Mental Health and Addiction Services in Regionalized Health Governance Structures: A Review

Final Report

March 2005

Prepared for:
The Centre for Addiction and Mental Health (CAMH)

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Introduction

The Centre for Addiction and Mental Health commissioned the development of a discussion paper on the place of mental health and addiction services in jurisdictions with regionalized governance structures. Specific aims of the paper were to:

- Describe approaches to governance of mental health and addiction services within regional health structures in selected jurisdictions;
- Obtain key informant input on the effect of regionalized health structures on mental health and addiction services, including elements that were perceived to be working well or not well;
- Summarize findings on the range of configurations, perceived strengths and challenges;
- Explore the implications of these findings in the context of the emerging Local Health Integration Networks (LHINs) in Ontario, both for the larger mental health and addiction service sector and for CAMH, an organization with local, regional and provincial roles.

Methodology

The project was conducted from December 2004 through February 2005.

Project steps included:

1) A high-level, focused review of relevant key articles and reports:

   As we learned early on in the project that there is a lack of evaluation research on regionalization (see later discussion), we instead reviewed a selection of key Canadian descriptive reports and critiques on regional governance structures for health and mental health care (see Reference list and Findings section).

2) Jurisdiction reviews

   Information was collected from a selected number of jurisdictions that have both had experience with regionalization of health governance and have produced a considerable body of documentation (e.g., policy and planning reports) in English. These included six provinces (Alberta, British Columbia, Saskatchewan, Manitoba, New Brunswick and Quebec) and three Commonwealth countries (England, Australia and New Zealand). The United States was excluded from the review as private health care is mainly delivered through managed care organizations rather than regional health authorities, and public mental health systems are mainly administered by state mental health departments, sometimes employing local mental health authorities.

   Data were obtained from two sources. First, available jurisdiction policy and planning documents were reviewed (see Reference list). Second, telephone interviews and e-mail

correspondence were completed with 16 key informants - researchers and managers (see Appendix A).

The interviews followed a semi-structured format (see Appendix B), with the interview guide informed by the review of key articles and reports. Information was sought on a number of key issues related to the structure and governance of mental health and addiction services in each jurisdiction, including:

- History and current configuration of health and mental health governance structures;
- Re: current governance and management of mental health services
  - Existence of policy, standards, targets
  - Functions performed regionally and centrally or cross-regionally
  - Funding approach, including use of protective mechanisms
  - Accountability mechanisms
- Governance and management of addiction services, in relation to mental health

Informants were also asked to comment on the perceived effectiveness of the current governance configurations. Perceptions of impact were based on little evidence and only minimally informed findings offered in this report.

A standardized template to profile each jurisdiction was developed (see Table 1) and completed, based on the informant feedback and document review. These jurisdiction summaries are provided in Appendix C. For the off-shore jurisdictions, some additional contextual information (e.g., on the population size, governance structure, and health care system) also is provided.

4) Presentation of a brief report of emerging findings:
Collected information was reviewed, and emerging findings were summarized in a brief report and presented to the PRDC.

5) Preparation of final report:
This final report incorporates the feedback on the interim report.

Table 1
Jurisdiction Summary Template

Central structures
For mental health policy/planning
For addictions policy/ planning
Ministry/body responsible for funding mental health services
Ministry/body responsible for funding addiction services
Regional structures
Regional health governance structure
Mental health services included
Addiction services included
Mental health & addiction services not governed by regional governance body
Mechanisms, if any, used to protect mental health/addiction funding within regional health budgets
Provincial/cross-regional functions: Where does responsibility lie for…
Performance monitoring
Promotion and prevention
Workforce development
Best practices dissemination
Research

Findings

It is generally agreed that the research on and evaluation of regionalized health governance structures in Canada and elsewhere is in its infancy (e.g., Lewis & Kouri, 2004; Davis, 2004; Dwyer, 2004; Denis, Contandriopoulos & Beaulieu, 2004). A number of factors are offered as explanations for this including the lack of stability in most structures, the plethora of approaches/models; the uneven, often incomplete, implementation; and the challenge of isolating the contribution of any given governance structure from other system characteristics and context. It is not surprising, therefore, that there is no research evidence on the effects of regionalized health governance structures on mental health and addiction services. The available written materials on the regionalization of health services are largely conceptual and/or descriptive, and mental health and addiction services are almost never addressed.

We could identify only two recent reports – one research and one policy – that offer some tentative observations about regional health bodies and mental health and addiction services. Hollander (2002b) reports that among the key informants interviewed there was no consensus as to the benefits accruing to mental health and addiction services from the inception of these bodies. The author notes that in large urban centres where all services are under the authority of a regional health board, there is generally a stronger perception of a system of care than in less populated regions. However, the informants also identified large urban settings where regionalization had not lead to greater service integration, and smaller communities where greater integration had occurred. Hollander (2002a:30) also suggests that his research clearly raises "questions about the efficacy of regionalization" for comparatively disadvantaged population groups such as persons requiring mental health services. The concerns relate to service availability, variability in service mix, portability and accessibility.

The second source is the Interim Reports of the "Kirby" Standing Senate Committee (see Kirby, 2004a, 2004b, 2004c). In reviewing current mental health, mental illness and addiction policies and programs in Canada (Report 1), the Committee notes the increased awareness of the need to better integrate addiction services with mental health services as well as with the larger social support systems. Chapter 8 of this Report provides a brief review of selected (four) provincial frameworks and concludes the following: that British Columbia is unique in having a separate Minister of State responsible for mental health and addiction services; that mental health and addiction policy development is not well coordinated across the relevant social policy ministries; that regionalization has facilitated both the tailoring of services and supports to meet regional needs more closely as well as collaboration among providers; and, that best practice reform strategies are largely agreed-upon across Canada. Despite the above, the Committee concludes that there is no particular Province or Regional Health Authority that could be considered a model to emulate in terms of policy development, organizational structure, governance and service delivery. It also concludes that "significant questions" remain: should the central authority for mental health and addiction be at the provincial rather than the regional level?; has any province or region been particularly successful at integrating hospital and community services and supports?; how can mental health services and supports best be integrated with addiction services?; and, has a particular province or region been able to

coordinate mental health and addiction services with the broader social/human service systems (education, housing, justice, income support etc.)?

A review of the available materials, some of which are referenced above, and the informant interview responses, has identified three main issues: the scope of mental health and addiction services governed and managed by regional health authorities; the assignment of responsibility for the residual, post-devolution system/cross-RHA functions; and, the strategies to keep mental health and addiction services on the "radar screens" of regional health authorities.

1. Scope of RHA services

There is notable variability in the scope of services under regionalized health governance structures both generally and related specifically to mental health and addictions. It appears somewhat more common for community and acute hospital-based mental health services to be included than addiction services, although there are examples where addiction services and not mental health services were initially included (e.g., New Brunswick), and where only mental health services have recently or are just now in the process of being included (e.g., Alberta). In several jurisdictions (e.g., Alberta, Manitoba and Australia), governance of addiction services is separated from mental health, often through a separate commission or foundation. Most interviewees were of the opinion that primary and secondary mental health and addiction services should both be included, supported by a number of cogent reasons, not the least of which relates to the large and often poorly served concurrent disorder population. The frequently noted need to integrate services for this latter population also strongly supports the wisdom of including both mental health and addiction services under the RHA umbrella.

The issue of who governs tertiary-level mental health services (including forensic services) has been dealt with differently across jurisdictions. In some, the regional health authority in whose catchment area the facility resides is the governing body (e.g., Quebec). Alternatively, governance may be managed centrally, either directly by the provincial/state government (e.g., New Zealand, England), or by a separate provincial-level body.

This latter approach has been taken by four of Canada's nine regionalized provinces – B.C., Alberta, Nova Scotia and Prince Edward Island. Of the four, B.C., followed by Alberta, has the most highly developed model for defining and managing a "provincial envelope" of services outside of government, in the form of a Provincial Health Services Authority (PHSA). The PHSA is one of six health authorities in British Columbia, the other five being regional. Although the criteria for determining which services are included in these central envelopes vary somewhat across these Provinces, common are services that are highly specialized, resource intensive, available on a limited basis and not suitable for local planning and purchasing. Application of these criteria doesn't always produce the same results, but cardiac services, cancer care, transplantation and neurosurgery are often included. Regarding mental health services, only in the B.C. provincial authority are tertiary and forensic services included, and some informants believe that mental health issues and priorities are not being adequately acknowledged and addressed under the PHSA, perhaps because the relative roles of the

provincial Ministry of Health, the PHSA and the five regional health authorities are not clearly delineated and differentiated.

