been provided by the NZ Community Funding Agency and Work and Income New Zealand, formerly the NZ Employment Service. Voluntary groups, such as the Accommodation for Mental Health Society (see Best Practice Example 1), try to fill some of the gaps.

However, the overall feeling is that not enough is being done to provide effective employment services, which would reduce the long run consumption of health resources and greatly improve the quality of life of those with MH problems.

Therefore, achieving the goals of the MH Strategy will require additional commitment and funding from other sources besides the HFA. Failure to do this is likely to result in cost shifting onto the health sector, with consequent failure to meet demands in that sector.

Housing issues

One of the key goals mentioned repeatedly by people with mental health problems is the desire for a home. A home is defined as somewhere where you choose when to arrive and leave, there are no strangers in your home without your permission and no-one has an office in your home. The belief is that, if someone has a home, this gives them stability of accommodation, a stake in the community and the opportunity to improve their health status.

Housing New Zealand has places to rent, but no-one appears to be helping people with mental health problems to find them. While an accommodation supplement is payable to help people pay rent, the real problem is that there is no supportive housing agency. Housing NZ see themselves as simply another provider. When problems occur, there is a tendency to pull resources out quickly.

What is required are services like cleaning and budgeting and link services to help people liaise with landlords. The key to helping people is three-fold:

- find (or build) affordable housing;
- liaise with Income Support agencies and the landlord;
- provide on-going housing support.

ComCare - an innovative organisation based in Christchurch - has obtained funding to house 90 clients in 1 to 5 bedded accommodation, with self-contained facilities for women who desire privacy. They have set up a voucher scheme to help deal with services that often get overlooked or that people find hard to budget for, such as laundry services, spring-cleaning, lawn-mowing and rubbish removal.

In some ways, the position has got harder in recent years for people with mental health problems. There used to be an entitlement to a one-off housing loan for first-time purchasers; this has since been replaced by a state-supported rent-to-buy scheme.

As in the UK, housing and health agencies do not really talk to each other. There is a tendency for housing bodies to try to cost shift onto health agencies - with the local authority demanding that conditions be fulfilled and procedures be enacted before a potential house is renovated or brought up to standard. Dialogue would help: health authorities could have biannual meetings with relevant housing bodies, eg community housing and enter into some joint planning. This would help to prevent the withdrawal of support from people in times of crisis.

A possible solution?

One policy that could be developed further (as is being done in the UK) is to empower an agency to purchase services for people with the most severe mental health problems (around 3% of the population, ie about 12,000 individuals) across the whole spectrum of health and non-health needs. Ring-fenced money could be provided to purchase services for prevention, treatment, housing, education and income support on the basis of a comprehensive risk assessment.

Such a model is being experimented with in Wellington under the Fair Access to Care Services (FACS) initiative. Here, one agency is responsible for understanding the needs of a catchment area of around 50,000, assessing needs and then co-ordinating access to services for people with disabilities.

B2.3 User-centred services

Some people in New Zealand believe that the country is still too far down a 'crisis' model of service delivery and there is a clear need to have a less fragmented service model, where providers collaborate more and operate in a longer-term contracting framework. However, an encouraging feature of New Zealand MH services is the recognition of the need to make a fundamental shift from 'treating' individuals towards a partnership relationship, which acknowledges each consumer as a whole person with strengths of their own to contribute.

The Ministry of Health has set out a vision whereby there is greater clarity about services required and the territory covered by particular providers. The development of a more user-centred focus will highlight the need for good mental health managers and higher training levels for staff.

Integration of an ethnic cultural awareness into service delivery

One of the most interesting - and relevant - features of the New Zealand mental health system is its recognition of the special needs of Maori people. Rates of mental ill health among Maori people have risen dramatically between 1900 and 1990. This was mainly due to: the loss of their land; deliberate strategies to prevent Maori being taught, or able to speak, their language; the world wars and spread of unfamiliar diseases which killed old people; the phenomenon of urbanisation and the desire by the young to leave their ancestral lands with the consequential breakdown of the old structure of Maori society.

Maori cultural advisers are attached to institutions (see Best Practice Example: Mason Clinic) and their use is agreed by doctors to lead to lower tension levels and therefore an important indirect help with diagnosis and appropriate treatment. Other benefits from involving 'cultural advisers' include reductions in the resistance of people to medication, less violence within clinics and hospitals and a better understanding of the perception of the way mental illness is perceived (often as a 'curse') by Maoris.

New Zealand has developed the concept of the Maori health worker, who works in inter-disciplinary teams whose central tenet is that the service should fit the client and not the other way round. Workers in this kind of service aim to support the physical, mental and spiritual needs of their clients. The client is seen as having the right to choose how to live and how (and whether) to die. A Maori health worker (who was herself a Maori) summed it up well: "the user is the ruler of their domain".

B2.4 Lessons for other countries

New Zealand has a more culturally aware service than in many, if not all, other countries. There are lessons for services for ethnic minorities in Europe from the Maori experience in New Zealand. Positive outcomes for Maori clients were associated with the following factors:

- using a broad cultural understanding to inform practice;
- bringing in more Maori professionals and generally developing a better cultural understanding of Maori clients;
- using Komatua and advocates in other fora;
- involving the family in care decisions;
- respecting cultural norms, eg for male clients, female workers should be older/mother figures, not young women who might socialise with the male clients;
- services should be tailored to age and gender groups.

B2.5 Outcomes measurement

There is a New Zealand epigram about outcomes measurement: 'apples grow on apple trees'. The meaning of this, in this context, is that outcomes are dependent on the social, cultural and political context.

In 1998/99, the HFA, Ministry of Health and the Mental Health Commission were all working on the development of systemic outcome measures. This work was building on goal-based work in Australia, which focused on setting individuals a lifetime goal, which then fed into an overall standardised measure.

Research has been commissioned in New Zealand into mental health tools, which would have the greatest community acceptance. Focus groups were used, but it was found that mental health clients were reluctant to be on these groups. Hence, there tended to be an over-representation of less mentally ill clients. To improve attendance, it was found useful to pay people to attend the groups.

Key findings from the research were that people wanted balance, functioning, the ability to maintain relationships, to be able to 'look people in the eye' and to be able to live independently and be socially accepted. Examples of individual goals which are commonly cited include: having a 'home'; having enough money to meet basic needs; having a vocation/job and employing time constructively; obtaining good quality clinical care; having supportive friends.

Examples of outcome measures which are used include:

- *suicide and homicide rates;*
- *stability of accommodation* placements;
- *relapse rates* - individual unplanned admissions and crisis calls.

There is a feeling that outcomes should be widened to include: the amount of information that people are given and how people experience the use of a service judged according to issues such as autonomy and respect.

B3 Best Practice Examples

Example 1: Accommodation for Mental Health Society (Auckland)

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The Accommodation for Mental Health Society (North Shore) Inc. (AMHS) is an independent organisation providing long-term accommodation and a range of community-based support and related services to people with mental health problems in North Shore City near the city of Auckland. ASMH offers a supported accommodation service, a staffed residential unit, an outreach service offering practical advice to people with chronic mental illness in the community; counselling and a vocational employment service.

The Society is a partnership between health providers and funders (Waitemata and North Health), a housing agency (Community Housing Ltd), the Department of Social Welfare and an employment services agency (NZES/ Workbridge). It established its first house in April 1990, when there was a near complete absence of any suitable accommodation for people with psychiatric disabilities in the North Shore - a relatively densely populated part of New Zealand.

The key aspects and principles of AMHS' work are:

- the involvement and support of the community. AMHS believes that the closer services are to the 'real world', the more effective they will be;

- the provision of long-term housing, which functions as a resident's permanent home, to help integration and recovery;

- the provision of a vocational support service to further facilitate integration of individuals into society.

The AMHS philosophy is one where the community should be - and is - involved at all levels in the service provided from defining mental health services to being involved in the running of the Society as Trustees or members of the Management Committee. Staff and residents are encouraged to take part in significant events (birthdays, etc) in each other's lives, which provides genuine opportunities for informal learning and development. Perhaps the most innovative aspect of service provision is the active involvement of key elements of the community, such as neighbours of supported homes and employers, in the Society's management decisions.

The housing service is a good example of this consultation process. The Society adopts a low-key and pragmatic approach to establishing a house in a residential area. AMHS have a clear policy of acquiring tenancy of a house before informing neighbours, which commits the Society and residents to accommodation. This is justified on the basis that people do not have the right to choose their neighbours. Once the house has been obtained, a door-to-door consultation process follows with the aim of getting neighbours to accept the process and get involved.

The Society acquires accommodation by renting houses from Community Housing Ltd, who provide support and assistance to the 'keyworkers' employed in the houses, as well as training in life skills, social skills and assistance with budgeting/benefits, etc. Support provided by keyworkers is oriented towards the practical needs of people experiencing chronic mental illness. A key ingredient in the care package is that the house acquired by the Society functions not as a hostel, boarding house or 'half-way' home, but as a home for life for residents.

Another innovative service is the Transitions' supported employment service, established in 1992. It is based on the premise that many people with mental health difficulties are capable of, and can benefit from the process of looking for, finding and working in a rewarding job, if given adequate supports and services tailored to needs of these people. Services offered include exploration of work/training/further education options, the development of a CV, opportunities to develop and practice interview and presentation skills, support and practical assistance in looking for a job, advocacy, placement and on-going support after a job has been secured.

Comment

When the Society was founded the prevailing perception was that Auckland's North Shore was a suburban haven of normality and affuence, without any mental health needs. The project now fills a much-needed gap in the provision of housing and other support services for people with mental health difficulties.

The Society's philosophy seems to go beyond older paternalistic or professional models of care in ensuring that an effective consultation process is established. The key principle - and differentiating feature - of this organisation is that it has actively sought community involvement in its work. This has enabled it to develop housing in a suburban area, which in the UK might be seen as a no-go area for clients recovering from a mental illness.

In a country where consultation on health initiatives does not have a good name, the Society can point to a pragmatic model of providing community-based services, tested under difficult real-life circumstances. Mental health practitioners readily point out the importance of providing adequate and supportive housing, alongside an opportunity for people to earn meaningful amounts of income.

Example 2: The Mason Clinic & the Forensic Psychiatry Service

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The history of services for people with criminal and mental health problems (the 'forensic psychiatry' population) broadly follows the course of developments in the UK. Following the development of regional 'Special' hospitals, a network of psychiatric hospitals was developed in New Zealand, usually on former farm land.

Out of a mental health service population of around 1,200 in the 1950s, there were 200 forensic beds, ie for those with a criminal record. In 1966, a 55-bed National Secure Unit was set up at Lake Alice. Today, this houses 38 people, of whom 25 are deemed to need long-term secure care.

However, with calls for de-institutionalisation in the 1980s and periodic crises, a wide-ranging enquiry - the Mason Enquiry - was set up which recommended in 1990 that 7 regional forensic units be set up. The Mason Clinic in Auckland was started in 1992 as one of these units to provide a medium secure and community unit for the offenders with chronic mental health problems.

The clinic comprises two 15-bed Medium Secure Units, a 20-bed Minimum Secure Unit, a 9-bed Open Unit and a 5-bed long-term Open Unit. The total staff (including administrative staff, drivers, etc) to patient ratio is high - of the order of 2 to 1, ie around 130 staff to 65 people in the Clinic. Referrals come from the courts, Prison Service and community mental health teams. There is no tailor-made system for sex offenders. Maori people are disproportionately represented in the clinic.

The philosophy of the clinic, which is seen as a leader in its field, is to "maximise people's freedom within their clinical presentation". The clinic operates with minimum necessary security and little physical presence of barred doors and noisy locking and unlocking of doors - the external and the few internal doors are controlled by card detector pads. The clinic is designed with small multiple use - internal areas and allows inmates the freedom to come and go from their rooms as they want and use external exercise areas and gyms. There are seclusion areas, but these are not frequently used.

The staff emphasised the usefulness and importance of various factors in the clinic's practice:

- the availability of Maori cultural advisers (komatua) on site. Advisers helped to lower tension, provided valuable diagnostic assistance to the resident psychiatrists and helped to reduce isolation and promoted integration with families. Without their help and knowledge, there would be resistance to medication, longer delays in response to treatment and more violence;

- the importance of active positive role modelling and mentoring for inmates. The recreation officer was one such person who played a very useful role;

- the use of group/extended family counselling sessions. This helped in providing care and led to greater understanding of individual problems.

Difficulties still encountered by the clinic in its work include:

- the fact that there are not enough beds in the forensic system to handle all mentally ill offenders;

- prisons still have very inadequate facilities to deal with inmates with mental health problems;

- there is no tailor-made system for sex offenders in New Zealand;

- the quality of community facilities is often also poor, and there is no community forensic team to assist with discharge and rehabilitation.

