MENTAL HEALTH SYSTEMS COMPARED

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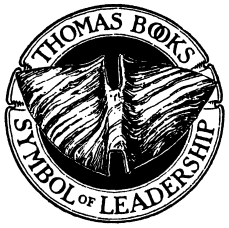
Great Britain, Norway, Canada, and the United States

Edited by

R. PAUL OLSON

Minnesota School of Professional Psychology
at
Argosy University–Twin Cities



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FOREWORD

It is a pleasure and honor to write the foreward to this book. As psychologists, as educators, and as individuals committed to the promotion of health -- captured by WHO's depiction as a "state of complete physical, mental and social well-being" (WHO, 2001) -- the authors of this volume have collectively undertaken an overview and comparison of the mental health infrastructures and services in four countries – Canada, Great Britain, Norway and the United States. Their very comprehensive, thorough and comparative approach makes this a unique volume – they address mental health services as part of a larger social service and health care delivery system, embedded in larger systems of culture, history, attitude and belief.

What you will learn from this book. The authors, psychologists from the four countries surveyed, used a common framework to organize their information on the mental health systems of Canada, Norway, the United Kingdom and the United States – countries that vary in size, wealth, population, and governmental and social services organization. Collectively, the chapters on these countries offer a trove of information that will educate readers about the current status of mental health care in a rich context from a public policy and public health perspective. Understanding mental health care in any one country requires both detailed and organized understanding of how that system is positioned within the larger health care system. This volume provides that overview by describing the many layers comprising the system. These include a snapshot of each country's social, political, demographic, geographical and economic history with an eye to capturing the context in which health and mental health are addressed; an overview of important policies and programs, and the resulting health and mental health systems, including indications of effectiveness, cost, and serving the needs of the population. No one can help emerging from this book without two things – an appreciation of the broad-ranging attention paid to health and mental health by commissions, researchers, politicians, agencies and global bodies, and a sense of awe at the extent to which an ideal world with quality health and mental health care, accessible in a timely fashion to all is still not fully realized even in those countries with a vast protective net.

Why you should read this book. As editor Paul Olson points out, the time is right for a volume that provides a common framework for looking at

information across countries. Thoughtful comparative summaries concern such broad issues as access to services, mental health workforce needs, and meeting the needs of the population; a section on lessons learned provides a wealth of information and inspiration for those who want to understand and improve their country's mental health system services. We always benefit from looking beyond our own borders to see how others, with different histories, systems and expectations have approached solving common challenges. This volume contributes to that discussion.

Merry Bullock
Senior Director, Office of International Affairs
American Psychological Association

PREFACE

> In September 2000 representatives from 189 countries, including 147 heads of state, met at the Millennium Summit in New York City to adopt the United Nations Millennium Declaration. The declaration set out the principles and values that should govern international relations in the twenty-first century. (WHO, 2003, p. 25)

National leaders made commitments in several areas including the development of nations and eradication of poverty. Goals prepared subsequently in this area are generally called Millennium Development Goals (MDGs). The MDGs are the collective expression of desired ends and intended outcomes, not a prescription for the means by which these ends are to be achieved.

Three of the eight MDGs, eight of the 18 targets required to achieve them, and 18 of the 48 indicators of progress are health-related (WHO, 2003, Table 2.1, p. 28). Mental health was not cited specifically or separately as one of the health-related goals, targets, or indicators. Though not mentioned explicitly, mental health is an implicit goal by virtue of the WHO definition of health as ". . . a state of complete physical, mental, and social well-being" (WHO, 2001, p. 3).

Moreover, as a component of health, the WHO has endorsed mental health as both a universal human right and a fundamental goal for the health systems of all countries irrespective of their stage of development. The right to health was affirmed in the Constitution of the WHO drafted in 1946: "The WHO Constitution identifies 'the enjoyment of the highest attainable standard of health' as 'one of the fundamental rights of every human being without distinction'" (WHO, 2003, p. xi). Health, including mental health, is viewed as a goal closely connected with two other core values to be actualized internationally in the twenty-first century – the values of security and justice. An essential aspect of justice is the promotion among nations of universal access to affordable mental health care of the highest attainable quality.