In Ontario under the emerging Local Health Integration Network (LHIN) plan, decisions about who should govern tertiary or specialized mental health services may be more obvious for two reasons: under the Health Services Restructuring Commission's recommendations, the governance of all but two (Whitby Mental Health Centre and Penetanguishene Mental Health Centre) of the provincial psychiatric hospitals has already been devolved to local community hospitals and their Boards (the MOHLTC recently announced that it would be devolving the governance of WMHC to a newly created Board by April 1, 2005); and, each of these devolved facilities has functionally had regional catchment areas for some long time. Only a small number of the tertiary mental health programs in these hospitals remain truly "provincial" in nature, with the largest one being the maximum secure forensic program ("Oak Ridge") in the Penetanguishene Centre. For these tertiary-level programs that are provincial but fall under one LHIN's umbrella, it will be important to ensure ongoing access for residents from all LHIN regions. The same applies to the Oak Ridge maximum-security program, whether it remains government-owned or devolved to a separate board.

2. Residual System/Cross-Region Functions

One of the prominent issues emerging from the review is the need to define the functions to be performed centrally in jurisdictions that have devolved the governance of their health services to regional authorities. These may be functions that, if performed at all pre-regionalization, were performed centrally – i.e., by the provincial/state/national/federal government.

There is general agreement that, in regionalized health systems, the role of the central government is to lead or steer the system - that is, a governance role - while the role of regional structures is to manage the care delivery system (e.g., Flood & Sinclair, 2004; Levine, 2004). A critical central role is policy development. Lewis & Kouri (2004) identified other important macro-level functions such as setting performance standards and human resource strategies that, if anything, are even more critical post-regionalization and that should be retained centrally. On the other hand, functions that regions should perform include aligning needs and resources, ensuring quality and integrating services This division of labour between the regions and central government is sometimes described in terms of the steering and rowing of a boat.

The question of who should perform these functions does not always get the attention it deserves in the often-rushed processes of devolving. In some regionalized jurisdictions, the relative roles and responsibilities of the two levels of governance are clearly articulated (e.g., Alberta); in others this is not at all clear. In Manitoba and Saskatchewan, for example, many of these functions were performed historically by in-house Ministry policy and research staff. However, it is reported that post-regionalization the capacity of these Ministries to do that work has been severely eroded, while no other agency has been assigned the responsibility.

While government has historically performed the central functions, another approach is for an arms-length body (i.e., external to the government) to assume a leadership role in performing system-wide functions. This leadership role generally implies responsibility for ensuring that functions are performed in collaboration with a range of stakeholders. In Alberta, for example, the Alberta Mental Health Board has been restructured and given responsibility for: provincial leadership, collaboration, coordination and support activities in areas such as Aboriginal mental health, forensic services, mental health research, performance standards and measures, province-wide prevention and promotion initiatives, and mechanisms for making decisions and providing treatment for extremely hard-to-serve clients. Similarly, New Zealand has established an arms-length body – the New Zealand Mental Health Commission – to perform functions related to implementation planning, performance standard development and monitoring, workforce development, and public education/health promotion. The National Institute of Mental Health in England (NIMHE) is another example of an arms-length body created to provide technical assistance and oversee implementation of the National Mental Health Framework. The NIMHE allocates funds and commissions activity to address different program elements – e.g., in training, research, service delivery. It also conducts an annual financial mapping of mental health spending. It is worth noting that none of these bodies has a service delivery role.

The recent and ongoing reorganization of Ontario's cancer service system provides an in-province example of an "intermediate" agency performing important central system-wide functions related to one disease entity. Cancer Care Ontario (CCO) no longer directly provides cancer treatment services but rather purchases secondary and tertiary services from regional cancer centres. Its role and responsibilities are now focused on policy development, planning, coordination and monitoring. This is achieved through fund-holding, setting performance standards, comparing performance against those standards, and ensuring the necessary specialized information management infrastructure is in place to do that. CCO also advises the Minister of Health and Long-Term Care on all matters related to cancer services. In this arrangement, CCO is an "intermediate", arms-length organization that is helping the government perform the range of work required to govern and manage complex service systems, while emphasizing a more narrow but appropriate role for government as the maker of system policy, including that related to funding.

Five functions examined in the jurisdiction reviews were consistently found to be performed by a central body: performance monitoring; promotion and prevention; workforce development, best practices dissemination, and research. The next section briefly illustrates jurisdiction experiences in performing these functions. The discussion draws mainly on the experiences of the off-shore jurisdictions, as they have well-documented activity in these areas.

a) Performance Monitoring

At a minimum, the central government's steering role includes the development of system policy, including that related to funding. Some jurisdictions take this one step further. In Australia, England and New Zealand, the central governments have translated mental health policy frameworks into more detailed mental health plans or standards, and attached where possible performance expectations and specific targets. Ongoing monitoring and annual reporting are conducted to compare performance to expectations. This is viewed as being very

helpful in keeping the regional health bodies on course. Central government will likely need to provide support to the regions to develop the required information management structure.

New Zealand illustrates this process well. One of their strategic objectives is 'to increase specialist mental health services to ensure that 3% of the adult population can access specialist mental health services when needed (Blueprint for Mental Health Services in New Zealand, 1998). To guide implementation of this objective, resource targets across a range of service areas have been set, and annual reports compare current to targeted performance (see Table 2). These targets are also used to calculate national funding requirements, and it is believed that having a costed set of benchmarks against which to compare current performance has been a powerful advocacy tool.

In Australia, the National Mental Health Report is published annually and is the agreed tool for monitoring progress in implementing their national plan. Performance is closely monitored for the following policy objectives:

- Stability of government spending on mental health;
- Relative spending on community versus inpatient mental health care;
- Amount of care (i.e., beds) in stand alone institutions (versus general hospitals);
- Increased consumer participation in decision making (through formal mechanisms)

While system performance related to service capacity and spending are the most concrete to measure, efforts are underway to assess other areas of care delivery. In England, Standard 4 of the National Service Framework for Mental Health states:

> *All mental health service users should: receive care which optimizes engagement, anticipates or prevents a crisis and reduces risk; have a copy of a written care plan; and be able to access services 24 hours a day, 365 days a year.*

Implementation of this complex standard is difficult to assess, and is currently limited to monitoring availability of services that can respond appropriately and quickly to user needs – i.e., assertive outreach programs, crisis services and early intervention (Appleby, 2004).

Table 2
New Zealand Mental Health System Resource Targets, 1998*

Resource		National target	National current
Inpatient	Beds or 'care packages'	1,535	1,424
Residential	Beds or 'care packages'	3,243	2,576
Community mental health	FTEs	3,822	1,923
Community support	FTEs	1,284	388
Advisory services and initiatives (consumer and family)	FTEs	246	63
Access to newer anti-psychotic medication	People	8,500	3,547
Detoxification	Beds or 'care packages'	113	96
Residential alcohol and drug	Beds or 'care packages'	378	376
Community alcohol & drug FTEs	FTEs	614	262
Methadone treatments	Places	5,666	3,030
Mental illness prevention FTEs	FTEs	378	0

* From Kirby (2004b) and Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).

b) Promotion and Prevention

Prevention and promotion are increasingly prominent policy goals (e.g., see national policies for England, Australia and New Zealand), in part due to increasing recognition of the importance of improving population health and promoting a program of social change. In some cases policy statements have been accompanied by development of a separate, detailed national prevention and promotion strategy (e.g., Australia). Responsibility for planning lies at the national level, although approaches vary. In both New Zealand and England, the national, arms-length organizations[1] have mandates in this area. In England, the national Department of Health is also active, collaborating with other government departments (e.g., with mandates related to public health, youth, homelessness) to plan and commission prevention initiatives. In Australia, implementation of a National Action Plan for Promotion, Prevention and Early Intervention is being overseen by central government.

While activity in this area is growing, a recent evaluation of a major anti-stigma initiative in England concluded that there is a need for longer-term funding of public campaigns and robust evaluation.

c) Workforce Development

Workforce development often is addressed at the national level, overseen by central government or national arms-length organizations. In Australia, for example, a National Mental Health Education and Training Advisory Group was funded by central government to develop mental health practice standards in collaboration with the involved professions (Commonwealth, 2002). In both New Zealand and England, the national arms-length bodies have responsibility for mental health workforce development. In England, central government also is involved. For example, a collaboration between the Royal College of Psychiatrists and the England Department of Health is addressing recruitment and retention of psychiatrists (Appleby, 2004, p44). In Quebec, the central government is responsible for planning workforce development, including setting or recommending numbers of places in medical and other health-related professional and technical programs, as well as setting policies relative to the amount of training required to exercise various roles in the system.

d) Best Practices Dissemination

Again activity is led mainly by central government or by a national, arms-length body. In England, the NIMHE is mandated to disseminate expertise and propagate best practice, and is working with the National Institute for Clinical Excellence to implement a series of guidelines that they developed. In Australia, the central government has funded the Royal Australian and New Zealand College of Psychiatrists to develop clinical practice guidelines in five priority areas. However, there is no plan to support implementation. In New Zealand, the central government commissions the development of best practice guidelines and has assumed a role in providing guidance in their dissemination but this is not seen to be an area of strength (Improving Mental Health 2005-15, p15). Quebec is expected to designate up to three university/hospital-based institutes in mental health to stimulate the development of best practices in the areas targeted by their provincial mental health action plan.