SYSTEMS FOR THE CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS IN DEVELOPING COUNTRIES

3. COUNTRY CHAPTERS

C. AUSTRALIA

Summary and Overview

The National Mental Health Strategy was agreed by all health ministers in 1992, providing a national strategy for mental health reform for the first time in Australia. The strategy has provided a framework and direction that has maintained an agreed focus across Commonwealth, state and territory jurisdictions.

Strengths of the Australian system

Through a genuinely national approach, health ministers have set the context for unprecedented cooperation to improve policy and service responses through sharing of information, trialling innovative service initiatives (eg coordinated care trials) and developing nationally consistent approaches (eg multi purpose services). Since 1992, substantial changes have occurred in the delivery of mental health services across Australia.

The main positive change is a gradual communitisation of mental health care. Changes in public mental health service mix have resulted in:

(i) a reduced reliance on stand-alone psychiatric hospitals: nearly two-thirds of acute psychiatric beds were located in general hospitals by 1995/96, and this total is sure to have risen further since then;

(ii) an expanded delivery of community-based care integrated with inpatient care: an overall reduction of 36% in psychiatric beds from mid-1993 to mid-1996, while spending on community mental health has risen from $18 to $27 per capita. This appears (at least in Victoria) to have taken place without an increase in re-admission rates;

(iii) mainstreamed mental health services with other components of health care. The resources previously invested in specialist psychiatric hospitals are being progressively transferred to community-based services and general hospitals. Only 35% of the total national mental health budget is now spent in psychiatric hospitals - a situation which contrasts markedly with a country such as Singapore, which is still heavily reliant on institutional MH care.

A couple of cautionary notes need to be sounded. First, while the *location* of services has changed, in practice many of the same types of (unresponsive) care are still being offered. Critics of the established psychiatric system would say the same service is being delivered -just in a different location - and that service is still experienced by some going through the system as damaging. Second, in any event, some 'community' spending in fact takes place in hospital ambulatory care facilities and so is not genuinely spent 'in the community' (eg on mobile crisis/assessment teams and in people's own homes).

Besides structural reform of mental health services, other positive aspects of the Australian system include:

- improved consumer and carer participation in decision-making and advocacy. A National Community Advisory Group on Mental Health and state/territory consumer advisory groups have been established to advise on the implementation of the national strategy and, importantly, participating mental health clients has been supported through training programmes, etc;

- better data collection, accountability and monitoring mechanisms, eg a series of annual National Mental Health Reports are now being published; targets and performance indicators are being developed and the optimum use of specialist medical workforce in psychiatry has been examined;

- improved linkages between governments, sectors and external agencies, in particular working towards improved links with housing and disability sectors;

- identification, development and trialing of innovative service and funding models eg the development of funding models across the full pathway of care, from inpatient to community care, and better service models for indigenous people and people living in remote and rural communities.

Weaknesses

There is substantial evidence that the burden of mental illness on Australian society is growing: a 1997 ABS survey revealed that one in five adult Australians met the criteria for a mental disorder in the previous year. But only 38% of people with a mental disorder had used health services. This points to a large unmet need for mental health services. The low usage rate may be because using the service is not experienced positively by users and carries enormous social stigma.

Although staff usage plans, targets and performance indicators are being developed (in itself, excellent), it is not clear whose agenda - health professionals, eg doctors, nurses, etc, family members or users of the service - is determining the choice of data being collected and targets for monitoring.

Despite a good strategy and targeted plans, service improvement has been patchy. In particular, the rather vague priority the first plan gave to services for the most severely mentally ill meant that people with less 'serious' conditions were often excluded. Care and treatment for groups with high level, but not *top,* priority needs to be addressed. The second plan aims to do this.

C1 The Strategic Framework

C1.1 The national Mental Health Strategy

In 1992, a National Mental Health Strategy was endorsed by all Australian health ministers, with users, carers and service providers having been consulted. This strategy provided a direction and national agenda for mental health policy and reform for the first time in Australia. Three documents, plus a schedule within the Commonwealth/state Medicare agreement for the period 1993/98, were agreed: a Mental Health Statement of Rights and Responsibilities (1991); the National Mental Health Policy (1992) and the National Mental Health Plan (1992).

Probably the most important aspect of this process is that the policy has been fully agreed by states and territories, and a collaborative framework has been established to assist the states in delivering the strategy's objectives. The goal was to generalise the policy direction recommended in the Richmond report to all states and provide transitional funding through the accompanying National Mental Health Strategy to shift services from institutions to local communities.

There was a strong emphasis in the 1992 strategy on ensuring accessibility of services and on promoting the mental health of the Australian community and assuring the rights of people with mental disorders. Specialist mental health services were to be community based and 'mainstreamed', ie integrated with, and accessible through, general health services. Strong links were to be formed with groups of consumers, families, GPs and NGOs, as well as other local services such as housing, disability services, social security and employment.

Nevertheless, from the viewpoint of users of mental health services, some feel that these 'rights' have not been implemented, eg a person's right for respect (rather than simply to 'treatment' and medication) versus a doctor's right to treat someone as they see fit. The 'strong links' desired with users may be seen merely as politically motivated tokenism, rather than a genuine desire to tailor services to what users themselves actually say they want.

The 1992 policy document noted that health surveys suggest that one in five Australians will at some point in their lives experience significant disruption to their mental health and quality of life. Furthermore, at *any* point in time, 3%-4% of Australians will experience severe mental disorders, which will significantly interfere with their ability to participate in community life. This sort of figure is common to much of the developed world and may relate to 'stress' encountered by people living in modern, capitalist societies. In any event, ministers are clear that the shift to community-based care means that only a small fraction of those with mental disorders need to spend extended periods in psychiatric hospitals.

The policy stance was - and still is - community focused. The 1992 Policy stated that, while the former institutional approach enabled a person's needs to be met relatively conveniently in one place, this was often at the cost of the individual's quality of life. It accepted that closing or reducing large psychiatric hospitals and replacing them with suitable services in community settings would be complex and contentious. It noted that the challenge of responding to a person's 'whole-of-life' needs in a community setting, while maintaining continuity of care, raised new questions, which revolved around two main issues:

- service mix and, in particular, the need for psychiatric inpatient care: what mix of inpatient psychiatric care and community mental health services should be provided and what were the extent, and needs, of those who would require ongoing institutional care?

- the relationship between mental health and other services: how should specialist mental health services relate to general health and other community-based services to ensure mental health service clients' housing, income support and employment needs are met?

C1.2 Principles guiding mental health policy

The policy principles applying to the Australian health care system (see Annex A) apply to mental health. In addition, a more detailed set of principles has been framed for mental health, which are worth spelling out in detail. These are:

- services should be provided in a multi-faceted and multidisciplinary manner;

- positive consumer outcomes are the first priority in mental health policy and service delivery. Priority should be given to those with severe mental health problems and mental disorders;

- the stigma attaching to mental illness is undesirable, and people with a mental disorder should have the same rights as others in the community, and in view of their potential for personal growth, the right to opportunities to support it;

- mental health service systems should be responsive to the varying needs of particular groups in the community. The quality and effectiveness of services are enhanced if they are responsive to consumers and communities and if avenues are created for individuals/families to participate in decision-making;

- all providers should receive appropriate support and training as positive outcomes depend on informed and well-trained mental health staff and strong support from carers and advocates.

Arising out of these principles, policies were framed in the areas of the relationship between mental health services and the general health sector: linking mental health with other sectors; service mix; promotion and prevention; primary care services; research and evaluation; consumer rights; standards; monitoring and accountability. The first two areas are of most interest in this context. Regarding the link between mental health and the general health sector, three points stand out:

- the policy calls for an "integrated mental health programme" covering the full range of mental health services in each region or area, so there is continuity of care and a balanced mix of services;

- second, it says that mental health financing should be incorporated into general health financing arrangements, rather than remaining separate. This (slightly untypical view) is then modified by saying that mental health resources should remain "identifiable" and be allocated through a mental health programme. How this differs from a separate budget, within the health portfolio, is not clear;

- third, it recommends a continuity of care provider across inpatient and community settings and the use of case management where a single person is responsible for the overall coordination of a person's care across various agencies. This can include budget or fundholding, where the programme manager has responsibility for purchasing services for the client.

Regarding the link with other sectors, the policy notes that the separatist model of mental health care has often led to (sometimes subtle) discrimination against people with a severe mental health problem and, in some cases, people with these problems have been excluded from mainstream services altogether. It therefore encourages inter-agency links and service arrangements at the local and area/regional level to ensure proper access for people with mental health disorders.

C1.3 Elaboration and refinement of the strategy

The Second National Mental Health Plan issued in July 1998, builds on the 1992 plan and aims to consolidate existing reform activity and expand into new areas of reform. Primarily it seeks to influence broader health and welfare agendas through the development of inter-sectoral and intra-sectoral links and through partnerships and collaboration with consumers of services, carers and providers.

This second plan provides a five-year framework (1998-2003) for activity at the national and state/territory levels. In the 1997/98 Budget, the Commonwealth Government committed $28 million for three years (from July 1998) for the renewed strategy. A total of $300 million over 5 years has been made available for mental health activity, of which the bulk - $250 million - will be allocated to states on a per capita basis to states and territories for continued service reform. The rest ($50 million) will be made available for two main tasks: first, to develop and implement empirical measures (consumer outcome measurement, a national case mix classification system and service quality indicators) and, second, to enhance the integration and coordination of public and private mental health services.

The plan identifies further priority areas for reform within 3 key themes:

- promotion and prevention of emotional and social well-being, defined as action to maximise mental health and well-being among populations and individuals. The aim is to undertake joint planning with the national Public Health Partnerships to ensure mental health promotion activity is not marginalised. Strategies will aim at reducing the incidence of illness and suicide, as well as building resilience and enhancing coping mechanisms for dealing with lifetime stresses. Projects include projects in educational settings (healthy schools, anti-bullying and protective behaviours campaigns); and life programmes such as improving parenting skills, preparing for retirement and healthy aging;

- partnerships in service reform. This element of the plan recognises - correctly - that consumers of services should have a key role in planning and evaluating the services they use. It aims to entrench partnership arrangements at both the system and service levels through policies, procedures, protocols and funding. A wide range of partnerships are envisaged, including between: consumers, carers and families; GPs; private psychiatrists and others in the private sector; emergency services; the wider health sector; other government services, non-government agencies; community support services and the broader community. Access to disability support services and services in rural/remote areas are recognised as areas where much more work needs to be done;

- the quality and effectiveness of service delivery. This element focuses on the impact of the system on outcomes for consumers and carers. The main components of action are identifying and agreeing on standards for service delivery and clinical practice; establishing benchmarks and models of best practice - including the availability of community-based care, extended care and respite care options as an alternative to hospital admission; the use of evidence-based practice methodologies, as well as education and training of staff to deliver services in new ways.

C1.4 Roles and responsibilities of Australian agencies

Services for people with mental health problems are provided through a range of health and welfare programmes funded by Commonwealth, state and territory governments, private health insurance and individual co-payments. In the health sector, mental health services provide treatment and support services in inpatient and community settings. Housing, disability support, employment and income security services are funded under other Government programmes.

The Commonwealth influences service delivery by setting policy orientations, for example through the National Mental Health Strategy. This arrangement has been formalised in recent years through the Australian Health Ministers Conference (AHMAC), which has sought consensus about policy programmes, and through binding Commonwealth/states agreements (Schedule F of Medicare agreement) with national (tax-financed) funds set aside for implementing the agreement.

The National Mental Health Strategy has enjoyed bi-partisan support even through a period of change of government, although the funding has been wound back in recent years. The strategy brings together work which could be described as setting the framework within which states and regions operate, including:

- developing national mental health standards to be implemented through independent national accreditation bodies;
- compiling national data sets and reports comparing mental health provision and performance across the country;
- undertaking national studies and projects, eg developing a mental health treatment classification for use for possible use for case-mix funding, evaluating outcome measures and promoting national networks and training;
- a range of awareness campaigns, setting up advisory groups and encouraging prevention and early intervention, etc.

State governments retain responsibility, through their health departments, for organising all their own health services and facilities on the ground, including mental health services. Consequently, such provision is pretty diverse. States usually have explicit state mental health policies, which form a blueprint for service development. The Mental Health Directorates in some states, such as Victoria - see Best Practice Example 2, below - have a high level of top-down control and close regulation of regional services. In others, such as New South Wales, the Directorate has more of a quasi-Federal policy direction function as administrative control of mental health services has been devolved to the area health services (semi-independent business units managing all health services for populations up to 750,000).

At state level, there are positive and negative features of these different models. The fact that a strong mental health directorate never developed in NSW meant that innovation could come up from the service level. By contrast, Victoria's historically strong central control meant that services could be re-oriented on the ground, for example in response to the national strategy in a systematic fashion, with resources retained for mental health services.