One year after the Millennium Summit, the WHO devoted an entire annual report (WHO, 2001) to a description of the mental health needs of 192 member nations. This landmark report included prevalence estimates of selected mental disorders and their contribution to the burden of disease worldwide evident in the death and disability attributable to mental disorders. Nations' health expenditures in public and private sectors were cited as indicators of how well the mental health needs were being met.

In the same report, the WHO reaffirmed that the prevalence and consequences of mental disorders have a substantial impact on health care systems generally. A large proportion of medically ill and injured individuals experience co-morbid depression, which interferes significantly with patients' adherence to recommended medical treatments (WHO, 2001, Box 1.3, p. 9).

Tragically, many individuals do not receive any health care for their mental disorders, let alone mental health services appropriate to their specific type and severity. The WHO cited two common barriers to treatment: (a) stigma and discrimination, and (b) inadequate mental health infrastructures to meet the large and increasing need for mental health services. The present volume addresses the second factor by comparing the mental health systems of four selected countries (WHO, 2003, Box 1.4, p. 19).

These four countries illustrate both strengths and limitations in the way mental health services are organized, delivered, and financed. An understanding of their commonalities and differences provides insights about both the challenges many countries face, and the possibilities for meeting them. It is the authors' hope that our respective countries might learn from one another what policies and strategies seem to work, and how the gap between mental health needs and mental health services can be bridged to reduce this form of human suffering worldwide. We believe that improvement in the mental health of countries will help to promote international security, justice, and peace, in addition to promoting the well-being of individuals.

The purpose of this book is twofold: First, to describe the mental health systems of four Western industrialized societies (Great Britain, Norway, Canada, and the United States), and second, to evaluate and compare these systems on a set of common criteria. Particular attention is given to how each society delivers and finances mental health services for their population with identified mental disorders. The authors from each country evaluate their own mental health system relative to six common criteria to facilitate comparison with the other three countries. Common criteria include access/equity, quality/efficacy, cost/efficiency, financing/fairness, and protection/participation. On the final criterion (population relevance), the authors provide a summative evaluation by addressing the degree to which their country's present mental health system meets the identified needs for mental health services. All six criteria are defined subsequently in the introductory chapter. The authors' evaluations lead to recommendations for improvement in mental health policies and in the structure and functioning of their country's system for delivering and financing mental health services. The book's final chapters address convergence and divergence among the four systems, and provide conclusions and recommendations for mental health system reform.

World Health Organization (WHO) (2001). *The World Health Report 2001: Mental health: New understanding, new hope.* Geneva, Switzerland: Author.

World Health Organization (WHO) (2003). *The World Health Report 2003: Shaping the future.* Geneva, Switzerland: Author.

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Chapter 1

INTRODUCTION

R. PAUL OLSON

OVERVIEW AND CONTEXT

Within the past decade mental health has received increased international attention. Stimulated by calls to action by the United Nations Secretary General (Boutrous-Ghali, 1995) and by World Health Organization (WHO) health ministers (WHO, 2001a), the WHO began a project on "nations for mental health" (Jenkins, McCallough, and Parker, 1998), and devoted its annual world health report to mental health (WHO, 2001b). "In 1999, the World Bank established positions for mental health in its Washington, DC headquarters and for the first time, considered the funding of mental health interventions within its lending program as well as including mental health in its policy dialogue with countries" (Gulbinat et al. 2004, p. 6).

Within this same period, there have been significant advances in technical knowledge and cost-effective interventions (WHO, 2001b), but the application of empirical research in mental health delivery systems has been limited, and especially in developing nations, with the result that the large majority of people with mental disorders remain untreated. Estimates of *untreated* mental and neurological disorders in developing countries (85%) is much greater than in developed countries (54%), but remains high in both (Institute of Medicine, 2001).