[1] The National Institute of Mental Health in England (NIMHE) and the New Zealand Mental Health Commission.

e) Research

The experience of England is informative regarding progressing a research agenda. The Department of Health is committed to implementing a national program that ensures that mental health policy and service development are backed by the best possible evidence. Under the arms-length NIMHE, a new national research infrastructure – the Mental Health Research Network - has been established. It is managed by a partnership between the Institute of Psychiatry (the research arm of a mental health hospital) and the University of Manchester. It includes participation from 18 universities, more than 40 regional authorities and a number of provider organizations. Aims are to:

- deliver large-scale research projects to inform policy and practice;
- broaden the scope of research and gain full involvement from service users and carers;
- identify research needs of front-line staff, mangers and carers;
- develop research capacity.

Research dissemination is proving to be challenging. Efforts are being made to keep clinical staff connected to research activity in their respective service areas, and the NIMHE is to assume a crucial role in disseminating evidence.

A similar research agenda is being developed by the arms-length Alberta Mental Health Board, which will encompass traditional academic research; regional capacity building; provincial/university partnerships for technical support and knowledge transfer; and commissioned research.

3. Keeping Mental Health and Addiction Services on the RHA's "Radar Screen"

It is well documented that in the complex and competitive process for obtaining scarce public dollars, mental health and addiction services have difficulty in obtaining consistent and adequate attention. This historical phenomenon occurs in relation to its share of provincial dollars (e.g., allocations to community mental health agencies and psychiatric hospitals) as well as its share of, for example, an acute hospital's global budget. For providers and consumers, this issue takes on greater importance when decisions about planning and funding are devolved from central government to regional/local bodies. The experience across jurisdictions has highlighted a number of strategies/mechanisms that are viewed as being important in keeping mental health and addiction services on a regional health authority's active agenda. It is not surprising that many of these same strategies have been used within provincial/state governments to raise the profile of and protect/enhance resources for this service sector.

a) Central/Cross-Regional Vision and Leadership

As noted in the previous section, in many jurisdictions with regional health authorities, the central government (national/provincial/state) plays a critical role in articulating and updating mental health (and where applicable addiction) policy and plans. This approach gives mental health a greater profile among the health system stakeholders and the broader community; increases stability and continuity of policy over time, even with changes of government; and

provides a common vision and goals for the regional authorities, keeping them more attentive and reducing cross-regional variation.

Further, central government can move mental health policies from the abstract to the concrete by translating them into specific standards and plans, with accompanying performance targets. Regular monitoring of performance against these targets, with regular public reporting of results, is another powerful strategy for focusing attention on the mental health system and increasing the likelihood that regional health authorities will attend to well-documented mental health and addiction service needs.

Other functions that are performed centrally (see previous section) and contribute to maintaining a profile for mental health among health care stakeholders and the public include: promotion and prevention; workforce development; best practices dissemination; and research.

b) Mental Health and Addictions as a Distinct Program Area with Clear Accountability/Leadership

Interviewees believe that mental health and addiction services are more likely to thrive in regionalized health structures if they are constituted as a distinct program entity with their own leadership and management position, the more senior the better, created with specific responsibilities, including integrating these services with other relevant services and supports. In many jurisdictions, it appears that this position does not report directly to the regional health authority CEO, but rather to a VP level position labelled community health or a variation on that theme. The "program" scope includes both community and hospital-based services (the Winnipeg Regional Health Authority tried separating the above into two distinct program areas and recently decided to merge them into a single program under one person's leadership). The mental health and addiction program within the regional structure should also include resources not just to fund/purchase services, but also to facilitate planning activities such as needs assessments and to monitor and measure program and service performance.

c) Protected Funding

Typically, central governments transfer a global budget to the RHA, which then has authority to allocate according to need. Several of the reviewed jurisdictions have attempted to prevent authorities from spending these resources for non mental-health care through 'ring-fencing', an approach wherein part or all of the regional mental health and/or addiction funding envelope is stipulated as being protected (i.e., cannot be decreased). As noted by Martin Knapp, however, this approach has both advantages and disadvantages. On the negative side, ring fencing makes a false distinction between mental health and other health, and it may constrain service expansion. As well, it is dependent on having an accurate funding formula. The plus is that resources ear-marked for mental health are actually spent in that area. Ring fencing may be valuable when hospitals are down-sizing to protect newly realized revenues.

Ring fencing was used in several of the reviewed jurisdictions. England ring-fenced special mental health grants awarded to authorities by central government. The central Australia government embedded a 'maintenance of effort' commitment in their agreements with the States

regarding receipt of special Federal mental health grants as well as funds released through downsizing. In addition, central monitoring was implemented to ensure that state mental health spending did not decline. In New Zealand, the central Commission implemented a ring-fence policy in 2002/03.

In Australia, informants suggested that efforts of the past 10 years to protect mental health funding are no longer needed, in part because mental health as a priority area for expenditure has gained political support at the regional level. This appears to be becoming more common - the mental health and/or addiction regional funding envelope is ring-fenced in the transition years, but subsequently the protection is dropped. Another example is Alberta where mental health services have recently been devolved from the Alberta Mental Health Board to the regional health authorities. The protected regional mental health envelopes will remain until a new, more rational funding formula is developed. This latter point is critical – indefinitely protecting a budget that is not based on a carefully developed funding formula may, as noted above, be counter-productive.

The importance of having adequate 'commissioning' expertise at the regional level for distributing funds was also noted.

d) **Consumer and Family Participation**

Some interviewees report that a strong voice for consumers and their families in the planning and delivery of mental health and addiction services within a region is very helpful in keeping the needs of this population on the agenda/radar screen. The government of B.C., for example, in its first regionalization process stipulated that each authority convene and support consumer and family advisory committees/councils. Although the notion of appointing disease-specific representatives to the Boards of regional health bodies has had virtually no uptake as best we can tell, the development of some disease-specific advisory bodies as an adjunct to the regional governance and/or management structure has been more widely encouraged and accepted.

Conclusions

There is a lack of research evidence on regionalized health governance structures and the effects of these structures on mental health and addiction services. This review, therefore, is informed by a focused review of relevant documents that are largely conceptual and/or descriptive in nature and the observations of 16 purposefully-selected key informants from a number of Canadian provinces and three external jurisdictions.

The findings, in general, reflect the reality that, although there may be a small number of common features, there are significant differences in each jurisdiction's model of regionalization. To begin with, it is not yet the norm that both mental health and addiction services are encompassed by regional health authorities (RHAs). It is more common for mental health than addiction services to be included in the RHA mandate, although there is a strong consensus that they both should be included. There are two main approaches to the governance

and management of tertiary mental health services: retained by the provincial/state/central government or devolved to the RHA in whose catchment area the facility is physically located. The latter is probably more common. A third approach is that taken by British Columbia (we could not find other examples of this approach) in which a separate authority, the Provincial Health Services Authority, has been created to govern and manage a range of specialized tertiary health services including mental health and forensic mental health services.

The second issue is how to maintain a range of what are consistently viewed as critical system-wide/cross-RHA functions once health services have been regionalized/decentralized. There are three main approaches: government retains this responsibility and the resources appropriate to perform the functions; government appears to retain this responsibility but does not allocate appropriate resources to the tasks; and, government creates an arms-length body and gives it the mandate and resources to perform all (rarely) or some of these functions. The Alberta Mental Health Board, the New Zealand Mental Health Commission and the National Institute of Mental Health in England are examples of the latter approach, although, once again, there are differences in the responsibilities assigned to these intermediate organizations. What is common is that in each of the examples, the central (provincial/state/national) government retains at a minimum the core function of articulating system policy including that related to funding.

The third issue is that of how to ensure mental health and addiction services receive adequate attention in competitive and resource-constrained regionalized health systems. Multiple and concurrent strategies are consistently recommended: a clear system-wide policy and plan with detailed implementation targets; regular arms-length monitoring/reporting of RHA performance; a separate mental health and addictions program and budget with strong leadership within each RHA; protected program funding, at least until monitoring/reporting is demonstrably effective; and, strong consumer and family participation.

Despite the lack of research evidence and the varying approaches to how mental health and addiction services are organized in regionalized health systems, it is possible to identify two key system requirements:

- The need to retain strong central government leadership related to policy, standards and performance targets; and
- The need to be clear about who is responsible for performing a small but critical number of other system functions

A final observation is that Ontario's recent decision to create 14 Local Health Integration Networks provides an opportunity to study this regionalization process and its outcomes over time, particularly as it relates to the evolution of mental health and addiction services.