Though services and policy are generally less developed in the less-populous states (eg Northern Territory, Tasmania and Western Australia), these states have contributed to improved services through developing innovative multicultural services, involving consumers and developing remote interactive teleconferencing. The Victoria-NSW differences may have parallels to, and implications for, those that exist between Scotland and England. For example, the Scots have had institutionally-based health services for much longer.

C1.5 Financing arrangements and accountability mechanisms

Spending on mental health services rose by a quarter between 1992/93, and 1995/96, partly as a result of the implementation of the National Mental Health Strategy. Commonwealth spending has increased fastest in percentage terms to around $250 million in 1996, bringing its share of spending up to around one-third of total national spending. Within the total, spending on community-based services has risen most (by 75% between 1992/93 and 1996/97), although much of this is due to an increase in spending on 'ambulatory' services provided in hospitals or clinics. Whether this can be properly termed 'community-based' care is debatable.

Nevertheless, the Australian inpatient census peaked in 1962, and spending on specialist psychiatric hospitals has fallen significantly: the number of public sector psychiatric beds has fallen by 20% (by 1,623 beds) and inpatient bed-days have fallen by a similar magnitude just since the new strategy was announced.

There has been a resource redistribution from state-managed separate psychiatric institutions to new services in most states. The (alleged) 'leakage' of mental health resources before the new strategy was put in place in 1992 led to resources released from the institutional closure programme being tied to the development of replacement resources. Also, significant new funds ($190 million over 5 years) have been committed on top of the redistributed funds to allow further growth of non-stand-alone psychiatric services.

Funding mechanisms

State-funded specialised mental health services are largely funded through grants based on the previous year's level of funding. Evidently, such funding arrangements contain no mechanisms to link funding to performance or efficiency. One State - Victoria - funds specialised mental health services on the basis of unit costs, ie number of beds available and staff employed. The state is keen to keep a ring-fenced budget for mental health provision and would like to move towards more efficient and outcome-focused measures.

Victoria is looking to introduce a Quality Incentive Strategy, where providers would be paid more if they did 'better', using carer/consumer satisfaction surveys, the quality of care to minority groups and provision of timely management reports, etc. But they are aware that the move to funding providers on the basis of, for example, occupancy rather than availability could create a perverse incentive to institutionalise or medicalise care.

Three states and territories fund acute inpatient services on a case mix basis (Australian DRGs). Under these case mix funding arrangements, providers are funded according to the number and type of patients treated. This has the potential to promote efficiency and equity by rewarding more complex care and providing incentives to reduce lengths of stay in hospital, although this is balanced by dangers associated with premature discharge.

However, this system can still be criticised as output, rather than outcome-based. Also, where the use of case mix is confined to acute inpatient care, and community-based services are still funded on a block grant basis, a systemic incentive will exist to admit patients to hospital where they attract per capita funding. This is contrary to the policy objective of the national mental health policy. The Commonwealth has therefore put a lot of work into developing a case mix classification and funding basis for mental health services.

C1.6 Service delivery models

The National Strategy advocates the reduction and replacement of separate psychiatric hospitals with a mix of general hospital, residential, community treatment and other support services. In line with other developed countries, a continuing role for a much reduced number of separate hospitals is envisaged - limited to specialist care for that small number of people who are unable to maintain their quality of life in less restrictive settings.

The number of public psychiatric beds has reduced, but reductions have not been uniform across states. Between 1992/93 and 1996/97, the two most populous states (accounting for around 55% of the population) - Victoria and New South Wales (NSW) - together account for 80% of the total drop of inpatient beds. Victoria has reduced beds roughly twice as fast as NSW (by 1,067 and 627 beds respectively), while the more rural states have reduced inpatient beds the least - and Western Australia has actually increased total bed numbers.

In June 1997, the number of beds located in stand-alone psychiatric institutions accounted for 55% of total inpatient beds, compared to nearly 75% four years before, with the proportion of mental health spending on stand-alone hospitals falling from 50% to just over 30% over the same period. In June 1997, 1,240 acute beds remained located in separate psychiatric hospitals. Transfer of these remaining beds into mainstream provision depends on capital funding being made available to expand and improve existing units on general hospital sites.

There seems to be an emerging state/territory consensus for a public acute bed provision of 20 per 100,000 population, but no clear consensus exists on the provision of non-acute beds. Practice in the latter area depends crucially on the availability of alternative services that substitute for longer-term inpatient services, eg 24-hour staffed residential beds.

C2 Broad policy debates

States are wrestling with how to coordinate community health services, home and community care (HACC) services, the district nursing service and traditional meals-on-wheels type services. In many ways, the biggest problem for states is how to link up in financial and organisational terms with GPs since states do not control primary care funding. The aim is to develop a model of shared care whereby once people are through the acute phase of their mental health episode, they can then either be referred to a GP or to a private psychiatrist.

C2.1 Boundaries of care: psycho-geriatrics - aged care in mental health?

The treatment of people who are both old and deemed to require mental health services is unsatisfactory. The problem here is that most aged care facilities do not accept the mentally ill elderly - service providers want to keep people with mental health problems in a psychiatric 'box'. State mental health services define their client group as being between 18 and 65 years of age, while the aged care service only accepts people over 70 years of age. The Commonwealth has traditionally considered the mentally ill as out of their competence and is resistant to accepting mentally ill people in nursing homes.

This problem is mainly the result of the division of responsibilities between the Commonwealth and states. Since there are stricter controls over the aged care system - and, particularly, residential homes - than the health system, people with mental health problems tend to end up in health settings. However, in South Australia, in recognition that acute care for the aged has not been handled well, they plan to divide services for the aged into mainstream medical, mental health and co-morbid units.

C2.2 Outcome-based funding measures

The state of Victoria has given some thought to how to move towards outcome-based funding. In order to move from inpatient to community-based treatment capacity, Victoria has decided to move from funding bed availability towards funding bed occupancy. But this gives providers an incentive to admit people in order to secure funding and raises the more general issue of how do you pay for care that can be over-provided?

The Victorian answer is to have a strategy to incentivise quality by paying providers more if they perform 'better'. This strategy is now in the third year and includes questions asking about: consumer/carer satisfaction; care provided to marginalised groups and ethnic minorities and timeliness of reporting data.

C3 Examples of good practice

Example 1: North Shore Community Mental Health Service, Sydney

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The Royal North Shore Hospital & Community Mental Health Service (RNSMHS) attempts to provide integrated care for people with mental health problems, people with intellectual disabilities and the elderly on the North Shore in Sydney. It is an innovative service - they were the first community-based service in Australia to offer 24-hour care in 1979 and still provide a 24-hour community-based alternative to hospital-centred care.

Services provided include assertive case management of mental health clients, 24-hour supervised residential services, outreach services, rehabilitation as well as vocational programmes (workshops) and a cafe on the same site. The key innovation by RNSMHS is the espousal of an integrated and active mental health case management system. The organisation's philosophy is to draw all the fragments of services and resources in the community into a system and safety net *around the service user.* Or, in their words "to recreate asylum, in the best sense in the community; that is, a haven of safety and a harbour from which to set out again" (Rosen, Australian Hospital Association Management Issues Paper No 4, 1994).

RNSMHS operate under the assumption that effective management of severe psychiatric disabilities requires local comprehensive service systems with the following features:

- a unified management;
- integrated 24-hour community and hospital care;
- continuity through all phases of care from assessment, acute treatment, rehabilitation and follow-up;
- an active involvement of service users and their families.

Case management is seen as the cornerstone of an integrated mental health service. Because all the other building blocks of a comprehensive service depend on it to integrate the services required into one coherent local system.

The most interesting feature of this comprehensive care model (described in more detail in the mental health section of the Issues Chapter) is the use of intensive mobile case management teams. These teams work with individuals isolated on the brink of homelessness, or actually homeless people, with the combination of psychosis and severe substance abuse, and those in too poor a state to take the necessary medication. RNSMHS intensive teams work in a ratio of one to ten, often backed up by 24-hour crisis services. The organisation attempts to limit caseload sizes - one caseworker may only have around a dozen clients - because care recipients have complex needs and often cannot or will not access existing clinical and welfare services. Caseworkers will not only provide help with recovery, but will assist with tasks of daily living (shopping, etc), which helps to form a bond of trust with clients.

With residential care, the organisation has opened up congregate settings and provided care to people who have moved back into their own homes, backed by a 'graduate' network of people who have used mental health services.

Example 2: The State of Victoria's Mental Health Service

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The state of Victoria has an impressive developing community-based mental health system and strategy. A five-year plan for service redevelopment and the establishment of a comprehensive network of services across Victoria was set out in the 1994 policy document *Victoria's Mental Health Service: The Framework for Service Delivery.* This policy framework initiated major mental health reform in Victoria, including the mainstreaming and re-development of services along with a significant expansion of community-based services.

Strategy, administration and policy direction

Victoria's Aged, Community and Mental Health (ACMH) Division within the Department of Human Services is responsible for purchasing a range of services to improve the well-being and mental health of Victoria's residents. The Division has responsibility for the elderly, primary care and mental health, though it is working towards two output groups - primary and community health care and mental health. It has a budget of $1.2 billion in 1998/99 - a fifth of the Department's budget. By unifying these three areas and bringing together most primary health services provided by the Department of Human Services, this:

- provides a single point of responsibility for initiatives to develop models of coordinated care;
- reduces the number of interfaces between divisions on health-related issues;
- enables better integration of policies, including a common approach to purchasing across the non-acute health field;
- combines existing programmes with similar ways of operating, consistent objectives and client overlaps.

ACMH outputs are administered through three programme branches and sub-branches (eg within the Mental Health Branch there are 5 sub-branches: adult, child & adolescent, aged and forensic mental health services, plus psychiatric disability support services) and through nine regions (4 metropolitan & 5 rural). Programme branches are responsible for programme development, strategic programme directions and the overall service purchasing framework. Regional offices are responsible for regional planning, contract management and monitoring.

What makes Victoria particularly interesting is that within the last five years there have been fundamental reforms to the financial management of Victoria's health care resources and the way health services are provided to the community. In line with Government strategy, the ACMH Division has separated its policy, regulation and contract management functions from operational service delivery. From 1 July 1998, all major ACMH services are delivered by external providers.

There has also been a dramatic shift in the way ACMH services are purchased. The traditional funding approach based on inputs (eg salaries and historical budget levels) is progressively being replaced by a system that funds services according to the number and type of their outputs. In 1998/99, the Division will begin work on a comprehensive performance management framework. This will assess organisational financial position; document the level and type of services being delivered; assess the health status of consumers; measure customer satisfaction and measure compliance with contracted responsibilities. This framework will streamline agencies' reporting and will form the basis of management reports to the ACMH Executive.

Mental health policy goals and initiatives

1998/99 is the end of the initial five-year reform plan for mental health services. Major redevelopments in mental health services include the development of local area mental health services (see Part IV - Issues Section - of this report for discussion of catchment areas), replacing large isolated institutional facilities. The second phase strategy in Victoria will parallel the development of the Second National Mental Health Plan. Future priorities in both the National and Victorian strategies will include:

- developing strategic partnerships with primary health and other key services in the Government, private and community sectors;
- strengthening prevention and early intervention services, particularly for those at high risk;
- improving service responses to all mental disorders, including the development of more effective responses to depression;
- improving the quality and effectiveness of existing services for people with serious mental illness;
- ensuring that the most vulnerable client groups receive appropriate care, treatment and protection.

Victoria has been at the forefront of implementing the National Strategy. Health Service agreements on prices and volumes (outputs) of services have been in place since 1989. Monitoring occurs on the basis of a set of performance indicators: the 1998/99 Business Plan lists 23 'Key Tasks' for mental health services under six headings: quality improvement; research/evaluation; service development, integration and linkages; customer service; planning, purchasing and monitoring and legislation. Under integration and linkages, the key tasks are to:

- improve service responses;
- develop and implement a strategy for improved and integrated service delivery to joint clients of mental health, protection/care and drug treatment services;
- provide input into the Victorian Women's Health Plan;
- strengthen linkages between specialist mental health services and primary health care providers;
- strengthen consultancy services provided by public mental health services to improve early identification and treatment of people at risk of mental illness.

In the last two areas, work is focusing (as elsewhere) on improving the skills of GP's and other key primary care providers in identifying and responding to people experiencing depression and other forms of mental illness. $360,000 per annum has been allocated to a mental health/drug abuse dual diagnosis project. With key staff now in place, the team is focusing on the development and trials of best practice models and establishing collaborative links between the two services.

Comparisons between local services are published quarterly. Key indicators used in Victoria include: caseload and cost per full-time equivalent staff member, contact hours per client per month, involvement of extended hours crisis services and involuntary care, as well as inpatient utilisation data.