Among the causes for the wide treatment gaps both within and between countries, three system factors have been identified: (a) the lack of a policy on mental or neurological health; (b) the failure of professionals in the fields of mental health and neurology to engage in the economic aspects of the health and social policy dialogue; and (c) the lack of preparation and training for leadership in policy development and dialogue (Gulbinat et al. 2004, p. 6).

A fourth factor implicated in the treatment gap is the small number of international comparative studies of mental health needs and mental health systems that are more or less successful in meeting their population's needs. Gulbinat et al. (2004) observed that international comparative studies of mental health services, programs, and policies have been very limited, if not nonexistent until the late 1990s when a few studies were published (e.g., Global Forum for Health Research, 1999; Gulbinat et al. 1996; Jenkins and Knapp, 1996; Manderscheid, 1998; Sartorius, 1998). This limited research is itself one of the barriers to establishing evidence for the impact of mental health policies and mental health systems.

In recognition of the need for comparative studies, particularly on the impact of mental health policy formulation and implementation upon sector-wide reform, the International Consortium on Mental Health Policy and Services developed (a) a framework (template) identifying key domains and elements of a national mental health policy, and (b) a standardized method (mental health country profile) to assess a country's current mental health status. Additional goals of this international effort included (c) establishing a global network of expertise in mental health policy and services, (d) evaluating the cost-effectiveness of implementations of various elements of mental health policy under different conditions, and (e) generating guidelines and examples for improving mental health policy and mental health system performance appropriate to existing delivery systems and demographic, cultural, and economic factors (Gulbinat et al. 2004, p. 9).

Among mental health specialty groups, clinical psychologists have not been trained systematically, if at all, in mental health policy formulation and

implementation, nor in systems theory or mental health services research. One consequence has been much less psychological research on the performance of mental health delivery systems than on the development of cost-effective, evidence-based clinical interventions. There has been a particular deficit in professional psychology curricula devoted to understanding the language of health economists, finance experts, and health policymakers and politicians. Psychologists who have contributed to systems level research on policy formulation and implementation have been those with a keen interest and practical experience in positions that require a system-wide perspective. We have found examples of these experts from the four countries that constitute the focus of the present comparative study of how countries finance, organize, and deliver mental health services to meet their population's needs.

None of our contributing authors claim to represent a consensus or official perspective on the performance of their mental health system. All of them have been immersed in the operations of these systems at clinical and/or administrative levels, in the education and training of clinical psychologists, in research, consultation or supervision related to the delivery of mental health services and/or in mental health policy formulation and implementation.

Our authors have volunteered to share their own expert views of the mental health systems operating in their own country. They have not been asked to create a complete "mental health country profile" according to the specifications of the International Consortium on Mental Health Policy and Services (Jenkins et al. 2004), but elements and domains of the guiding framework (template) have been selected to facilitate comparisons among these four developed countries (Townsend et al. 2004). To be more specific, the authors have been invited to address some, but not all of the elements of all *four domains* pertinent to mental health policy formulation: context, resources, service provision, and outcomes.

The purpose of this chapter is to provide an overview and context for the planned comparisons among the systems for delivering and financing mental health services in Great Britain, Norway, Canada, and the United States. Because this book addresses specifically the systems for treating mental disorders, the introduction begins with definitions of two central terms: "mental health systems" and "mental disorders." Thereafter, an international perspective is provided on the significance of mental disorders by citing current statistics summarized by the World Health Organization on the prevalence and the contribution to the burden of disease evident in the death and disability attributed to mental disorders (WHO, 2001b, 2004).

A mental health system does not exist as an autonomous sector within a society; rather, it functions as a subsystem within a society's overall health care system. How mental health services are delivered and financed is influenced significantly by the way in which a society organizes, delivers, and finances all health services. Consequently, to understand similarities and differences among the four mental health systems selected for this study, it is helpful to appreciate the comparative estimates of both total health expenditures and the predominant sources of public versus private financing. The World Health Organization (WHO) provides these estimates in its annual reports, though not for mental health spending separate from total health expenditures. The latter data have been reported most recently in the *Mental Health Atlas – 2005* (WHO, 2005a).