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Appendix 1 – List of Key Informants

Dr. Carol Adair, University of Calgary, Department of Community Health Sciences/Psychiatry
Leslie Arnold, Vice President Mental Health, B.C. Provincial Health Services Authority
Laurie Beverly, Executive Director, Programs and Research, Alberta Mental Health Board
Susan Chipperfield, Mental Health Policy and Planning Specialist, Winnipeg Regional Health Authority
Dr. Michael Clinton, Dean of Nursing, University of Calgary
Eleanor Grant, Senior Operating Officer, Mental Health, Capital Health Region, Edmonton, Alberta
Dr. Martin Knapp, Professor of Social Policy, Co-Director London School of Economics Health and Social Care
Carl Lakaski, Senior Policy Analyst, Mental Health Promotion Unit, Health Canada
Dr. Eric Latimer, Department of Psychiatry, McGill University, and Psychosocial Research Division, Douglas Hospital Research Centre, Verdun, Quebec
Dave Nelson, Executive Director, CMHA/Saskatchewan
Peter Portlock, Executive Director, CMHA/Alberta
Ken Ross, Assistant Deputy Minister, Mental Health Services, Health and Wellness, New Brunswick
Dr. Terry Sullivan, CEO, Cancer Care Ontario
Judith Tompkins, former Regional Director of Mental Health, Vancouver Regional Health Board
Dr. Mary Wicktorowicz – School of Health Policy and Management, York University
Christine Windsor, Principle Analyst, Mental Health Directorate, Ministry of Health, New Zealand

Appendix 2 – Key Informant Interview Schedule

Part A – For researchers and policy makers

1a) Is there evidence indicating that the implementation of regional health governance structures has positively or negatively effected mental health and addiction services?

b) If so, in what respects? E.g.,

- Client-centred care
    i. Client outcomes
    ii. Range of client choices
    iii. Client participation in all domains
    iv. Continuity of care
- Service / program delivery
    i. Client access to services
    ii. Range/continuum of services and supports
    iii. Use of best practices
    iv. Focus on SPMI population
- System integration
    i. Service coordination at local and regional levels
    ii. Linkages between mental health and addiction services
    iii. Decreased duplication
    iv. Seamless continuum of care
- Accountability
    i. Clear roles and responsibilities
    ii. Service/program cost effectiveness
    iii. Performance measurement/monitoring
    iv. Protection/enhancement of funding base
    v. Evaluation of the model
- Research and education
    i. Amount and range of research
    ii. Teaching/training of providers
    iii. Development of provincial best practice guidelines
- Health promotion, public policy, and system support
    i. Knowledge transfer in health promotion and treatment domains
    ii. Partnerships to fill knowledge gaps
    iii. Contribute to provincial policy
    iv. Advocacy for service system requirements
    v. Policies/practices to reduce stigma
- Other

c) Where is this evidence to be found? (e.g. identify key researchers, articles, reports, etc.)

2a) Is there evidence available to inform the question of whether protected mental health and addiction funding envelopes (i.e. "ring fencing") in such regional health governance structures are helpful or not in achieving some of the outcomes identified above?

b) Are there any other protective mechanisms noted in the research literature?

c) Where is this evidence to be found? (e.g. as in Q. 1c.)

3a) Is there any evidence to support the position that both mental health and addiction services should be included under these regional health boards?

b) Where is this evidence to be found? (e.g. as in Q. 1c.)

4a) Does the available research evidence suggest what is the most effective way to treat organizations that have a provincial role (i.e. beyond the region in which they are physically located) in implementing regional health governance?

b) What functions require a provincial/cross-regional mechanism to ensure their performance?

c) What is the source of this evidence?

5) Are there any other aspects of this issue that are important but that we haven't yet discussed? (e.g. other key researchers, articles, individuals)

Part B – For individuals working in regional health governance bodies

1) Please describe briefly the history of regional health boards in your jurisdiction (e.g. in place for how long, how many, important changes since inception, etc.)

2a) What is the scope of services governed by your regional health board? (i.e. what is included? what is excluded?)

b) If mental health and addiction services are both included, what are the advantages?

c) If addiction services are not included, why not? And, does this make sense?

d) Are there any mental health or addiction services that are not governed by your regional health board (e.g. tertiary services)? If so, what? And, who governs them?

3a) In your opinion, has your regional health board effected either positively or negatively mental health and addiction services?

b) If so, in what respects?

- Client-centred care
    i. Client outcomes
    ii. Range of client choices

iii. Client participation in all domains
iv. Continuity of care

- Service / program delivery
  i. Client access to services
  ii. Range/continuum of services and supports
  iii. Use of best practices
  iv. Focus on SPMI population
- System integration
  i. Service coordination at local and regional levels
  ii. Linkages between mental health and addiction services
  iii. Decreased duplication
  iv. Seamless continuum of care
- Accountability
  i. Clear roles and responsibilities
  ii. Service/program cost effectiveness
  iii. Performance measurement/monitoring
  iv. Protection/enhancement of funding base
  v. Evaluation of the model
- Research and education
  i. Amount and range of research
  ii. Teaching/training of providers
  iii. Development of provincial best practice guidelines
- Health promotion, public policy, and system support
  i. Knowledge transfer in health promotion and treatment domains
  ii. Partnerships to fill knowledge gaps
  iii. Contribute to provincial policy
  iv. Advocacy for service system requirements
  v. Policies/practices to reduce stigma
- Other

c) If so, what is the evidence to support this view?

4a) Is funding for mental health and addiction services protected in your regional health board's budget?
b) If yes, how does it work and is this a helpful tool or not?
c) If no, what, if any, problems does this create? And, would a protected funding envelop be helpful or not?
d) How are increases in funding for mental health and addiction services determined (e.g. same as/different from increases to other health services)?

5a) Pre-regionalization, were there organizations in your province/jurisdiction that had a provincial role related to functions such as research, public policy, health promotion, and system support (e.g. education/training)?
b) Do they still exist?
c) If so, who governs them?

d) If not, who performs those functions?

6a) How are mental health and addiction services reflected in your board's management structure?
b) Is this effective? Why/why not?

7a) Are there any other important issues related to the position of mental health and addiction services in your regional health board that we should be aware of?
b) Are there any other individuals in your province or elsewhere that you think we should speak to?

Appendix 3 – Jurisdiction Summaries

Alberta

Population: 2,941,150 (2001 Census)

Domain	Description
Central structures	
For mental health policy/planning	Alberta Health and Wellness has responsibility for overall policy development, implementation, funding, service planning and evaluation in the fields of mental health and addiction. The current policy framework for mental health is Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta (April 2004). That plan called for a restructuring of the Alberta Mental Health Board (AMHB) involving the devolution of mental health services from it to the regional health authorities and the assignment to it of a range of central-cross RHA functions. The Plan also clearly articulates the roles and responsibilities of the Province, the AMHB and the RHAs. An Alberta Alliance on Mental Illness and Mental Health is a voluntary group of stakeholders which has no official status. However, a Provincial Mental Health Council has recently been convened under the joint auspices of the Alberta Health and Wellness and the AMHB to steer the implementation of the 2004 Mental Health Plan. The new Provincial Mental Health Plan (PMHP) argues that the effective functioning of its mental health system also requires attention to a small number of functions and supports where "provincial collaboration, coordination and support is critical" (PMHP, 2004:16). It gives the AMHB "primary responsibility" for this role in a number of key areas that require the involvement of both Alberta Health and Wellness and the RHAs including: facilitating periodic updates to the PMHP as well as other government policies affecting mental health; identifying system information requirements to support outcomes measurement; measuring progress in the implementation of the PMHP; and, initiating, coordinating and facilitating related provincial mental health initiatives and functions such as aboriginal mental health, managing on behalf of Alberta Health and Wellness the contract with the RHAs for the delivery of forensic psychiatric services, coordinating the development of a provincial mental health research plan, coordinating the development of recommendations to Alberta Health and Wellness on performance standards, coordinating selected province-wide prevention and promotion initiatives, and leading the development of a framework for treating hard-to-serve clients.
For addictions policy/ planning	The Alberta Alcohol and Drug Abuse Commission (AADAC) is a Crown agency accountable to the Minister of Health and Wellness. It is mandated to operate and fund services addressing alcohol, other drug and gambling problems (such as detoxification, residential treatment services; prevention, education, counseling),

	and to conduct related research. The Commission offers hospital-based addiction services in all regions. Alberta Health and Wellness, as noted above, retains overall policy responsibility for addiction services.
Ministry/body responsible for funding mental health services	Alberta Health and Wellness
Ministry/body responsible for funding addiction services	Alberta Health and Wellness funds AADAC which allocates the service dollars (see above).
Regional structures	
Regional health governance structure	The province now has 9 Regional Health Authorities (RHAs). Seventeen RHAs were first created in 1994/95, with the recent reduction occurring in 2003. A full range of community and hospital-based mental health services is now delivered by RHAs, a change that began in 2004 with the release of the new Mental Health Plan. As noted above, the AMHB mental health service delivery role was eliminated as part of the Plan. Alberta's four tertiary mental health facilities are now governed and managed by the RHAs in whose catchment area they are physically located. Each RHA is currently developing a regional mental health plan consistent with the provincial Plan. RHAs, the Alberta Mental Health Board and AADAC work in partnership with the Alberta Health and Wellness and other ministries and agencies in the implementation of the province-wide Children's Mental Health Initiative (July 2001). This Initiative focuses on reducing the risk of mental health problems and substance abuse and on providing support and treatment for children, adolescents and their families.
Mental health services included	Yes – see above
Addiction services included	No – see above
Mental health & addiction services not governed by regional governance body	None
Mechanisms, if any, used to protect mh/addiction funding within regional health budgets	A new funding framework for mental health services is under development, a collaborative process lead by the AMHB. It is targeted to be in place by April 2006. In the interim, funding for mental health services is provided to RHAs in a separate funding envelope. RHAs have flexibility in how they allocate these funds within that funding envelope, but must not allocate any of these funds to non-m h services. It is expected that once the new funding formula is in place, this "protection" may end.

Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	RHAs and the AMHB
Workforce development	Alberta Health and Wellness, RHAs, Academia
Development of performance indictors & benchmarks, and monitoring	AMHB is the lead in collaboration with the RHAs, Alberta Health and Wellness and the Alliance
Best practices dissemination	Alberta Health and Wellness and AMHB
Research	AMHB is the lead in developing a provincial mental health research plan.

British Columbia

Population: 3,868,875 (2001 Census)

Domain	Description
Central structures	
For mental health policy/planning	Responsibility for policy development, implementation, funding, service planning, monitoring and evaluation in the fields of mental illness and addiction rests essentially with the Ministry of Health Services and the Ministry of State for Mental Health and Addiction Services. Responsibility for mental health policy for children and adolescents belongs to the Ministry for Children and Family Development which works in collaboration with the Ministry of Health Services and the Ministry of State for Mental Health and Addiction Services. The broad policy framework for reforming B.C.'s mental health system is outlined in the Ministry of Health Services' 1998 report Revitalizing and Rebalancing British Columbia's Mental Health System – The 1998 Mental Health Plan. More recently, the Ministry's Mental Health and Addictions branch released the report Development of a Mental Health and Addiction Information Plan for Mental Health Literacy, 2003-2005. The Government of B.C. released its Child and Youth Mental Health Plan in February, 2003. Two other province-wide initiatives are also in the process of being implemented: an anxiety disorders strategy (April 2002) and a depression strategy (October, 2002). A Minister's (of Health Services) Advisory Council on Mental Health composed of representatives from a range of stakeholder groups had been in existence for many years, but was disbanded in the fall of 2004.
For addictions policy/ planning	As noted above, mental health and addiction services fall under the purview of the same two Ministries. An addiction planning framework titled Every Door is the Right Door: A B.C. planning framework to address problematic substance abuse and addiction was released in May, 2004.
Ministry/body responsible for funding mental health services	Ministry of Health Services
Ministry/body responsible for funding addiction services	Ministry of Health Services
Regional structures	
Regional health governance structure	Governance, management and delivery of mental health services and addiction treatment including community-based services are the responsibility of Regional Health Authorities (RHAs) which operate in 5 defined geographic areas. Core mental health and addiction services provided by the RHAs include: emergency response and short-term intervention services; intensive case management; outreach services; clinical services (assessment, diagnosis, treatment and consultation); addiction treatment (since 2002), preventive measures (research, education, early identification and intervention); psychosocial rehabilitation; case

	management and social supports, including respite care for family caregivers; residential services and when required, assistance in accessing housing, income assistance, and rehabilitation services and benefits. The number of RHAs has been decreased significantly since they were created in the mid-1990s and addiction services were added to the RHA mandate in 2002.
Mental health services included	Yes – see above
Addiction services included	Yes – see above
Mental health & addiction services not governed by regional governance body	British Columbia has one large long-stay psychiatric hospital, Riverview Hospital, six community forensic psychiatric clinics and a Forensic Psychiatric Services Commission. RHAs are responsible for the community forensic psychiatric clinics. The Provincial Health Services Authority, the sixth health authority of the province, administers services provided province-wide by Riverview Hospital and the Forensic Psychiatric Services Commission. This arrangement for the governance and management of tertiary mental health services is unique in Canada. The PHSA is also responsible for: B.C. Cancer Agency, B.C. Provincial Renal Agency, B.C. Transplant Society, B.C. Drug and Poison Information Centre, B.C. Centre for Disease Control and Children's and Women's Health Centre.
Mechanisms, if any, used to protect mh/addiction funding within regional health budgets?	None
Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	There is no document which articulates which body has responsibility for performing these functions.
Workforce development	
Development of performance indictors & benchmarks, and monitoring	
Best practices dissemination	
Research	

Manitoba

Population: 1,103,700 (2001 Census)

Domain	Description
Central structures	
For mental health policy/planning	Manitoba Health is the responsible Ministry. Mental Health Renewal was initiated in 2001 and provides the policy framework and plan for mental health services. Work continues on the implementation of that plan which reorients mental health towards a primary health care approach that stresses delivery strategies focused on promotion, prevention and early intervention. There is a Provincial Mental Health Advisory Council composed of representatives from stakeholder groups which at times is asked to collaborate with Manitoba Health on specific policy issues, a recent one being a provincial policy on meaningful consumer participation.
For addictions policy/ planning	Manitoba Health
Ministry/body responsible for funding mental health services	Manitoba Health
Ministry/body responsible for funding addiction services	Manitoba Health funds the Addictions Foundation of Manitoba (AFM), a crown corporation, which in turn funds addiction services.
Regionalized structures	
Regional health governance structure	There are 11 Regional Health Authorities (RHAs) in Manitoba. Pre-2001, there were 2 RHAs in Winnipeg – one for community services and one for hospital services – but in 2001 these 2 RHAs were merged. Most RHAs cover rural and remote areas, and cover populations as small as 10,000 with the larger areas covering 60,000-100,000.
Mental health services included	Yes
Addiction services included	No – see above re: AFM role
Mental health & addiction services not governed by regional governance body	There are 2 remaining provincial psychiatric hospitals and these are governed and managed directly by Manitoba Health. In addition, consumer self-help programs receive their funding directly from Manitoba Health.
Mechanisms, if any, used to protect mh/addiction funding within regional health budgets?	The new RHA system does not included protected budgets for mental health services, perhaps because of the emphasis on building primary health care organizations within RHAs at the local level which include mental health services.
Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	RHAs

Workforce development	The assignment of these functions is not at all clear. It is reported that, post-devolution, Manitoba Health lost its ADM, Mental Health and the 20 or so policy and research staff who worked in that area have been reduced to 3-4 staff.
Development of performance indictors & benchmarks, and monitoring	
Best practices dissemination	
Research	

New Brunswick

Population: 719,710 (2001 Census)

Domain	Description
Central structures	
For mental health policy/planning	The Department of Health and Wellness through its Mental Health Services Division is responsible for providing central leadership and accountability for all mental health services in the province. A Mental Health Services Act, passed in 1997, articulates the policy framework for these services, including the underlying philosophy and strategic directions. A Mental Health Services Advisory Committee, established through the MHS Act, provides advice to the Minister of Health and Wellness.
For addictions policy/ planning	The Department of Health and Wellness through its Mental Health Services Division. Although there is no provincial addictions policy, there are provincial standards and strategic plans.
Ministry/body responsible for funding mental health services	Department of Health and Wellness
Ministry/body responsible for funding addiction services	Department of Health and Wellness
Regional structures	
Regional health governance structure	In 2002, New Brunswick's existing hospital corporations were transformed into 8 Regional Health Authorities (RHAs). (There are 7 Regions but 1 Region has both an Anglophone and a Francophone RHA). The first elections to RHA boards occurred in May, 2004.
Mental health services included	The RHAs are responsible for managing services provided by 8 acute psychiatric units, one child and adult psychiatric unit and two tertiary facilities. The Mental Health Services Division has purchase-of-service agreements with the RHAs for these services.
Addiction services included	All publicly-funded addiction services are included.
Mental health & addiction services not governed by regional governance body	The Mental Health Services Division currently directly oversees the operation of 13 Community Mental Health Centres (CMHCs), and directly funds consumer/family programs. A plan is now being developed to devolve the CMHCs (as well as public health) to the RHAs, a process that is likely to be completed before the end of 2005. The question of who will fund in the future consumer/family initiatives is not yet decided. The latter would prefer to remain funded directly by the Division.