Service provision

The state is divided into 22 catchment areas, each with hospital facilities and access to secure extended care beds and ambulatory facilities. Services are organised into three points of access:

- the Crisis and Assessment team (CAT) - with a psychiatrist, social workers, psychiatric nurses or allied health professionals - usually based near a hospital will visit and assess someone in need of help. After the assessment, options range from hospital admission, respite care for 1 or 2 nights, help to stay in a residential facility or in their own home or assistance with finding somewhere else to stay;
- the Community Mental Health (CMH) team, who are usually based in a

stand-alone clinic with good access for the general public. They undertake case management (around 20 people per worker) and provide clinical support, consultancy services and do medication and treatment reviews;

- the Mobile Support and Treatment (MST) team provide the outreach services to the community that the CMH team cannot provide.

Five years ago Victoria ran a 750-bed mental hospital, but now all patients have either been transferred to an acute medical hospital or into the community, and non-acute services have been re-shaped. The state estimates that it requires 20 acute beds/100,000 population, together with secure extended care units (90 beds at the moment). All non-acute patients are treated off hospital sites, in a range of residential sites (20-bed town-house developments) with decreasing levels of support. Non-acute respite care is provided to 'triage' people out of nursing homes.

On the basis that CATs and CMH teams have cut acute lengths of stay from an average of 30 to 12 days, Victoria has recently allocated a further $8 million to expand the staffing complement in CATs to allow them to operate 24 hours a day - with 5 workers on a 24-hour shift. Currently, the state finds that 10% of the client group (typically with diagnoses of schizophrenia) represent 40% of admissions.

Housing

The state has put resources into housing programmes, recognising that the mentally ill often fall through service nets and end up poorly (if at all) housed. The Victorian Housing Department has allocated $30 million for places in public housing, and the Mental Health department arranges for care support. There is a need, though for more accessible and affordable general housing. Congregate housing and supported residential services are still provided, but new housing options include housing with on-call cover (no 24-hour support) through a psychosocial support unit and 1-2 bedroom public housing with visitor and support arrangements.

Example 3: Wintringham - Services for the Homeless, Melbourne

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Wintringham is a highly innovative award-winning niche social services provider operating in and around Melbourne in the state of Victoria. It is one of the very few specialised agencies of its kind in Australia and has developed a range of integrated housing, community care and outreach programmes for the elderly poor in the Southern and Western Metro regions of Melbourne. Wintringham has been instrumental in getting the needs of the elderly homeless on the agenda of Government and community decision-makers and representative bodies.

The organisation was started in 1989 by Bryan Lipmann as an independent non-profit, non-religious organisation with the primary aim of providing high quality care and affordable accommodation to frail elderly homeless men and women and those at risk of becoming homeless. It now employs around 100 staff (50 FTEs); has about A$18 million invested in housing and provides services to almost 300 residents in three hostels, apartments and independent living units.

The idea of a new company to specialise in aged care services for homeless people won strong support in the late 1980s from the Federal Government, who provided funds for three hostels. The organisation now provides permanent accommodation for the people the aged care system has not been able to service, eg people from the streets, night shelters and boarding and rooming houses.

Principles and aims

Wintringham is a good example of an independent value-driven organisation motivated by ideals of social justice to bring a vision of decent housing for the elderly homeless into reality. Its founder - Bryan Lipmann - became aware of the plight of the elderly homeless through his work at a Melbourne night shelter. Like all large cities, Melbourne has a significant population of homeless people who have been traditionally housed in rooming houses, cheap hotels or night shelters, that are often places of violence and intimidation.

Wintringham was started because elderly homeless people were not getting access to mainstream aged care services, and on the rare occasions where they were referred to nursing homes, etc, the environment was so alien that former night shelter residents did not stay for long. Since the elderly homeless were not being served by established aged care organisations, Mr Lipmann decided to set up an organisation that would provide better services for the homeless. Wintringham emphasises that people who are both elderly and homeless should be treated as elderly first and homeless second, rather than categorised as 'homeless'.

Wintringham is an example of a specialised agency catering to the needs of a specific group, but with a clear focus on each person as an individual. Its annual report states that Wintringham is "founded on the social justice principles of 'options', 'rights' and 'dignity' - all our services aim to maintain and enhance independence and dignity, whilst offering clients lifestyle preferences of their choice". Specifically, the organisation aims to ensure that:

- the dignity of older people is protected and, where possible, enhanced;
- aged people are encouraged to attain their optimum level of independence and to exercise informed personal choices so that their emotional, physical, spiritual, social and cultural needs are met;
- residents come first: each individual's identity, beliefs and choices are acknowledged and respected - service users are treated fairly and equitably.

Services and programmes

Wintringham operates residential care, housing and community care programmes. It has three residential care facilities with a total of 129 beds: McLean Lodge, a 34-place facility in Flemington; Wintringham Hostel, a 60-place facility in Williamstown and a *Hostel in Port Melbourne* with 35 places (see below for details).

The housing component comprises 48 independent living units at Lionsville, adjacent to the Williamstown Hostel; a 40-bed Community Housing programme in Melbourne's Central Business District and 20 one-bedroom apartments at Kensington Banks. The community care programme consists of two outreach projects funded under the Commonwealth's Assistance with Care and Housing for the Aged (ACHA) programme and 30 housing-linked care packages in the city of Port Philip.

In addition to these services, Wintringham is involved in a variety of forums that seek to widen and improve the access to housing and community services for elderly homeless people or people at risk of becoming homeless.

Wintringham at work - The Port Melbourne Hostel

The Port Melbourne Hostel comprises bungalow-style accommodation in landscaped surroundings and care services for 35 frail men and women aged 50 years and over, who were formerly living on the streets or in temporary housing. The hostel was opened in July 1996 on disused railway land, now reclaimed for housing.

The hostel is a high quality timber design and consists of six cottages set within handsome landscaped gardens with administrative and staff accommodation on site. Apart from the private staff areas, the entire complex is on a single level with interest created by raised and sunken garden, fountains and water beds. The attractiveness and thought which has gone into the design of the facility (by Allen Kong architects) - which would not disgrace a 4-star hotel - has been recognised by the award of a 1998 World Habitat Award. This annual award was initiated in 1987 (the International Year of Shelter) by Britain's Building and Social Housing Foundation to identify, recognise and promote innovative and replicable solutions to housing problems. Wintringham is the first Australian winner of the award.

Accommodation

Each of the bungalows houses 5, 6 or 7 residents, with each house having its own lounge and dining area, fully-equipped kitchen and laundry. Residents have their own fully-furnished room with a personal shower and toilet. All rooms face onto a private verandah, which gives each resident additional private space. A part-time house carer is responsible for purchasing and preparing meals for the residents in one cottage, which allows individual likes and dislikes to be catered for in a way that would be impossible with a central dining room and kitchen, and is available for support and assistance to the residents. One of the cottages accommodates residents with dementia, but if they require full-time nursing care, they will have to move on to specialist nursing accommodation.

Cluster-style accommodation is favoured because of the small-scale, homelike and non-institutional image that is created. The design enables residents to live independently and to socialise, if they wish, with other residents. The exterior space is divided into courtyards linked along a central path with each courtyard having a distinctive landscaping theme. All parts of the hostel are accessible by wheelchair. The weather has been allowed for with wide verandahs, cross ventilation, ceiling fans and landscaping all providing cooling air in the summer.

Care services

Residents are required to be assessed by a Commonwealth Aged Care Assessment Team prior to entry. One place is reserved for people needing short term, respite care. Care services are flexible and tailored to the needs of each resident. Independence is promoted through everyday activities and a structured recreation programme designed on an individual basis. In practice, many of the residents choose to live pretty independently and rules are kept to a minimum. Besides accommodation, a wide range of services are available, depending on need, including:

- all meals and refreshments;
- cleaning and maintenance;
- linen;
- laundry services;
- assistance with daily living activities;
- help with medication and treatments;
- access to a range of health services, including podiatry, physiotherapy and nursing care;
- assistance with financial and legal matters;
- leisure and recreation opportunities.

Funding issues

The project was funded by a combination of Federal and state governments. Despite its innovative design and use of good materials, the project was pretty cost-effective, with costs at the low end of the cost spectrum for this type of housing. The total construction cost - met by the Federal Government - was A$2.3 million (US$1.86 million), equivalent to a little over US$50,000 per bed. This compares to costs elsewhere, which can often be as high as US$80,000 per bed. The land cost a further US$625,000, which was paid by the state government.

The use of standard domestic construction techniques, rather than commercial construction methods, helped to reduce costs. The use of verandahs as circulation space meant that less internal area was required in each bungalow. Many design elements perform multiple roles, eg balustrades and retaining walls provide a discreet continuous handrail to assist passage, and the fact that all bungalows face onto the common space makes premises more accessible and reduces the need for security features.

The costs of running the hostel are funded by the state, in the same way as other hostels. Resident fees are kept as low as possible to maximise residents' disposable income. The rent charged (for both accommodation and care services) is 75 per cent of the state pension received by the residents, which is 10% lower than that charged in other hostels. Fees are charged for some outreach and community care services provided by Wintringham or other providers, but only after negotiation with each person that takes into account income and living expenses. No-one is denied help because of their inability to pay.

Comment

I visited the Port Melbourne Hostel and was impressed by the client-focus and dedication of the staff. The fact that accommodation of the standard provided by Wintringham's projects can be provided at a cost of a little over US$50,000 per bedspace is heartening in an age when cost pressures on public funders have not abated. For the frail elderly who do not need constant nursing care, this model seems to be very popular with residents and is preferable to the institutional settings seen elsewhere.

ANNEX 1: A BRIEF DESCRIPTION OF AUSTRALIA'S HEALTH SYSTEM

The overall health system

The Australian health system is a mixed public and private system. Public hospital and most out-of-hospital medical services are covered by universal tax-payer funded health insurance; private hospital and a range of non-medical out-of-hospital services are funded through private health insurance or other sources of funding such as workers compensation insurance or individual co-payments. Under the Government-funded health insurance system, all Australians are eligible to be treated in public hospitals free of charge and to receive rebates on private medical practitioners consultations. 30% of the population have private medical insurance.

Total (capital and current) spending on health in Australia was A$41.7 billion in 1995/96 - 8.5% of GDP. Health expenditure has grown in absolute terms and as a percentage of GDP compared to 10 years ago, although over most of the decade spending has been stable as a percentage of GDP: spending grew from 7.8% in 1989/90 to 8.6% in 1991/92 and has been stable at 8.5% since 1993/94.

Funding for health service provision is shared between the Commonwealth, state, territory & local governments and the private sector. In 1995/96, the funding breakdown was:

- Commonwealth: $13.4 billion (34%)
- state, territory & local: $13.1 billion (34%)
- Private health insurance: $ 4.4 billion (11%)
- Other non-government sources: $ 8.0 billion (21%)

Policy principles

Five key principles guide the operation of the Australian health-care system:

- universal access to health care, which will guide the level, mix and distribution of services to individuals;

- provision of high quality care, commensurate with other developed countries;

- equitable financing, with people paying for care according to their means;

- a mixed (public and private) delivery and financing system (though the equity and universal access principles require a strong role for government in funding, planning and regulating health care);

- accountability for the allocation of resources and a focus on efficiency.

Mental health care

A brief history

Mental health provision dates back to a small institution for the 'insane', which opened in New South Wales in 1811. Over the next 80 years, a further dozen 'asylums' were built - most between 1860 and 1890. Up until the 1960s, the history of mental health services follows the pattern elsewhere in the developed world, with many more institutions opening and the growth of private psychiatric provision. An Australian feature (as in New Zealand with the Maori people) is the disproportionate number of aboriginal people kept in mental institutions.

The trend towards de-institutionalisation gathered pace in the 1960s on the basis of scandals and enquiries as well as renewed clinical optimism, fuller employment and changing social attitudes. But, as elsewhere, mental health services and resources did not follow their patients into the community, eg although by the mid-1980s 90% of people with severe mental illness were living in the community, 90% of public mental health staff and funding were retained in hospitals (Rosen, Parker et al, 1997). The division of inpatients with severe illness between psychiatric hospitals and general hospital units followed much the same path as in the UK - most stayed in designated psychiatric institutions.

By the 1980s, Australia developed a substantial private medical sector, funded by private health-insurance schemes and national taxes through the Health Insurance Commission. There was a parallel growth in private psychiatric inpatient beds and private psychiatrist practices, which were moving 'upmarket' to deal increasingly with less severe disorders and the demand for psychotherapy.

In the early 1970s, the Australian Assistance Plan set up some community health teams across the country. But these were often idealistically focused on primary prevention and offered generic, rather than specialist, services on a traditional office hours basis. In 1983 in New South Wales, David Richmond was commissioned to report on the availability of community services and recommended a gradual shift of services to community settings. With up-front funding, 24-hour mobile community mental health services were established in some localities in the mid to late 1980s. For more details on the development of Australian mental health services and system, see the chapter on Australia by Professor Alan Rosen in Thomeycroft & Tanzella, 1999.