Following the report of health expenditures by each of the four countries, the domains and criteria are discussed in this chapter relevant to the twin goals of description and evaluation of the mental health system for each country. This discussion is followed by presentation of the common chapter outline adopted by the contributing authors to facilitate comparisons. The introduction concludes with comments about our authors and intended audience.

In its annual report devoted to mental health, the WHO recognized that mental health is crucial to the overall well-being of individuals, societies, and countries. The report also acknowledged the following:

> Unfortunately, in most parts of the world, mental health and mental disorders are not regarded with anything like the same importance as physical health. Instead, they have been largely ignored and neglected. Partly as a result, the world is suffering from an increasing burden of mental disorders and a widening 'treatment gap.' (WHO, 2001b, p. 3)

It was estimated that in 2001 about 450 million people worldwide suffered from a mental or behavioral disorder, but only a small minority received even the most basic treatment. There continues to be significant unmet needs for mental health services around the world. The WHO projected that the burden of disease attributable to mental disorders will increase from ten percent in 1990 to 15 percent in 2020 (WHO, 2001b, p. 19).

The annual report devoted specifically to mental health (WHO, 2001b) reflects the growing awareness

within the international community of the significant impact of mental health upon the social, economic, political, and individual well-being of the world's population. Moreover, the WHO acknowledged the significance of mental health by including it as an essential component in the basic definition of health. Health is "not merely the absence of disease;" rather, health is ". . . a state of complete physical, mental, and social well-being" (WHO, 2001b, p. 3). This definition reflects a consensus about both the holistic nature of health and consequently, the integral part mental health plays in general health.

Although the present volume focuses on the ways the diagnosis and treatment of mental disorders are organized, delivered, and financed, it is important to appreciate conceptually and empirically that mental health is more than the absence of a mental disorder. Moreover, the contributing authors share the conviction that the promotion of mental health and the prevention of mental disorders are as important as their diagnosis and treatment, but it is the latter that our contributing authors have been asked to emphasize, though not exclusively.

Use of the terms "mental health" and "mental illness" would seem to imply endorsement of a medical model of these phenomena. Mental illness is a general term, which refers to all diagnosable mental disorders regardless of their etiology. While acknowledging the major advances biomedical science has brought to our understanding and treatment of mental disorders, the authors of this volume embrace a biopsychosocial model of these forms of human suffering. Appreciation for all three dimensions in the etiology, diagnosis, and treatment of mental disorders provides a more comprehensive and inclusive approach, which recognizes and invites the contributions of multiple disciplines and professions to multimodal interventions.

The preferred term for the phenomena under study will be "mental disorders" to connote the more holistic, biopsychosocial model and to appreciate the impaired (disordered) functioning that individuals suffer as a consequence of these conditions. Nevertheless, we adopt the conventional term "mental health services" utilized in the specialized area of research called health services research, of which this text is one example. More specifically, this book compares mental health systems from four countries in terms of the way they organize, deliver, and finance mental health services. Since mental health systems are the focus of this volume, it is appropriate to elaborate on the meaning of that term prior to defining mental disorders and discussing indicators of their prevalence and consequences.

Definitions

Mental Health System

Based on the WHO definition of a "health system" (WHO, 2000, p. xi; 2003, p. 105), the working definition adopted for the purposes of this study is as follows: *A mental health system comprises all organizations, institutions, and resources that produce actions whose primary purpose is to improve mental health.*

In order to describe a mental health system, one needs to ask such questions as who delivers what services to whom, when, where, how, and why. Ultimately a description of a mental health system requires researchers to attend not only to providers, patients, and payers, but also to health plan managers, regulators, and policymakers as they interact in their various roles as members of the system. One of the goals of this volume is to provide information to these constituencies to help them understand how their own and other mental health systems work, and how to work their system in order to ensure high quality mental health services at affordable cost, distributed equitably, and financed fairly.