Mechanisms, if any, used to protect mh/addiction funding within regional health budgets?	Addiction services budgets and "extra-mural" hospital service budgets (that is psychiatric services) are protected within each RHA global budget. It is not yet clear whether or not the provincial government will ensure similar protection for the soon-to-be devolved CMHCs (and public health), although strong lobbying on the issue is currently occurring.
Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	Not clearly articulated, although there is a provincial Service Prevention Program.
Workforce development	Not articulated
Development of performance indictors & benchmarks, and monitoring	Department of Health and Wellness. The Mental Health Services Division is currently refining 17 performance indicators it will use in monitoring RHA performance re: mental health and addiction services. One of the indicators relates to meaningful involvement of consumers in their care plans and service planning processes.
Best practices dissemination	Not articulated
Research	Not articulated

Quebec

Population: 7,125,580 (2001 Census)

Domain	Description
Central structures	
For mental health policy/planning	Department of Health and Social Services of Quebec *(Ministère de la Santé et des Services sociaux du Québec* or MSSS) A Mental Health Directorate (Direction de la Santé Mentale) was established in 2004 but has very limited capacity - about 6 staff (Latimer, 2005) Key recent reform documents: - Plan D'action Pour La Transformation Des Services De Sante Mentale (1998) - Plan d'action en Santé Mentale 2005-2008.
For addictions policy/ planning	Department of Health and Social Services of Quebec Advisory body – Comité permament de lutte à la toxicomanie
Ministry/body responsible for funding mental health services	Department of Health and Social Services of Quebec Funds are channelled from the MSSS to the regional authorities.
Ministry/body responsible for funding addiction services	Department of Health and Social Services of Quebec Again, funds are channeled from the MSSS to the regional authorities
Regional structures	
Regional health governance structure	Regionalization started in 1989. Currently there are 18 RHAs (called *Agences de développement de réseaux locaux de services de santé et services sociaux* or **ADRLSSSS** – Agencies for the development of local networks of health and social services), whose roles have been in transition since November 2003. Boardmembers and CEOs are appointed by the province, and CEOs are accountable jointly to the Quebec Deputy Minister of Health and the regional board. However, a reorganization is currently underway.
Mental health services included	Community health centers (CLSCs) have recently been combined with hospitals and long-term care facilities to create 95 local services networks responsible for health and social services, including primary mental health. Each of these networks, called Health and Social Service Centers (*Centres de santé et de services sociaux* or CSSS) is responsible for providing services (either directly or through service agreements) for the population on its territory. Hospitals that do not belong to a CSSS – usually, teaching hospitals - are accountable to the ADRLSSSS (i.e., RHA) in which they reside.
Addiction services included	Yes
Mental health & addiction services not governed by regional governance body	The province's four academic health science centers are currently being delineated into four networks (*Réseaux universitaires intégrés de santé* or RUIS – Integrated university health networks), with catchment areas that together cover

	the entire province. The RUISs are intended to provide tertiary, specialized care for people on the territory for which they are responsible
Mechanisms, if any, used to protect mental health and addiction funding within regional health budgets?	There are none. According to the Plan d'Action en Santé Mentale: Document de consultation – 2005-2008, the proportion of public health and social service expenditures allocated to mental health fell between 1998 and 2002, but appears to have stabilized since then at about 7%. This is attributed to the rapid rise in the cost of medications for mental illness as well as 31 M$ in new funding. Steiner (2002) describes the experience of the Centre-West Montreal District (as documented in the financial reports of the Metropolitan Montreal RHA) where funds saved through bed reductions between 1994 and 1997 were not reinvested in community, and funds allocated to the local Community Health Center Network for mental health services in subsequent years were diverted to other health areas.
Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	The MSSS coordinates Quebec's Strategy for Suicide Prevention. The National Institute for Public Health of Québec (Institut National de Santé Publique du Québec or INSPQ) is also responsible for supporting the MSSS and ADRLSSSs in their public health mission, which includes prevention and promotion. One of the objectives of the INSPQ's National public health program 2003-2012 (*Programme national de santé publique 2003-2012,* or PNSP*)* is to increase the proportion of people of all ages who are in good mental health. This national plan is implemented through regional and local action plans, to be put into effect by the ADRLSSSS and CSSS. The INSPQ itself primarily carries out consultative, research, and informational activities.
Workforce development	The MSSS is responsible for planning workforce development, including setting or recommending numbers of places in medical and other health-related professional and technical programs, as well as setting policies relative to the amount of training required to exercise various roles in the system.
Development of performance indicators & benchmarks, and monitoring	Activity reports from hospitals are collected annually and allow monitoring of measures such as bed-days in acute care. Recently the Direction de la Santé Mentale has been developing and following additional indicators to better track community-based care, especially pertaining to numbers of people receiving various types of services such as intensive and non-intensive case management. This information is collected by the ADRLSSSS and relayed to the MSSS. Performance agreements between the ADRLSSSS and the CSSS can provide for budget reductions if certain targets are not met.

Best practices dissemination	The MSSS provides general guidelines on the services it wants to see available throughout the province. It has avoided being very prescriptive as to what these services should look like clinically; for instance it has until now resisted calls to promote the Assertive Community Treatment (ACT) model specifically, but it does promote the concept of multidisciplinary teams offering treatment, rehabilitation and support services in an integrated way. In general (with some exceptions) the ADRLSSS have similarly been fairly vague. Thus the onus for promoting the adoption of evidence-based practices has been largely left to clinical personnel in the field. The case of ACT is somewhat unique in that a group of researchers and clinicians, working under the aegis of the Québec Hospital Association between 1998 and 2004 (now independent but funded by a consortium of hospitals), has banded together to produce practice guidelines and organize conferences to promote the adoption of ACT at the provincial level. The intent however is that the future Instituts universitaires en santé mentale, will play a key role in best practices dissemination. The province is expected to designate up to three University institutes in mental health (*Instituts universitaires en santé mentale*) which are supposed to stimulate the development of best practices in the areas targeted by the Plan d'Action. These are expected to be university-affiliated psychiatric hospitals, or consortia consisting of a psychiatric hospital and other psychiatry departments. A hallmark of these Institutes, who together would house a significant proportion of mental health researchers and mental-health-related faculty in the province, is supposed to be close integration of clinical, teaching and research activities.
Research	Mental health services, policy and epidemiological research in Québec is carried out primarily at research centres funded by the Québec Health Research Fund (*Fond*s *de la recherché en santé du Québec,* or FRSQ). Researchers at these centres are university-affiliated and derive their salary support from peer-reviewed granting agencies (primarily FRSQ and CIHR), university and hospital foundation sources. Some is also carried out by staff of the Institut National de Santé Publique. In all cases researchers obtain operating grants primarily from the usual granting agencies and foundations. Most operating grant funds available specifically for Québec mental health services researchers comes from a specific program designed for that purpose, funded by the MSSS and administered by the FRSQ.

Saskatchewan

Population: 963,150 (2001 Census)

Domain	Description
Central structures	
For mental health policy/planning	Ministry of Health. The Saskatchewan Health Quality Council (HQC) occasionally develops reports on specific mental health topics – a recent 2003 report focused on mental health care in primary care settings and identified best practices, but mental health and addictions do not appear to be a priority. The Mental Health Sector Survey (the "Conway" report) was completed in 2002 but its role in provincial policy is not clear.
For addictions policy/ planning	Ministry of Health
Ministry/body responsible for funding mental health services	Ministry of Health
Ministry/body responsible for funding addiction services	Ministry of Health
Regional structures	
Regional health governance structure	There are 12 newly developed Regional Health Authorities – this is the result of a restructuring which saw the number of these bodies (previously health districts) significantly reduced and their mandate more clearly articulated. Two policy documents spell out this transition.: The Saskatchewan Action Plan for Primary Health Care (June 2002) in which mental health is identified as a core service, and Guidelines for the Development of a Regional Health Authority Plan for Primary Health Care Services (October 2002). There is also an emerging voluntary provincial Mental Health Coalition of stakeholder groups which is being supported by CMHA, Saskatchewan.
Mental health services included	Yes – legislation passed in 2003/04 formalized this
Addiction services included	Same as above
Mental health & addiction services not governed by regional governance body	None
Mechanisms, if any, used to protect mh/addiction funding within regional health budgets?	Under the new RHA legislation there is no protection included, although pre-RHA, there was a government "expectation" that these budgets would be protected.

Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	It is unclear which body, if any, has assumed these functions. It is reported that the devolution of health services to the RHAs has "gutted" the Ministry of Health's capacity to perform these functions.
Workforce development	
Development of performance indictors & benchmarks, and monitoring	
Best practices dissemination	
Research	

Australia

Population: 20 million; states range in size from 0.2M to 6.6M population.
Health system information:

- federated system of govt. with 6 states and 2 territories
- health care shared responsibility between Commonwealth (national) government and sub-national (state & territory) govts;
- Australian states are more dependent on Commonwealth govt for health care funding than are the Canadian provinces
- Universal health coverage provided through Medicare, a national, publicly funded health care insurance plan; there is a private system and 1/3 of Australians have private health insurance
- Commonwealth govt – directly funds physician and drug services, and residential aged care
- States – fund/administer public hospitals including psychiatric facilities, rehabilitation & community health services including mental health; community residential services including mental health residences;
- national body responsible for health care is Department of Health and Aged Care
- distance is a challenge in delivering health services