Mental health funding

In 1995/96, spending on mental health services was $1.96 billion, 6.3% of total health spending. State and territories funding is more important in mental health. The breakdown is: Commonwealth own-purpose outlays: $660 million (34%); state and territory governments: $1,160 million (59%) and private sector: $143 million (7%).

ANNEX 2: AUSTRALIA'S DEMOGRAPHIC PRESSURES

Like other countries, Australia's older population is growing, not only in absolute terms but also as a proportion of the total population. Today, around 2.2 million Australians - an eighth of the total population - are aged over 65, and 1.5 million of these are over 70.

The Australian Bureau of Statistics estimates that this will double in percentage terms to 5.7 million (23%) by 2041, as a result of both an increasing life span and declining birth rates. As elsewhere, the fastest-growing population group will be the oldest 'old'. As the baby boom generation (born between 1946 and 1965) reach advanced old age, the number of people aged over 85 will increase dramatically from 200,000 today to over 1 million in fifty years time. This represents an average increase in population of 11,000 a year until 2026 and 29,000 a year between 2026 and 2041.

As in the UK, officials have concluded that the costs of Australia's aging society should be manageable. The press and public hyperbole about the aging population 'explosion' and the generation of an associated sense of crisis will be used by politicians to push through reform, although the reality will not be quite as bad. For example, the shift towards compulsory superannuation will reduce the reliance on front-line funding in the longer-term.

Although there is no demographic 'crisis', the aging of Australian society will have cost implications for the Government, community and individuals, mainly associated with ensuring people have adequate retirement incomes and access to appropriate health and long-term care facilities. Population aging is estimated to have added 0.6% a year to real health outlays over the last 20 years - around a fifth of real increase of 3.3% in total health care spending. But this needs to be seen in context - it is well below the 1.4% each accounted for by population growth and demand/expectation factors.

SYSTEMS FOR THE CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS IN DEVELOPED COUNTRIES

3. COUNTRY CHAPTERS

D. SINGAPORE

Summary and Overview

The principles of the mental health care system, as with the wider system, are based on the twin themes of individual responsibility and government subsidy for the needy or those who are unable to provide for themselves. Insurance, assistance and co-payment schemes are designed to allow people to save for health care costs while they are still young and working. Similar to health services for the elderly, Government funding for mental health services includes subvention to hospitals, assistance to VWOs and the Medifund, which provides for those unable to pay even Government subsidised rates, who are treated in public wards.

Singapore's mental health system is still based on a medical model. Hence, it resembles, in design if not in fabric (which is more modern), a European system of 30-40 years ago. It is predominantly institutionally based: the centre piece of the service is the Woodbridge Hospital which, along with private psychiatrists, provides treatment for the 'acutely' ill. Non-institutional provision is pretty limited (see below) and is really limited to the three main dedicated mental health voluntary welfare organisations (SAMH, SAWC and Sunlove) and a few CPN services. The Ministry of Health is reviewing services, and the National Council of Social Services is trying to broaden access to help and advice by educating Family Service Centres and reaching GPs and nurses through the medical associations.

D1 The Strategic Framework

D1.1 The mental health strategy

There is no centre piece Singaporean mental health strategy as in Australia. Instead, there are a series of policy orientations and objectives. The framework for service provision has been adapted from a UK document *Mental Health promotion, a Quality Framework* published in 1997.

The overall care philosophy - as with the broader health system - is meant to be consistent with the WHO's 'Surround With Care' model. The WHO model envisages the client and patient at the heart of the system, surrounded in concentric rings by the family, community and formal care organisations respectively. The aim is therefore to help the individual and family cope with stress through community support (eg family service centres), with hospitals and care institutions seen as a last resort.

There is also a growing emphasis on networking. This has the objective of bringing together community care and geriatric care networks, nursing homes and mental health projects, eg those run by the National Council for Social Services. The aims of networking (see Community Care Network in Best Practice Examples) are to strengthen relationships and partnerships between different organisations, identify service gaps (eg rehabilitation), increase the number and comprehensiveness of services and improve efficiency and effectiveness.

The Government recognises the need to provide a range of different services. For example, recognising that the number of day centre places for dementia sufferers (provided by organisations such as Sunlove and New Horizons) is not likely to keep pace with the predicted tripling of the dementia population over the next 10-20 years, other services are being put in place. These include:

- assessment and stabilisation services;
- family support groups (eg run by the Alzheimer Disease Association);
- teaching and training (eg run by Tsao Foundation);
- residential and respite care options, provided by Voluntary Welfare Organisations, nursing homes, etc.

D1.2 Roles and responsibilities of agencies

Responsibility for care is shared by a number of different agencies and organisations. The main provider and Government agency is the Woodbridge Hospital. This is a large institution and provides the vast majority of inpatient psychiatric care in Singapore: it has 2,880 inpatient beds, of which nearly 2,000 are long-stay beds, and operates at about 85% capacity. The budget is around $60 million with 60 doctors, of whom 45 are psychiatrists.

The accommodation is fairly basic with the vast majority of people receiving treatment staying in 6-10 bedded rooms or in open wards. The most noticeable feature of the institution, besides its size, is the low staff ratio. For the night shift in the long-stay wards (the acute wards have a higher staffing ratio), the staff ratio may be as low as 1 staff nurse to 80 'patients', although the staff nurse will always be assisted by 1 or 2 assistant nurses or hospital attendants. For the day shift and the short-stay wards, the ratio is about 3 times higher than the above ratio. Overall, on a 24-hour basis, the hospital has a ratio of 1 staff nurse to every 5 beds.

There are two other public institutional mental health facilities:

- the View Road Hospital provides long stay and rehabilitation facilities for 290 patients admitted via Woodbridge;

the Pelangi Home, which provides around 500 beds for 'burnt out' patients on long-term medication, mostly admitted from Woodbridge.

There are 150 further beds elsewhere in Singapore: in three major public hospitals - National University, Changi General and Tang Tock Seng Hospitals - and two private hospitals (Adam Road and Mount Elizabeth Hospitals).

With around 3,700 psychiatric beds, the Singaporean inpatient bed to total population ratio is therefore around 1:830. This compares with around 1:3000 in Australia. Singapore now probably has more beds in psychiatric facilities than exist in the whole of Australia, where beds in dedicated facilities are on a sharp downward trend. There were 3,990 beds in Australian stand-alone psychiatric hospitals in June 1996, but this is sure to have fallen further with the implementation of the National Mental Health Strategy. Of course, this situation reflects the fact that other countries have diversified residential mental health provision into other settings, including group homes and supported accommodation.

Outside hospital, due to the ethic and Government policy of individual and family-provision, there are few facilities, although the number of voluntary organisations is growing along with the community-based services they are providing. These organisations include:

- the Singapore Association for Mental Health. This receives funding from the 'Community Chest' and runs a group home (38 beds), as well as day care, a social rehabilitation club and provides counselling services;

- the Singapore Anglican Welfare Council. This is based at the old Changi Hospital and provides care centres (charging $50 per month per person) and residential accommodation (costing around $300 per month). Services in which they are active include rehabilitation and counselling;

- the Sunlove Abode, for the intellectually disabled;

- the Alzheimer's Disease Association;

- the Salvation Army, who have a nursing home with a wing for dementia patients who are destitute or on public assistance;

- the Ju Eng Home, which houses some dementia patients;

- a variety of ethnic and religiously-based organisations and services.

Outpatients are either seen at the hospital itself or are treated at polyclinics at a low (subsidised) cost to the patient ($8 every 2 weeks or a month). There are also 3 day centres, one also at the hospital and two outside along with 13 community psychiatric nurses.

D1.3 Funding and accountability issues

Currently inpatient and outpatient treatment facilities are mostly Government funded, and public-sector funded coverage is expanding through Medifund, etc. Recently, government funding has also been granted for certain community-based services. There is general consensus that fees should be charged, but there is no universally applied fee structure. There is a schedule of fees for hospitals and community psychiatric clinics, which are assessed by medical social workers. NCSS cover the deficits faced by the agency when clients are unable to pay.

No-one suggested that the costs of treating mental illness are a heavy burden on the Singaporean economy. This may be explained by the fact that the relatively high inpatient bed ratio is balanced by the low staff: patient ratios employed and patient co-payments.

Nevertheless, the Singaporean Government heavily subsidises the cost of inpatient (and outpatient) care. In theory, Government subsidy for hospital beds is based on a four-point sliding scale target (these subsidy levels have not been achieved yet):

-	Class A	(individual rooms with air conditioning)	Zero subsidy
-	Class B1	(4 bedded rooms with air conditioning)	20% subsidy
-	Class B2	(6-10 bedded rooms, no air con)	65% subsidy
-	Class C	(Open wards, no air conditioning)	80% subsidy

But, in practice (and this is officially sanctioned), to satisfy demand and maintain affordability, even Class A rooms are subsidised to some extent and B2/C Class beds in Woodbridge receive around an 85% subsidy.

Institutional services are directly accountable, via a Management Board, to the Ministry of Health. Agencies funded through NCSS are held to account and monitored through workload indicators. A comprehensive review system is being planned in the future to keep track of agency performance.

SYSTEMS FOR THE CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS IN DEVELOPED COUNTRIES

3. COUNTRY CHAPTERS

E. GERMANY

No individual visits were made to psychiatric institutions in Germany. This section is therefore only a brief overview of German mental health services.

E1 Summary and Overview

There is no strong tradition of social medicine or psychiatric care in Germany. Little help, advice or access to social services is available to people with psychiatric diseases, including dementia, although some sickness funds employ nurses who can give some advice and education.

New concepts of treating the mentally ill have, however, made an impression in Germany as elsewhere. For example, an official enquiry into the State of Psychiatry in Germany reported in 1975 and recommended that psychiatric care follow these principles:

- care should be integrated into the community;

- psychiatric illnesses should have an equal status in the medical system with somatic illnesses;

- suitable comprehensive care should be available for the mentally ill;

- care services should be coordinated.

The Lander, local authorities and voluntary organisations have developed a variety of activities directed at the treatment and the medical, social and occupational rehabilitation of the mentally ill. There are some places, for example, such as the Martin Luther Stiftung in Hanau near Frankfurt-am-Main which offer specialist residential accommodation for older people with dementia, within an organisation offering a variety of residential and ambulatory care services. But most elderly with dementia find themselves in residential facilities, or inadequately cared for at home.

The Government recognise that for hospitalisation to be avoided and lengths of stay reduced, it is crucial that community-based care options exist. As a result, semi-inpatient, complementary and outpatient facilities have been gradually established and expanded and specialist psychiatric departments were created at general hospitals to ensure community-based inpatient care. The Federal Government has also run pilot projects in the field of psychiatry, which are likely to yield useful lessons which can be applied more widely.

However, we were told by a leading health insurance fund that mental health care is still largely reliant on medical institutional care, with the use of specialist psychiatric institutions and drug therapy. Some states have clinics, but this is rare. The development of integrated programmes of benefits and services, which include outpatient treatment, rehabilitation and 'socio-therapeutic' measures for the mentally ill has yet to take place. An example of how long reform has taken to be enshrined in law is the fact that the reform of the law concerning guardianship for adults with mental health problems was recommended by the 1975 Official Enquiry into Psychiatry but only came into force on 1 January 1992.

Psychotherapy has been undertaken to date in private practice, and only in 1999 were some individual health insurance funds willing to pay for clients to have psychotherapy.

SYSTEMS FOR THE CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS IN DEVELOPED COUNTRIES

4. ISSUES AND THEMES

4.1 Executive Summary

The major trends

Two ***major trends*** have been picked up by commentators and analysts:

- a movement towards **more integrated delivery systems;**

- greater **concern with quality.**

There is still **over-reliance in many countries on hospital-centred care** and insufficient progress in deriving outcome measures within a framework of total quality management. Much more remains to be done.

The main messages

The key messages are:

- **everyone needs to be engaged** in a mental health strategy - including consumers and carers;
- **flexible resources will be needed** in the future to continue innovation;
- **better information systems** are still needed;
- **partnerships will be key,** eg with primary care, substance misuse teams, etc;
- a **population and public health focus** provides a common framework for discussion;
- there is a clear **need to develop quality tools** - guidelines, outcomes and report cards.

The ***future agenda*** will be dominated by five themes:

the move to a **public health focus;**

a growing **reliance on technology;**

the need to ensure that mental health **money is ring-fenced;**

how to provide **services in rural areas:**

resourcing **high-intensity services,** eg 24-hour and outreach services.

Lessons from mental health

Cutting-edge mental health practice is ahead of long-term care in recognising that **professionals need to pay greater attention to the needs, aspirations and desires of service 'users'.** This in turn implies a holistic, person-centred and comprehensive approach to strategy, funding and mental health care.