The previous statement suggests that a performance appraisal of a mental health system involves the application of values and criteria expressed in goals and performance standards. These will be discussed subsequently in this introductory chapter and by each chapter author. Prior to that discussion, a few more comments are offered here about the definition of a mental health system.

The general definition of a mental health *system* denotes structures and functions as elements for analysis addressed in general social systems theory (e.g., Ashley and Orenstein, 1990; WHO, 2000, Chp.1; Willing, 1989). The structures are not only organizations, institutions, and resources for delivering and financing mental health services, but include the statuses and roles occupied by various individuals who perform different functions that contribute in different ways and in varying degrees to the general goal of enhancing a society's mental health. Theoretically speaking, a mental health system is an abstract concept; nevertheless, it refers ultimately to concrete relationships and interactions among its members in their various roles.

A *mental health* system includes more than the human and financial resources organized to provide

diagnosis and treatment of a society's population suffering with mental disorders. The definition implies that integral components include the organizations, institutions, and resources that help to *prevent* mental disorders from developing and to *promote* mental health as an essential element to social and individual well-being. Neither prevention nor promotion can be subsumed by the diagnosis and treatment of already existing and newly developing mental disorders summarized in epidemiological studies of both prevalence and incidence. It is important to acknowledge these other vital aspects of a mental health system in a volume like this one, which emphasizes the delivery and financing of mental health services to people already manifesting mental disorders. The organization and financing of prevention/promotion activities are no less important, but do not constitute the primary focus of the present study. For a global perspective on disease prevention, the reader is referred to the WHO annual report devoted to identifying, measuring, and reducing risks to health (WHO, 2002, pp. 47–98, 79–81). Although its focus was on health in general, that report mentioned a small number of mental disorders and behaviors as risks to health, such as addictive substances and child sexual abuse.

One final comment about this working definition is in order. A mental health system is not limited to mental health services provided solely, or even primarily by mental health specialists such as psychiatrists, psychiatric nurses, clinical-counseling-health psychologists, social workers, professional counselors, case managers, or other mental health care workers. This statement recognizes both a fundamental reality and a preferred approach. The reality is that a majority of individuals with symptoms of mental disorders receive services in primary health care settings such as general hospitals and medical clinics, not in specialized mental health hospitals, psychiatric clinics, or community mental health centers. Family physicians, internists, and other medical personnel are more likely to see these patients before any of them are seen by mental health professionals, and many mental patients are seen by no mental health professional. While the latter may rightly lament this situation, there is a growing recognition that a functional mental health system must integrate mental health services into primary health care delivery systems, and that an integrated approach is preferred to a more fragmented system that segregates mental health patients from other health services and health professionals, or removes them from their local community.

Primary health care principles were reaffirmed recently by the WHO as a way to return to population health criteria upon which to base health policy decisions affecting how health care services are organized, paid for, and delivered (WHO, 2003, p. 108). This integrated approach seems consistent with the conception of the individual person as a psychosomatic unity, or more aptly, as a biopsychosocial unity. The United States Department of Health and Human Services has advocated a similar approach by recognizing "the inextricably intertwined relationship between our mental health and our physical health and well-being" (DHHS, 1999b, p. v).

Mental Disorders

In addition to the concept of a mental health system, a second term central to this work is the mental disorders these systems function to prevent, diagnose, treat, and manage. Mental disorders are generally conceptualized in contrast to mental health. The reader is referred to Secker (1998) for a summary of contemporary conceptualizations of mental health. These concepts are neither value-neutral, nor value-free; rather, they are rooted in value judgments. Because these judgments vary across cultures, any attempt to formulate a universal definition of mental health is subject to challenge (Cowen, 1994). Nevertheless, unanimity on a definition of mental health is not necessary to determine mental health service needs of a given country, nor to proceed with comparative evaluations of mental health systems (Gulbinat et al. 2004, pp. 11–13).