Domain	**Description**
Central structures	
For mental health policy/planning	Mental health policy and planning is the responsibility of the Mental Health Branch of the Ministry of Health and Aged Care in the Commonwealth (national) government. In 1992 a National Mental Health Policy was adopted by all states and the federal government. This represented the first effort in 100 years to coordinate nationally the development of public mental health services, which had previously been the sole responsibility of the state (Whiteford, 2002). The Policy was implemented through a 5 year National Mental Health Plan, called the National Mental Health Strategy 1993-98. A second plan was published in 1998 for 1998-2003; a third plan for 2003-2008 was recently published. The *Australian Health Care Agreements* include a specific 'mental health schedule' that defines obligations of the commonwealth and states and identifies the *'extra'* Federal funds being provided to support implementation of the plan (Whiteford, 2002). In the schedule, the *National Mental Health Report* is the agreed tool for monitoring progress in implementing the plan; the Report has been published **annually** since 1992 (National Report02, green tab#1). A *National Mental Health Working Group* of state directors of mental health services is advisory to the federal Ministry of Health on progress in mental health reform but is "embedded in the industry". Mid way through the second plan, a

	comprehensive independent review was commissioned by an international team (Clinton, 2005). *The Mental Health Council of Australia* was established in 1997 and is a non-governmental advocacy group that provides another source of oversight (Whiteford, 2000).
For addictions policy/ planning	Drug and alcohol problems are primarily the responsibility of a separate service system with a separate national strategy (See National Mental Health Plan 2003-2008). The policy is focused on three issues: supply reduction, demand reduction, and harm reduction (e.g., treatment and diversion) (Kirby, p16, report 2).
Ministry/body responsible for funding mental health services	Both the state and federal governments fund services, but most $$ for specialized mental health services are allocated by the state mental health director office. Federal resources are used mainly for special initiatives (e.g, to improve rural/remote service delivery), also for national portfolios such as promotion and prevention, drug & physician benefits. Federal government grants represent only 3% of annual state spending on mental health services (Kirby, p10, #2).
Ministry/body responsible for funding addiction services	Addiction services are funded through several program areas, separate from mental health. The public health area addresses promotion and prevention. In addition, acute hospitals have a role in providing detox services and primary care is focused on managing opiate dependency. Also, the federal government has funded a number of cross sector special initiatives (e.g., with health, law enforcement, education, customs) (Kirby, p16, r2).
Regional structures	
Regional health governance structure	For the most part, regional governance is at the state level although configurations have varied over the last decade. Currently only one state is fully regionalized, and two are partly regionalized (Dwyer, 2004, p83).
Mental health services included	Mental health is a separate program area at the state level. Administrative structure varies depending on whether the state is regionalized. The mental health allocations are distributed through different programs – e.g., for young, adult, elderly; and then for community or institution. Programs report to state mental health director (Whiteford, 2000). At the local/sub state level, service delivery is based on catchment area populations (called Mental Health Areas), and the organization receiving funds is responsible for serving the area (Dwyer, 2004; Clinton, 2005; Burgess, 2004). Hospital services can be shared across areas.
Addiction services included	Addiction services are delivered through a separate 'drug and alcohol service system', which has a separate national strategy (National Mental Health Plan 2003-2008).
Mental health & addiction services not governed by regional governance body	There are a number of special national initiatives in the areas of promotion ad prevention, workforce development, information and monitoring, advancing good practice, promoting partnerships outside of the mental health sector.

Mechanisms, if any, used to protect mh/addiction funding within regional health budgets?	A commitment by the federal and state governments to budget protection was part of the original National Mental Health Policy, embedded in the bilateral (between the Federal and State governments) Healthcare Agreements. A 'maintenance of effort' clause required Federal funding and resources released through downsizing to be used for mental health in addition to (not in lieu of) state funds (Whiteford, 2002). The aim was to ensure that states maintained the current level of expenditure on mental health services; reinvested back into m h programs any resources released from closure/rationalization of services (e.g., from psychiatric hospital downsizing) (see National MH Report 2002); and continued to use extra federal mental health funds for that purpose. Regular reporting provided a public accountability mechanism. This strategy seemed to work (despite many government changes) – mental health spending was preserved and the % of overall health spending has remained constant at about 6.6%. Explicit protection is felt to no longer be needed (Kirby, p8). In 1999-2000, % of mental health spending on community services and supports was 49%, 23% on stand alone inpatient (from 49% in 1992); and 28% general hospital inpatient mental health care (MH Report 2002). There is considerable variation across states in the per capita mental health spending (Whitehead, 2002). Funding still less than required to meet needs for care. Most developed countries spend more than 6.6% of health budget on mental health care (Kirby, p10, #2). Significant work is underway to develop a casemix-based funding methodology through the Mental Health Classification and Service Costs Project. Case mix categories have been developed for both inpatient and community care, but rely on clinical and functional measures. Data quality issues related to these data are present (Whitehead, 2000).
Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	Federal
Workforce development	Federal
Development of performance indictors & benchmarks, and monitoring	A National Mental Health Report has been published annually since 1992 to assess system performance related to the agreed outcomes; these pertain mainly to funding levels, portion of $$ spent in community care (shift from institutional to community care); portion of $$ spent on inpatient care in general versus specialty hospitals. An initiative to collect client level outcome data across the system is well underway, with measures selected, and data collection reporting implemented in some areas (unpublished paper 2005).

Best practices dissemination	Federal project has funded the Royal Australian and New Zealand College of Psychiatrists to develop clinical practice guidelines in five priority areas.
Research	A national framework for coordinated innovative research and development is to be established (see National Mental Health Plan 2003-2008). Findings from a recent stakeholder survey will inform decisions about research priorities. Implementation will be realized through partnerships between investigators, policy-makers and funders and, within the research community, between institutions and disciplines.
Other	Responsible for strengthening mechanisms to facilitate genuine participation of consumers, families and caregivers in decision-making at all levels.

Other Comments:
Main elements/foci of mental health reform:

1) Decrease reliance on stand-alone psychiatric hospitals
2) 'Mainstream' acute beds into general hospitals
3) Expand community sector
   2003-2008
4) Adopt population health perspective – acknowledge the continuum of activity encompassing promotion, prevention, early intervention, treatment, longer-term support (recovery), long term care (continuing care)

England

Population: 50 million;
Labor government took office in 1997;
The National Health Service (NHS) is the public health care system (similar to Canadian Medicare), and accounts for 82% of health care spending (vs Canada at 70%).

Domain	Description
Central structures	
For mental health policy/planning	Mental health policy and planning is the responsibility of the Mental Health Policy Branch of the Department of Health Key policy and planning documents produced by the Branch: 1998: Modernizing Mental Health Services White paper – set out new mental health strategy, including a recommendation for creating specialist mental health NHS Trusts; 1999: National Service Framework for Mental Health (NHS-MH) – This report set out evidence-based, national standards, performance measures and targets for mental health care for adults. These addressed promotion (pop health), treatment and continuing care. The framework gave mental health a greater profile and priority service status within the NHS (Appleby, 2004; Kirby, p44), although concern continues that other health areas are receiving greater priority and resources (e.g., acute care) (Kirby, p52). The framework was accompanied by a national commitment of resources. NHS Plan 2000: This 10-year plan built on the 1999 report by detailing specific service development commitments – e.g., for assertive outreach, crisis management, early intervention; also addressed workforce development & primary mental health care, and added substantial new revenue for mental health services (Kirby, 2004). Policy Implementation Guide 2001: The guide provided more detail on service commitments outlined in the NHS-MH 2000 report. 2002: Proposals published for reforming the Mental Health Act. 2002: National Institute for Mental Health in England (NIMHE) is a separate (arms length) body, established to provide technical assistance and oversee implementation of the Framework. 8 regional offices are linked with local communities and trusts. Responsibilities focus on training, disseminating expertise and propagating best practices. About 26 programs have been launched with central funds (Kirby, p42), including a minority ethnic program, models of best practice, anti-stigma campaigns, etc. For each program NIMHE allocates funds and commissions activity to address different program elements – e.g., in

	training, research, service delivery. NIMHE also conducts an annual financial mapping of mental health spending. 2004: National Service Framework for Mental Health – Five Years On – This report was published by the National Director of Mental Health, and assessed progress on the NSF for Mental Health.
For addictions policy/ planning	Separate program in Department of Health
Ministry/body responsible for funding mental health services	Central government provides a global, capitation-based allocation of funds to Primary Care Trusts (Kirby, p44), which then allocate funds for mental health and other health services. The PCT has discretion in how much and how funds are spent. PCTs commission services through Service Level Agreements with Trusts, social services, etc. There is some concern about the commissioning expertise of the PCTs and the priority given to re mental health (Appleby, p14) although overall, spending exceeds allocations (Appleby, p39). However, there is wide variation in area per capita spending.
Ministry/body responsible for funding addiction services	See previous section.
Regional structures	
Regional health governance structure	There are 28 Strategic Health Authorities run by boards of professionals and lay people appointed by the Secretary of State. Catchment area populations range in size from 250K to 1 million. These Health Authorities commission services from Primary Care Trusts, which receive 75% of the NHS budget and are responsible for managing health services at the local level. Catchment population sizes for the PCTs range from 50K to 250K (average size=100K). PCTs interpret national standards for local populations (Kirby, p38). PCTs directly provide primary care and community health services, and commission services from hospital trusts and secondary/tertiary providers. They also commission mental health services. Health services are delivered locally by National Health Service Trusts. The Trusts manage a unified budget, and amalgamate a number of agencies into a single provider responsible for a broad spectrum of services that include inpatient and community care (Kirby, p45). Specialty Mental health Trusts, emerged in the late 1990s to create a single local provider of specialist mental health services (Kirby, 53). These trusts provide/ purchase an array of secondary and tertiary mental health services (inpatient and community) (McCulloch, 2000; Kirby, p45). Several PCTs may work with a single Mental Health Trust (Appleby, 2004). Local Implementation Teams (LITs) – The NSF-MH directed each area to create