Special mental health services - **dual diagnosis (drug/alcohol and mental health) and dementia care are seen as problematic worldwide.** Best practice aims to co-locate medical and community mental health teams. Advocates for people with Alzheimer's disease believe that **there needs to be specialised care for dementia sufferers.**

Generally, mental health care is seen as a health authority rather than a local authority responsibility, though progressive practice abroad is trying to work in a multidisciplinary way and **move away from a pure 'medical model'.** A core acute service, involving specialist psychiatrists, is seen as crucial, along with **separate facilities for people with functional and 'organic' disorders.**

4.2 Introduction

> *"Once, people with mental illness were kept locked away from the rest of society, often in the most appalling conditions. Today, more subtly but just as effectively, they are imprisoned by negative attitudes which deepen their distress and deprive them of opportunities for living happy, productive lives."'*
> (UK Co-operative Society Newsletter, October 1999).

Mental disorders are now the biggest group of health problems in the country, causing more suffering and costing more to treat than any other kind of illness. Directly or indirectly, mental health problems affect virtually everyone at some time in their lives. In the UK today, around 7 million people are suffering some kind of mental disorder: around 15% of the entire population.

Many people suffering from mental disorders in this country (and abroad) are not getting the treatment they need. On the contrary, the 'treatment' they receive often makes their problems worse. In addition, they usually experience prejudice and discrimination in many aspects of life, from finding friends and a secure home to getting a job. In the worst cases, this can result in people with severe mental illnesses ending up lost and destitute.

Virtually everyone with mental health problems is affected by the pervasive stigma attached to mental illness. People believe that people with mental illness are dangerous, have inflicted their problems on themselves and, most damagingly, that they are beyond help. These are myths.

The majority of mental health problems are due to depressive illnesses and phobias and compulsive disorders, including anxiety attacks or depression, the psychological effects of alcoholism and severe eating disorders like anorexia and bulimia. With skilled primary care staff, international evidence suggests that 60%-70% of these disorders can be treated.

About 30% of those with disorders have severe mental illness, and of these around 3% of the population require specialist mental health services. A further sub-group - perhaps under 1% of the population - have severe mental illness caused by conditions such as Alzheimer's disease, dementia and schizophrenia - will need on-going intensive support.

Hence, in the vast majority of cases, people suffering from mental health problems *can* be effectively treated using physical treatments, drugs or through the growing use of psychotherapy, counselling and support in their everyday lives. As this section points out, while treatments do not necessarily offer a *total cure,* they can provide an opportunity for people to come to terms with the symptoms and live healthier and happier lives with a goal of *recovery* from disabling conditions.

4.3 Coordination and service delivery issues

Problems in the UK

Some of the problems in UK mental health services include:

Service structures

- health and social services boundary problems lead to struggles over appointments and premises as well as concerns about the dominance of the medical model;
- a lack of co-terminosity between GP, local authority and mental health Trust catchment areas;
- difficulties in securing sites, particularly in inner city areas where people with mental health problems can live and be cared for, resulting in a shortage of community asylum ('crash pad') places and high-support accommodation;
- responsibility for assessing population needs has been passed to commissioners - some believe that providers can better tailor services to ground-level needs;
- the brutalisation (via inappropriate placement) of people with mental health problems in prison, eg people with schizophrenia and personality disorders;

Information issues

- in the past, providers were so tied up in contract negotiations that they did not understand each others' problems;
- insufficient information about service needs in a given catchment area;

Care delivery issues

- too little time is spent with patients, eg people on in-patient wards can be neglected, leading to violence and alcohol/drug abuse;
- problems tackling people with a dual diagnosis - drug/alcohol and mental health problems;
- in-patient wards are run with agency and/or temporary staff, who are in a poor position to work with and empower users.

This section looks at practices and issues arising in developed countries and possible lessons for the UK.

4.3.1 Hospital versus community-based services?

Any service system needs to have a 'vision', but be solidly grounded in political and clinical reality. Since the 1960s the vision for mental health services, at least in English speaking countries, has increasingly crystalised around the twin concepts of de-institutionalisation and consumer involvement.

Factors that have generated and fuelled these trends include growing disenchantment by professionals, and especially clients, with the effectiveness of traditional services rendered by mental hospitals, the cost of hospitalisation (financial and personal) and the advent of new powerful anti-psychotic drugs. In Rosen's words (Rosen, 1984), hospitalisation is now widely seen as "stigmatising, de-personalising and promoting chronicity".

But the alternative - community care - has also come in for trenchant criticism. The failure of de-institutionalisation programmes and community mental health centres to provide adequate, continuous, comprehensive and coordinated aftercare has been extensively documented. Some of the problems include:

- the lack of a dedicated liaison person;

- all too often, the families, friends and carers for people with mental health problems are not given the basic tools for helping people to survive.

No simple solutions to severe mental health problems are therefore yet apparent: so far, there are no guaranteed ways of preventing schizophrenia and other chronic psychotic conditions and, despite intensive treatment, many people continue to have long-term disabilities. But there is a growing body of evidence from trials that the majority of psychiatric patients can be treated more effectively and economically in the community than in hospital, providing clients, their families and carers receive comprehensive and continuous community care services (Rosen, 1984 op cit).

In running community-based services, it is vital for clinicians and other professionals to have an understanding of the extent of the problems and the caseload they are dealing with. It is not unknown for a new consultant psychiatrist to be given little or no information about the total numbers of clients they are dealing with. Part of good practice is therefore for a service catchment area to be defined and for an up-to-date client list to be drawn up.

The need for "asylum' and residential services - a last resort?

Acute beds are viewed in most of the countries visited as a necessary component of the mental health system. Ideally, community facilities would be available, but in reality some assertive, intensive care will be needed to respond to crises. Primary care should be linked via comprehensive case assessment systems to a crisis intervention team with access to in-patient beds.

4.3.2 How to get a more responsive community-based care system?

Most countries are struggling to coordinate community health services, home and community-based social services and GP services. Studies have indicated that many primary care professionals are under-skilled in psychiatry. Around a fifth of a GP's patients in the UK are likely to have psychiatric morbidity, but GPs are only picking up about 60% of cases. Practice nurses, health visitors and district nurses have little specific mental health training. The more widespread employment of counsellors may be an answer, but qualifications, monitoring and confidentiality issues need to be addressed.

The problem with dealing with psychiatric patients in general practice is that GPs have very little time. There is evidence that linking primary and secondary care has led to reduced in-patient admissions through the adoption of a multidisciplinary team, including a psychiatrist, occupational therapist, psychologist and social work case manager. Other solutions, which have worked in various places at different times, include:

- social workers working out of a GP surgery;
- instituting links between GPs and community mental health teams using national and local mental health voluntary organisations;
- skilling up support workers who care or work with people with mental health problems. Education authorities would fun 75% of the course costs and the costs of release (for say 50 days) can be paid by health authorities.

Important ingredients of a community-based care model are:

- intensive care available for people in crisis;
- others can be managed by a combination of a GP, nurse and social worker;
- importantly, a range of supported residential care;
- an employment-oriented programme to develop skills and provide vocational training.

In particular, the link with work skills and housing is vital. Without those components, support arrangements collapse and there is a need for more beds.

19. A market-driven housing policy does not suit the provision of services to a deprived mental health population. They need a more targeted policy, usually involving public provision and/or rent subsidies.

4.3.3 The argument for a separate local mental health agency

20. There is no one best way to solve the problem of service fragmentation and diffusion of responsibility. A variety of models have been cited as the 'solution' to this fragmentation, including reversion to community MH centres; a 'core' service agency and a MH authority or board.

1. A local mental health authority was chosen by the Robert Wood Johnson (RWJ) Foundation in the USA for their Program on Chronic Mental Illness (PCMI) project. The linchpin of PCMI was the idea of one central MH authority per city or county. This Authority would plan, fund and coordinate care and run its own fiscal, administrative, and clinical systems.

The system in Baltimore is an example of such a system operating today (see United States Best Practice Example 1). However, having one MH authority is unlikely to solve all problems. Experience suggests that a MH authority might be necessary, but not sufficient, to create a comprehensive set of services.

4.3.4 Dual diagnosis services: alcohol & drug and mental health services

The interrelationship between alcohol and drug (A&D) and mental health programmes is problematic in most countries and needs to be given particular attention. Users of these services usually end up being the beneficiaries of multiple public programmes, at substantial public cost, and may end up in the most costly settings of all - prisons and acute medical facilities. In reality, many people with severe mental health problems also have substance abuse problems, with histories of addiction to crack cocaine, heroin and other drugs. Despite this problem, the interface between A&D and community MH teams is weak, at best, in many places.

Borderline issues

A widespread problem, which bedevils mental health practice, is a difference in treatment philosophies between health and social services. Health service substance misuse teams tend to require people to be committed to coming off drugs, while social services are inclined to deal with people even if they have substance abuse problems. This difference in philosophical approach needs to be resolved at a local level with central leadership, since it makes it hard for both types of services to work together and provide an integrated service.

An example of a difficult borderline issue is who is going to treat an elderly alcoholic at home. Usually, this kind of case falls to psychiatric services for the elderly as A&D services are often not set up to deal with frailer, less mobile clients.

Even if the difficult organisational issues could be solved through more joint working between social services teams, the police and community-based psychiatric services, funding remains a problem in many countries. In the UK, there is the perception on the part of UK service providers, eg the Mental Health Trust that A&D services are a poor relation within the NHS. Insufficient money has been provided by the NHS to support A&D services and, unlike HIV/AIDS, there are no dedicated funds for alcohol-related treatment.

Best practice

Some ideas on dual diagnosis clients that emerge from international practice include:

- there must be no delay in supporting someone and arranging treatment once someone comes forward, since their commitment to receiving treatment is likely to be very fragile;
- once a client is in the system, they should be quickly referred to dedicated or specialist services;
- material on dual diagnosis should be included in GP guidelines;
- there needs to be prominent consumer involvement in setting up and running dedicated drug/alcohol helplines.

4.3.5 Psycho-geriatric care - an aged care or a mental health service?

> *"Psycho-geriatric care springs from the family of psychiatry but is married to geriatric medicine.""* (Dr Chris Collins, Christchurch, New Zealand)

The modus operandi of psycho-geriatric care usually differs from hospital geriatric care. The departments have evolved from different service cultures within the mental health and medical fields respectively: psychiatric care often operates as an 'emergency' service, eg to deal with a sudden deterioration or a breakdown in an individual's functioning. Training needs are also different, and personnel need an understanding of counselling and therapy, as well as medical expertise.

However, the distinctions between geriatric and psychiatric services are artificial. The first national survey of Old Age Psychiatry is being undertaken by the PSSRU and will be published shortly. In practice, for elderly people (over 65 years old), geriatric care blends into geriatric psychiatry, which in turn has a border with general psychiatry. Hence psycho-geriatric patients require care from providers with expertise in both physical and mental health care.

Older people with mental disorders need services which allow them to move flexibly over the borderline between the specialist aged care sector and mental health services as their needs change over time. Neither sector can meet all their needs. Best practice in this area therefore seems to include:

- <u>flexible treatment locations</u> as rigid rules on treatment locations, etc, do not serve clients, and in general, integrated and holistic care services;

- <u>specialised training</u> for those dealing with the elderly with mental disorders;

- <u>particular services,</u> eg a 'delirium' service for those with dementia.

Some believe that an important distinction needs to be maintained in psycho-geriatric care between the treatment of organic (structural brain deterioration) and functional (behaviour-related) disorders. People with organic damage need social support and/or residential care, whereas people with functional disorders are more amenable to rehabilitation. However, psychiatric services often have little say in, and find it hard to influence, the number of beds/places in the community. Increasingly, community mental health workers will be needed to support the elderly at home.

Australian evidence shows that more than twice as many dementia patients discharge to nursing homes as opposed to their own home. This implies that the interface with the residential care sector is of critical importance.

For clarity and ease of administration, there is some merit in sticking with a firm age cut-off, eg at age 65 for access to care from a budget for geriatric care as opposed to mental health care. However, any age cut off is arbitrary, and there are likely to be cases where a 64-year-old might be better cared for in a geriatric setting, and a 68- year-old might benefit from mainstream mental health care.

Funding issues

There is an issue of how to fund old-age psychiatry when there is a partnership between old age and psychiatric care. Ideally, there would be adequate funding specifically for psycho-geriatric care. But, in practice, money can be drawn from several sources: through mainstream mental health funding, through the budget for elderly care or through a dual stream of money from mental health and geriatric care. The key point is that money is flexibly available to treat the elderly people with mental health disorders with specialised staff in a dedicated location.

In both the US (Los Angeles) and New Zealand (Christchurch), mental health practitioners saw advantages in merging the psycho-geriatric budget with that of mainstream geriatric care. Partly, this was a pragmatic decision as it was seen to be easier to access funding from aged care than from within the mental health service. Money is perceived to be 'lost' within the general mental health 'pot'.