The contrasts drawn between mental health and mental disorders are not absolute. Distinctions are drawn on a continuum, which suggests the presence of one or the other condition in varying degrees. For the purposes of this study, mental health services are construed as services provided to people with identified mental disorders. Consequently, it is the latter term that warrants elaboration.

According to the official nomenclature used in the United States, a mental disorder is:

> . . . a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the

> death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. (APA, 2000, p. xxxi)

This definition underlies and informs the current revision of the classification system of mental disorders called the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) published by the American Psychiatric Association (APA, 2000).

Like other diagnostic classification systems, this one has both limitations and its critics. *First,* attributing a mental disorder to an individual does not allow for the fact that an individual could be a symptom bearer of a dysfunctional family system; *secondly,* by using the term "mental" disorders in contrast to "physical" disorders, this nomenclature tends to perpetuate an anachronistic mind/body dualism; and *thirdly,* some of the discrete categories and differential diagnoses lack precise boundaries, which reduce the interrater reliability of diagnoses and their validity.

Despite these and other limitations, DSM-IV-TR is the official system used in the largest country in this comparative study. It serves as a satisfactory foundation for understanding the concept of a mental disorder. Moreover, the current revision provides codes and terms fully compatible with the current edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD–10) developed by WHO and published in 1992 (as cited in APA, 2000, p. xxix).

It must be granted that mental disorders have been defined by a variety of other concepts such as maladjustment, a failure to cope with conflict, maladaptive behavior, irrational thinking, distortions in perception, emotional dysregulation, or statistical deviation from social norms. In DSM-IV-TR, a single criterion has been rejected in favor of a multidimensional definition of mental disorders. The Surgeon General of the Department of Health and Human Services, U. S. Public Health Service has endorsed a similar multidimensional definition of mental health: "Mental health refers to the successful performance of mental functions, resulting in productive activities and fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity" (DHHS, 1999a, p. ix).

Where a multidimensional definition of a mental disorder is applied, it has implications for mental health policy, programs, and clinical practice. All dimensions of mental disorders (i.e., dysfunction, disability, distress, risk, and loss of freedom) are essential considerations in their etiology, diagnosis, and treatment. For example, treatment for a major depression that enables an individual to return to work (functioning) cannot be considered complete or successful if the individual's mood remains dysphoric (distressed), the person continues to be socially withdrawn, or remains at risk for suicide. Consequently, a "return to functioning" model for determining "medically necessary" mental health care cannot be considered satisfactory (Olson, 1999).

The multidimensional perspective expressed in the definition of mental disorders provides the context for the focus of the present volume. However, to provide a global perspective and to facilitate cross-cultural comparisons, researchers must rely upon international nomenclature and available data. The World Health Organization provides both definitions and global data.

The terms for mental disorders used by the WHO are "mental and behavioural disorders" and "neuropsychiatric disorders" (WHO, 2001b, pp. 10, 22). Both terms reference a set of disorders classified not by DSM-IV-TR, but by ICD-10 on the basis of international reviews of scientific literature, and on worldwide consultation and consensus in order to be applicable cross-culturally. Despite some differences between these two descriptive nomenclatures, mental disorders defined by both systems share in common some combination of abnormal thoughts, emotions, behavior, and relationships with others (WHO, 2001b, p. 10). Examples of major mental disorders include schizophrenia, depression, mental retardation, and disorders associated with alcohol and drug abuse.

A second term for mental disorders used by the WHO is "neuropsychiatric disorders." This category is also derived from ICD-10, but it is a broader term that includes disorders that are commonly considered as physical and neurological disorders (e.g., epilepsy, Parkinson's disease). The inclusion of the latter disorders is a further expression of the biopsychosocial model adopted by the WHO to encourage integrated care and in recognition of the obstacles to such care:

> The artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental and behavioural disorders. In reality, these disorders are similar to many physical illnesses in that they are the result of a complex interaction of all three factors. (WHO, 2001b, p. 10)

A comparable statement has been made by Dr. David Satcher, the Surgeon General of the U. S. Public