	an LIT to oversee development of mental health services in collaboration with local health and social care stakeholders (Appleby, p6; Kirby, p42). The 2004 National Service Framework for Mental Health – Five Years On reports the progress of the LITs in meeting the national standards. Integration strategies include developing protocols for sharing information, transferring clients, agreeing roles and responsibilities (Appleby, p21).
Mental health services included	Acute inpatient, crisis resolution and accommodation, early intervention, case management, clinical treatment, assertive outreach, residential care, employment rehabilitation.
Addiction services included	Drug and alcohol services are managed within mental health provider organizations (trusts), often as a separate internal directorate.
Mental health & addiction services not governed by regional governance body	Forensic – there are 3 special hospitals in England for the most dangerous patients (1500 beds), and a network of medium secure units providing regional or sub-regional service (1000 beds). Tertiary care is accessed through referrals from secondary level care but governance of these services is unclear.
Mechanisms, if any, used to protect mh/addiction funding within regional health budgets?	NHS expenditure on mental health care is about 12-13% (Kirby, p43), with 80% funded by NHS, 15% from social services budget, and 3% from special Mental Health Grants from central government. This latter is ring-fenced. Rate of increase in mental health funding has been lower than general health (i.e., share allocated to mental health by NHS is falling), and funding is perceived to be inadequate to implement the NSF (Kirby, p44).
Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	National responsibility. The NIMHE has lead responsibility for tackling stigma and discrimination around mental health problems. A recent report noted the need for longer-term funding and robust evaluation of public campaigns. NIMHE commissioned a literature review of international mental health promotion work.
Workforce development	This is overseen by the National Workforce Program within the NIMHE and put into practice by a Workforce Implementation Team.
Development of performance indictors & benchmarks, and monitoring	The NIMHE commissions an annual 'Autumn Assessment'. In addition, for the 2004 NSF review, additional analyses were commissioned from an independent organization - *Mental Health Strategies,* and an academic from University of Durham. Accountability monitoring is conducted by 3 independent bodies - Commission for Health Care Improvement; Commission for Social Care Inspection; Audit Commission. These bodies examine policy frameworks and the evidence base, and use these to develop criteria for the inspection and monitoring of services on the ground.

Best practices dissemination	Central- A collection of clinical guidelines have been written by national collaborating centres that are funded by or offshoots of the National Institute for Clinical Excellence
Research	Central, a new national research infrastructure has been established – the Mental Health Research Network. It is managed on behalf of NIMHE by a university partnership (Appleby, p52).
Other	Special populations: NIMHE's largest program of work is on improving mental health services for the Black, Minority and Ethnic Groups (BME). The program includes better information, research, appropriate services, and community engagement.

New Zealand

Population is 4 million;
Unitary (versus federal) state;
78% of health care cost is paid by public sector funds;
Patients pay partial costs for primary care and drugs.

Domain	Description
Central structures	
For mental health policy/planning	There is a Mental Health Directorate, within the NZ Ministry of Health which employs about 30 people and is responsible for developing policy, infrastructure supports (workforce development, performance monitoring), and administering the mental health act. Key policy and planning documents published by the Ministry of Health include: - 1994 - National Mental Health Strategy 'Looking Forward' - 1997 – National Mental Health Plan ' Moving Forward' - current - a 2nd National Mental Health and Addiction Plan 2005-2015 is under consultation In 1996 an arms length National Mental Health Commission was established by statute, with specific mandates to monitor and makes recommendations to government on performance of the Ministry of Health and 21 DHBs; reduce discrimination against people with mental illness; and ensure that the mental health workforce is strengthened. In 1998 the Commission released the Blueprint for Mental Health Services in New Zealand, which presents system targets for specialist mental health services and has been useful for clarifying capacity goals and monitoring progress. Since then the Commission has regularly published a 'Report on Progress' in implementation of the national strategy. It also commissions special reports such as an analysis of discrimination and how to overcome it (Wilson, 2000).
For addictions policy/ planning	Promotion is the responsibility of the Public Health Directorate. Alcohol and drug services policy is the responsibility of the Mental Health Directorate; in fact the current draft policy is entitled 'Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015'.
Ministry/body responsible for funding mental health services	New Zealand Ministry of Health determines resource allocations for mental health care, and receives recommendations from the Directorate and the Commission. Funds are allocated to the DHBs, and reporting is one accountability tool between the DHBs and Ministry of Health for assessing how the money is spent.
Ministry/body responsible for funding addiction services	The New Zealand Ministry of Health determines resource allocations for alcohol and drug services.

Regional structures	
Regional health governance structure	In 2000, central government devolved responsibility for health care to 21 District Health Boards/authorities. These boards are responsible to the Minister of Health for serving geographically defined populations (through both direct service delivery and contracting). Mental health care is one area of responsibility. Population sizes range from <50,000 to >400,000. The previous configuration included one central funding authority and 21 provider boards.
Mental health services included	Each DHB is responsible for providing a continuum of community services and inpatient acute care. These services are provided directly by the DHB or though contracting with NGOs (which provide residential, community support and vocational training services)(Wilson, 2000). The DHBs all have hospital "arms" that deliver inpatient and outpatient services on site. Each DHB has one board responsible for both functions of funding and providing services. (Hospitals do not have their own boards). In addition all DHBs provide treatment services from community bases or in the consumers home. This applies to mental health and alcohol and drug services (with the exception of the greater Auckland area which is serviced by 3 DHBs but only one provides the alcohol and drug services). Some DHBs provide limited support services but in the main they contract with NGOs for support services. There are also some limited clinical services provided out of the NGO sector. In total 72% of services by value are provided by DHBs and 28% by NGOs. The NGOs have their own boards (Windsor, 2005).
Addiction services included	Addiction services are also provided within specialized mental health delivery system, although more work is needed to integrate care for those with mental health and addictions disorders.
Mental health & addiction services not governed by regional governance body	Due to the small size of some DHBs, some regional level services are provided by regional mental health networks. These services are paid for by DHBs, with contributions determined by Inter-District Flows mechanisms (which apply across all services not just mental health). The Regional mental health networks are responsible for planning regional services or regional support for smaller services (Windsor, 2005). Examples of regional service areas include forensic, eating disorders, maternal mental health, early intervention for psychotic disorders, some child & youth services (Wilson, 2000). There are 2 psychiatric institutions (after a major deinstitutionalization effort that closed 8 /10 institutions during the last 20 years). These offer forensic and long-term rehabilitation services.

Mechanisms, if any, used to protect mh/addiction funding within regional health budgets?	The Blueprint document has become the method for informing the funding levels required to build more and better services for those with severe mental illness. Having benchmarks with attached costing has been a powerful advocacy tool in negotiations with treasury (Kirby, p25, report 2) - Mental health funding has increased since 1994 in size and changed focus such that currently 69% of mental health services funding is for community services - still there are fears that DHBs may not spend the money allocated to mental health - this concern reflects in part the workforce shortages that result in unfilled positions The Commission put a limited ring fence in place in 2001/02, and a more comprehensive ring fence policy in 2002/03 (Kirby, p27, report 2; Windsor, 2005).
Provincial/cross-regional functions: Where does responsibility lie for…	
Promotion and Prevention	Mental Health Directorate
Workforce development	This is a national function, governed by a Federal Ministry of Health and DHB partnership. It includes both mental health and alcohol/drugs workforce development.
Development of performance indictors & benchmarks, and monitoring	NZ Ministry of Health is responsible for assessing performance related to mental health standards, through contractual requirements or to receive accreditation. Alcohol and Drug standards are currently separate but there is a plan to merge them. A National Mental Health Information Strategy and a Mental Health Standard Measures of Assessment and Recovery Initiative are underway to improve information collection and reporting.
Best practices dissemination	NZ Ministry of Health contracts occasionally for development of Best Practice guidelines (e.g., with New Zealand Guidelines Group) , and provides in collaboration with DHBs guidance on best practice models of service delivery; also reviews sector standards, sets national service specifications (Improving mental health 2005-15).
Research	A Mental Health Research and Development Steering Committee (funded by the Ministry of Health) was established in 1997 by the Ministry of Health, Mental Health Commission and Health Research Council and published a strategic plan to guide its activity. An update is planned by 2007.

Comments:

Main goals of 1st National Mental Health Strategy:

1) Increased investment in mental health care.
2) Development of community-based services and move away from hospital-based care.

Emphases of 2nd strategy

1) Whole-of-government initiatives
2) Population health approach – promotion, prevention, social inclusion, de-stigmatization, reduction of inequalities
3) Primary care
4) Information to support decision-making

Successes:

- Investment has increased.
- All but 2 psychiatric facilities have been closed;
- Most inpatient care is delivered in general hospitals
- Access to specialist mental health services has increased (1.6% of pop.) but only 9-10% were served by inpatient teams – 2002/03; (rates are lower for children and elderly than adults)
- 1/3 public expenditure is spent on inpatient care vs 2/3 for community care

Mental health funding has increased since 1994 in size and changed focus such that currently 69% of mental health services funding is for community services