Funds are needed for different types of work. Funding is required for acute/medical purposes as a substantial proportion of the work of a specialist psycho-geriatric service is medical in nature and unlikely to fall within the ambit of general disability funding. But money is also required to undertake rehabilitation work.

4.3.6 Staffing issues

The expansion of community-based mental health services has led to more emphasis on short-term hospital and residential services, as well as an expansion of out-of-hours care and other services, with the primary goal of keeping clients functioning in their own homes. This increase in facilities has led to a commensurate increase in staffing, most notably among professional care staff - psychologists, social workers, registered nurses and other staff with mental health training.

The mental health field has also seen a downward substitution in care workers, with registered nurses replacing higher cost professionals such as doctors. This trend may be positive - freeing doctors up to provide more specialised care and giving other staff valuable clinical experience. The substitutability of staff, eg psychologists for psychiatrists and psychiatric social workers for psychologists, could be reviewed to ensure optimal work and caseloads.

Training

The same problems beset the training of mental health staff - particularly the lower level care and nursing auxiliaries - as for other community care staff. There is a question as to whether there needs to be more general mental health training, ie do the CCETSW arrangements in the UK need to be dissolved and replaced with something like an NVQ-linked Level 1 in mental health care?

4.4 Funding issues

In mental health services, the case is often made for higher spending without a clear idea of where, and how cost-effectively, existing resources are being spent. As a first step, information also needs to be improved: newly appointed psychiatrists can find it difficult to determine the size of their caseload and the scale of their responsibilities. Clearly, without a clear sense of the scope of the task, efficient and cost-effective care is hard to deliver.

4.4.1 Should mental health funding be ring-fenced?

There is widespread agreement from people administering or working in mental health services across the world that the mental health budget within the ministry or Department of Health needs to be ring-fenced. This view has gained currency in the UK and has been adhered to in Australia. For example, when the new Australian Federal Mental Health Strategy was introduced, existing mental health budgets were quarantined.

The logic for this view is that without ring-fencing, and given the pressure on existing acute health services, mental health monies are likely to be swallowed up by mainstream services, leaving mental health as an ill-funded 'Cinderella' service. Against the positive aspect of ensuring a given amount of funding for mental health, it is necessary to balance the inevitable boundaries - funding, service and accountability - that a separate budget entails. However, this is seen as a price worth paying.

A further worry, which needs to be addressed by financial planners, is that in practice even with a dedicated budget (eg assertive case management model in Wisconsin), money is not available for care <u>between</u> treatment episodes. Funding needs to be for ongoing, not time-specific, care.

As mental health professionals know, even <u>with</u> a ring-fenced budget, there is no guarantee that mental health services will be adequately funded. Most people in the field acknowledge that the case for additional funding has to be made in the face of other competing service demands. Benefit managers in the USA and state legislatures need to be persuaded on the basis of outcomes measures, guidelines and good practice protocols. In Australia, mental health planners sought to make the case for more resources on the grounds that most people who needed help were still outside the existing treatment system.

Furthermore, even if mental health funding is ring-fenced, it is still vital that other non-health funding streams are accessed for practical reasons, as well as due to a theoretical desire for seamless services. As one mental health service user put it, "seamless services seem to be one thing, but they are often less than they seem". The twin issues of housing and income generation are vital to improving people's mental health. A former UK Health Minister once remarked that more might be done for people's health by improving the quality of the housing stock than by devoting more money to the health service, and the same dictum probably applies to mental health. The question service planners in these different areas need to ask themselves is "how can we work with you to improve health outcomes?".

<u>4.4.2 Outcome-based funding measures</u>

"In God We Trust, the Rest Bring Outcomes Data. " (Ron Manderscheid, USA)

International experience shows that drawing up outcome measures is one of the trickiest parts of establishing a soundly-based mental health system. For example, what outcomes can you use to measure shared care? There are also issues about the degree of finality of outcomes and the availability of data. In site visits, *outcome* measures were often confused with *output* measures, eg length of in-patient stay, particular treatments provided, etc. A few countries are thinking seriously about consumer and carer satisfaction, but the problem here is that what consumers *want* and what is an objectively good *outcome* may be very different.

None of the countries visited had really implemented outcome-based measures. One difficulty with drawing up consumer-focused outcome measures is research methodology, and focus groups tend to under-sample the severely mentally ill. Some countries had thought about using access or delivery of services for hard-to-reach clients, such as those from ethnic minorities (eg Maori in New Zealand or aboriginals in Australia) or access to 24-hour care as proxies for outcome measures, but these are inevitably partial.

Consideration of people's unique needs requires the definition of specific outcomes, services and indicators that are sensitive to the needs of persons at different life stages. Specific performance indicators and tools for measuring outcomes should form the basis for contracts in the mental health system.

However, outcome measures can be a double-edged sword. On the one hand, using outcomes as a measuring rod can lead to better treatment, with an emphasis on doing what really works. But, on the other hand, the link to funding may mean that consumers who are deemed to be 'too hard' to deal with may not get treated.

Examples of outcomes which may be desirable include: improved clinical status, better social functioning (being able to live independently and 'look people in the eye'), higher quality of life, consumer satisfaction, an increase in self-knowledge of health conditions and a reduction in relapse rates. For carers and staff, measures might include improved carer satisfaction, higher staff morale and lower staff 'burn-out' rates. Particular measures that have been considered elsewhere include: the number of people 'in crisis' (but what constitutes a 'crisis'?); re-admission rates to acute facilities and lengths of stay in institutional facilities.

A useful grouping has been devised in Wisconsin (see US Chapter, Best Practice Example 2), which groups outcome measures into three broad categories - personal outcomes, clinical outcomes and 'social' outcomes, with the following examples of suggested measures:

Personal outcomes	*Social outcomes*	*Clinical outcomes*
consumer satisfaction	social relations and support	symptom relief
quality of life (goals)	meaningful activities & occupation	psychological health
personal safety	housing quality	physical health
equal opportunity	freedom from substance abuse	
empowerment & self-esteem	daily living skills	

In New Zealand, they are putting a greater emphasis on the cultural and spiritual context of treatment to reflect the high proportional incidence of mental health problems in the Maori community. Measures include subjective and objective assessments of health, as well as individual and collective outcomes. The importance of maintaining trust and having a vocation, job or socially-accepted role is recognised. The concept of good outcomes is widened to include the information that people get, as well as how they experience the use of the service.

4.5 Best practice and policy lessons from other countries

Two major global mental health trends are apparent: the movement towards integrated delivery systems and the movement towards quality.

4.5.1 Integration

The first trend - **integration** - can be thought of in different ways:

- putting funding streams together. For example, in the USA, there are 38 different funding streams for mental health care. This is clearly nonsensical;
- getting services to work together, eg health, housing and social services;
- third, ensuring that professional boundaries are blurred so that individuals with complex needs - drug/alcohol abuse and mental health problems, or those needing dementia and geriatric services - receive more effective care.

A good model seen in New Zealand was where a community/non-hospital mental health team had been set up along similar lines to that operating at one stage in Bristol, UK. The team is broken into four geographic areas and works in a multidisciplinary fashion. Given the history of community teams being seen as long-term crisis teams, with a reluctance to engage the community and involve GPs, liaison with the community is taken seriously. Thought has been given beforehand to consultation with the community and how the team would operate. Community liaison meetings take place monthly.

4.5.2 Delivering quality care

The second **quality** is a universal obsession - particularly in the USA, where perversely the care spectrum is widest (and very low quality care exists). Delivering quality services can be thought of as a *process* with sequential stages:

2. getting agreement on basic values and principles;
3. bringing groups of people together to establish goals and strategies;
4. establishing system protocols and care standards;
5. determining national quality, preferably outcome, measures;
6. drawing up an evaluation framework and ensuring feedback to practitioners as quality needs to be constantly maintained.

International progress against these criteria is variable. Australia, for example, has largely managed to achieve agreement on the first two stages (I and II) and is making progress on standards and protocols, although some consumer representatives still feel that the system is insensitive to the precise needs of individuals. Europe and most parts of the USA are further behind, and goals and strategies are not always clear or universally shared by people delivering long-term care services.

One of the hardest parts of establishing goals is *which client groups* should be prioritised. For example, a by-product of the Australian mental health strategy was an unintended focus on people with severe mental illness. This led to a debate about whether the severely (less appropriately called 'seriously') mentally ill were more deserving of support than child & adolescent, psycho-geriatric or forensic psychiatry services. This is reminiscent of the UK debate between 'major' and 'minor' disorders. Sorting out these priorities is far from easy. Ultimately, any strategy needs to get support from the wider mental health community, not just from those within the administrative or bureaucratic machinery.

4.5.3 Aspects of best practice

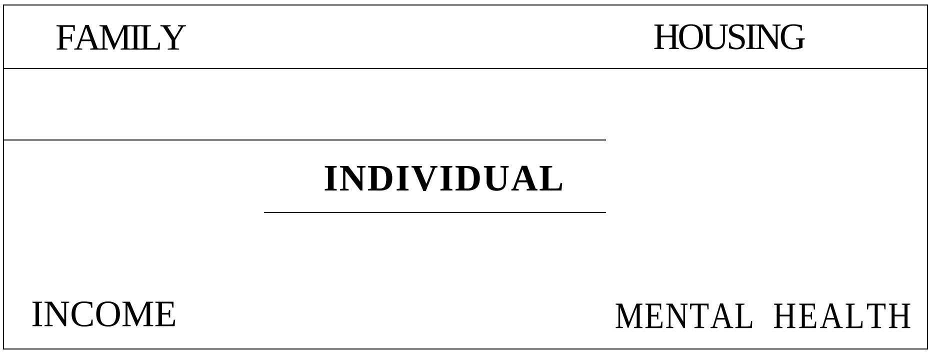
> "Too often we reorder the deckchairs, but no-one asks whether more of us are sitting in the sun." (Barbara Disley, New Zealand Mental Health Commissioner)

Best practice tends to see mental health care in terms of *recovery* not *treatment* and as crucially being as much about decent, safe and affordable housing, opportunities to earn income and being free from physical addictions as about mental health care per se. Two other aspects are also seen to be key:

- the promotion of self-determination and quality of life rather than dependence;

- the emphasis on prevention and early intervention to deal with targeted mental disorders.

Furthermore, international best practice, whether viewed from the USA, Australasia or Europe is increasingly placing the individual, consumer or client at the centre of the care process. The care diagram looks as follows:



From a consumer viewpoint, the aim is not to *cure* mental illness per se, but most often for *recovery,* ie for the illness to no longer be a central part of their life. The goal of treatment ought to be to enable the person to 'have a life'. The fundamental idea is to let go of the past and rebuild a new 'vision', ie to accept the realities of illness while focussing on life. Most service users testify that recovery from mental illness is a *process* not a *destination,* and as such is essentially *non-linear.*

The Wisconsin Blue Ribbon Commission report makes the point succinctly. In essence, it stated that a recovery-oriented mental health system:

- focuses on rebuilding full, productive lives despite a mental disorder;

- reaches beyond the critical issues of assuring personal safety and managing symptoms;

- learns from experience in the field of physical disability, with severe injuries and chronic pain management developing an approach which does not seek to eliminate pain but makes it less bothersome.

Aspects of an individual's behaviour, which American and other international research show as being important to recovery are (in no particular order):

- determination on the part of the individual to get better;
- accepting the illness;
- managing the illness (relaxing, affirmation, meditation practices, etc);
- self-help;
- having consistent friends;
- managing the negative effects of medication and 'pushy' professionals.

The professionals who are identified as most useful are often those with whom the client has an informal and friendly relationship. One of the invaluable functions the professional can have is to keep optimistic and hold a 'crucible of hope' for the client, which s/he can take back when they can.

Practical steps that seem to help to get good outcomes include:

- taking steps to ensure the individual's family are always consulted, and using ethnic 'elders', where appropriate, to advocate and advise on treatment;

- tailoring services to particular groups, eg by age and gender;

- paying clients of mental health services to attend groups (focus groups, etc) where their opinions are sought;

- assuring confidentiality of personal information at all times;

using people's underlying talents to help them recover.

From a purchaser or provider point of view, the goal is to move towards better mental health services. This perspective is inevitably different and revolves around a service model with the following aspects of good practice:

- all those affected, including **consumers and carers, need to be involved** and engaged in working out a service strategy and developing existing services;

- **a clear 5-8 year funding path and flexible resources** will be required in future in order to continue innovating;

- **better information systems** and **good use of technology** are urgently needed, both in the health sector and in national and local bureaucracies;

- **partnerships** will be the key in determining future performance, for example with primary care practitioners;

- a **population health focus** will need to be the common framework for discussion. This is perhaps more in place in the UK than elsewhere;

- **tools to develop quality** will need to be developed (an evaluation framework, guidelines, outcome measures, report cards, etc);

There is also a need to bring contract negotiations, care planning, audit and clinical effectiveness cycles together. The key task, however, is to apply and implement the framework, so that it actually starts making a difference to services on the ground.

It is particularly important in dealing with especially vulnerable groups, such as those experiencing mental disorder, that any system redesign is done in incremental steps to minimise disruptions in services to consumers. The 'First, Do No Harm' principle should guide system change.

Instituting a population health focus

Many believe that successful mental health policies need to be framed at the population and area level before they are applied in a particular unit or domestic setting. Important elements of a population or public health focus include:

- health screening. But there are difficult questions here, such as *how* to do it? How to do it *cost effectively?* And how to deal with the implications of uncovering morbidity?

- prevention and early intervention. Beds have been closing in psychiatric hospitals since 1962, but little early intervention has been done. In practice, the talk has been about diagnosis rather than need. Prevention can be particularly effective if effort is focused on groups, eg teenagers with depression or perhaps middle-aged and/or older people with problems as a result of loneliness or bereavement, etc, who might otherwise become long-term clients of mental health services at resulting high public-sector cost;

- monitoring of problems, eg on-line monitoring of diabetes;

- encouragement of peer support, for example through consumer or user groups.

Use of information, IT systems and telemedicine

Increasingly, the need is to separate useful **information** from the mass of data which modern health and broader care systems generate. Information should be generated bottom-up but monitored top-down. This means ensuring that information collected is generated, informed and even driven by consumers of services themselves. This will help to ensure that information collected is relevant to the people using the services.

At the other end, a population-based "report card" could be devised, which includes information on access (physical, telephone and cultural factors), appropriateness, prevention (ie dealing with high-risk groups) and clinical outcomes. One way of strengthening the force of this population/outcome reporting would be to link payment systems to the results.

In effective organisations, everyone has access to the same information. Questions, such as "what do we want?", "what is expected?" and "what data do we need?", drive the information collection process. A balance has to be struck between entrepreneurial behaviour/a drive for outcomes and consistency. Bureaucratic systems (and most health systems are heavily bureaucratic) tend to be good at consistency and poor at driving for outcomes.

The information that is collected can be applied at both the system and the clinical level.

System Level	Clinical Level
Guidelines	Guidelines
Performance measures	Consumer outcome measures
Continuous quality improvement	

IT systems are also increasingly coming together. These link practitioners in different locations (eg pharmacists, GP surgeries, consultant psychiatrists and community mental health teams). An advantage of these systems is that they do not have to be office-based, as information can be provided real-time to practitioners working in the community via mobile telephones, laptop computers and dial-in computer databases.

The potential for **telemedicine** is high. Cutting-edge practice is already making use of telemedicine to offer higher quality care without incurring the time and displacement costs of moving highly qualified personnel around. It is particularly useful for providing specialist services to remote or rural locations where specialist staff only work part-time, at best. Rural mental health teams need to work closely with, and establish the respect of, GPs. In doing this, continuity of staff is important.

An evaluation framework

A useful evaluation template, which is being used in Australia, covers population issues, quality and service and provider issues:

Population issues

- service or insurance coverage;
- administrative constraints;
- service planning.

Quality

- service availability (hours of opening, range of services provided);
- service accessibility (location, physical characteristics);
- service quality (competence of staff, use of technology, etc);
- cost of services;
- outcomes.

Service and provider issues

- interface and linkages between services;
- staff training.

A good practice lesson: the 'assertive case management' model

The best, and arguably the founding, assertive case management model is to be found in Madison, Wisconsin, in the USA. Madison has an extremely impressive commitment to, and practice of, consumer/user involvement in service planning, delivery and management. The service has a clear catchment area of around 400,000 people and has devised a 'Comprehensive Service System'. The service operates with 380 intensive community service packages - equivalent to around one per 1,000 people in the community, which is very low by international standards. This is partly made possible by the existence of a range of other supporting services.

In Madison, 90% of the funds for mental health services are spent in the community. This might be a benchmark for other worldwide mental health systems. In this case, all monies from county and city budgets are passed to the local authority.

The model for care is as follows:

Potential Admission (seen by a) **Mobile Crisis Unit** (who authorise the number of days in a) **Hospital**

Two of the key lessons from this model are first, that services require a fixed point of responsibility. The second lesson is that it is vital to make the best use of the existing strengths and resources of the community.

Assertive outreach practice works best when there is:

- low staff/user ratios of around 1:10 and no more than 1:15;
- flexible access to accommodation, not simply for acute crisis care (although that is necessary, too);
- budget holding by the teams and units directly responsible for care;
- flexible staffing as care needs change;
- 24-hour, 7 days a week, service availability.

4.6 Epilogue: What does mental health have to teach other services?

In some ways mental health treatment has had to be ahead of mainstream health/social care practice, as it deals with people experiencing extreme health states with multiple needs. Mental health care could also be a model for long-term care for older people as mental health models have been subjected to greater integration and testing than long-term care.

Mental health practice may also have lessons for care of older people in the way that intensive (acute) care has led to some innovative hospital nursing practices and a different relationships with doctors. Lessons exist in three main areas:

- the treatment of people from ethnic minorities;
- the need to address people's wider needs, eg income, housing and leisure;
- helping people to help themselves: listening to 'consumers' of care.

The treatment of ethnic minorities

In mental health practice there is a growing recognition of the importance of the social context in which treatment is delivered. This was well-encapsulated in a (suitably agricultural) saying in New Zealand: "you cannot grow apples without apple trees". In terms of health practice, this translates into the notion that you cannot get good outcomes without understanding the social, cultural and political context in which people live. This is particularly powerful in dealing with ethnic minority communities.

In practical terms, key elements of multi-racial care are:

- the inclusion of family members. In many (especially non-white) cultures, the health of the individual is felt to be dependent on the well-being of the family unit. This was seen in New Zealand with respect to Samoan peoples;
- different services and approaches are necessary for each ethnic minority;
- networks - physical and virtual - need to be set in different areas, so as to give people accessible 'contacts'.

Addressing the wider picture

The consensus among mental health practitioners spoken to is that it is not sufficient to get health and social services personnel working together to improve someone's mental health. Housing, safety and community networks, as well as employment and adequate work/income opportunities are essential to the promotion and maintenance of mental health.

The Ottawa Charter is a building block for an inclusive and holistic mental health strategy and process. Ingredients include:

- a public health policy which is applicable to the working environment;
- the fostering of supportive environments, such as in schools;
- an emphasis on developing personal skills and re-skilling.

Listening to consumers of care services and dealing with stigma

People with mental health (MH) problems face a variety of problems:

- people with mental disorder experience discrimination in many areas, including employment, insurance coverage and housing;
- the media present people with mental disorder as dangerous and unpredictable;
- stigma inhibits people from seeking help and MH services;
- the stigma associated with poverty and minority status compounds the stigma of mental disorder;
- the MH system itself uses stigmatising diagnostic labels;
- some children with special needs experience discrimination in the school system.

The key remedy for stigma lies in education and society's ability to recognise disorder as analogous to other long-term health conditions, such as diabetes or high blood pressure. Some call for dedicated public and private funding to be used to reduce stigma, perhaps in a similar way to advertisements (and soap operas), presenting physically disabled people as people with a full range of feelings, interests and ideas.

Dealing with stigma can also have beneficial side-effects. In New Zealand, a project to counter stigma and discrimination has brought together new partners, eg mental health and public health practitioners.

ANNEX 1: BRIEF HISTORY OF UK MENTAL HEALTH POLICY DEVELOPMENT

There have been significant developments in UK health policy in the late 1990s and in early 2000. The Department of Health (DH) 1998 Discussion Document *Partnership in Action* set the scene by stating that: "The Government's strategic agenda is to work across boundaries to combat social exclusion, encourage welfare to work, tackle inequalities between men and women and improve health in local communities."

NHS White Paper and 1999 Health Act

Concepts of effectiveness, managed care and a 'third way' underpin recent initiatives. Early after the election of the Labour Government in 1997, a National Health Service (NHS) White Paper called *The new NHS: modern, dependable,* was published, which set out a new policy orientation towards "integrated care" and moved away from the philosophy of an 'internal market' for health services. The White Paper also encouragingly set out a "Third Way" which aimed to "build on what has worked, discarding what has failed" and to "provide a system based on partnership and driven by performance".

Both the NHS White Paper and a companion Green Paper *Our Healthier Nation: a contract for health,* also published in 1997, laid an emphasis on the need for effective working between the NHS and local authorities. This emphasis is underpinned by a new duty of partnership and set in the context of a duty on health and social agencies to draw up a *local* Health Improvement Plan (HimP).

NHS White Paper Policy Commitments

The NHS White Paper noted that "people with multiple needs were passed from pillar to post inside a system where individual organisations were forced to work to their own agendas rather than for the needs of individual patients". It had four policy commitments of direct relevance to the boundary issues between health and social services which affect the elderly:

- the NHS should work more in partnership by breaking down organisational barriers within the NHS and by putting the needs of patients at the centre of the care process. The NHS would remain a universal health service available on the basis of need not ability to pay
  i
- links between health and local authorities would be strengthened;
- GP-led Primary Care Groups would take responsibility for commissioning, ultimately controlling a single unified budget, and would work closely with social services;

- new evidence-based National Service Frameworks would be set up to ensure access to services and improved quality of care.

The White Paper stated that the new NHS would build on its successes in:

- separating the planning of hospital provision from provision;
- maintaining the central role of GPs and community nurses;
- decentralising responsibility to hospital and primary care managers.

It would, though, discard the failures due (in its view) to excessively fragmented services. The White Paper identified the following problems and proposed solutions:

Problem	**Proposed Solution**
Fragmentation	Institute Health Improvement Plans (HImPs)
Unfairness	Treat patients according to need alone
Excessive competition	Find mechanisms to share best practice
Narrow efficiency measures	Devise broader measures of performance. unifying budgets where possible
Instability and secrecy	Allow longer terms contracts & funding agreements, promote openness and public involvement

A key part of the 1999 Health Act built on the NHS White Paper proposals and gives health and local authorities (social services departments) new powers to:

- enable health (health authorities or primary care trusts) and social services **authorities to pool their resources** into a joint budget which would be accessible to either party to commission and provide services;
- enable **one authority to transfer funds and delegate functions** to the other to take responsibility for commissioning both health and social care;
- allow **one organisation to provide an integrated service,** for example an NHS Trust or Primary Care Trust might provide social services, or a social services provider could provide a limited range of community health services.

It was decided that these powers should be permissive - in other words, it will be up to health and local authorities to decide between themselves which arrangements if any will be most helpful to their joint working.

The new Labour Government which came in 1997 was committed to improving the worsening situation of inequity between regions and social groups. A whole raft of new initiatives were set up under three broad headings - setting standards, delivering standards and monitoring standards:

Setting standards

- the National Institute for Clinical Excellence (NICE) was set up to write and propogate clinical guidelines. All prescribing advisory bodies were amalgamated into one organisation;

- National Service Frameworks, not dissimilar from New Zealand planning documents, were to be drawn up, based on reviewing international evidence on what works.

Delivering standards

- the concept of professional self-regulation was used to launch confidential enquiries into homicides and suicides;

- clinical governance was used to reverse the situation where the NHS had national and regional financial targets but few clinical care standards and to come up with a plan to fund continuing clinical education;

- more attention given to lifelong learning.

Monitoring standards

Elements of this included:

- a Commission for Health Improvement;

- National Performance Frameworks;

- a national survey of Consumers to help remedy the dearth of consistent national information.

Twenty-five years ago, the 1975 White Paper adopted a planning approach and set out the framework for the number of inpatient clinics, outpatient and day-care facilities. There was a hint of a requirement for multidisciplinary teams. Fifteen years later, the NHS and Community Care Act recognised that the UK had not made enough progress with community-based care. 90% of mental health funding came from health authorities/the NHS, and 10% came from local government. New notions of assessment and client-focus were introduced.

In 1991, the Health of the Nation framework was introduced. Mental health was one of the five areas chosen for a policy focus. However, the focus was still on mental illness, not health. The Treasury wanted meaningful outcome targets and, under pressure, the Department of Health chose the suicide rate as this was clearly measurable and acted as a proxy for better services (the argument went that with good and accessible services, suicides would be reduced).

In 1994, it was evident that there was a conflict of priorities between a primary care-led NHS and giving more resources to (mainly acute) mental health services. It was clear that there were also problems with resource allocation, with inner cities having four times the rate of psychiatric morbidity as rural areas, with more or less the same per capita resources.

In 1997, the new policy framework pushed the concept of a 'Third Way' through NICE, setting up a review of current legislation and producing evidence-based National Service Frameworks.