# A Comparative Analysis of Mental Health Reform: Canada, the United Kingdom, and Australia

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## Abstract

This dissertation explores the trajectories of mental health reform in Canada, the United Kingdom, and Australia, examining how each state's political and institutional contexts within universal healthcare systems have influenced these trajectories. Despite being parliamentary democracies, these states exhibit significant variations in mental health governance due to differences in government control and levels of privatization. Using a historical institutionalism framework, the research examines how state-based institutional configurations impact the use and outcomes of mental health policy levers. The research investigates the relationship between healthcare governance and government structure, financing and service system designs, and professional regulation and payment.

Drawing insights from Postpsychiatry and Mad activism, the research employs archival documentary analysis, policy analysis, and feedback from community service agencies to assess the effectiveness and reach of mental health reforms. It highlights the need for a moral transformation in global mental health, advocating for person-centered, recovery-oriented care that respects and integrates the social and structural determinants shaping health. The dissertation's comparative analysis reveals the strategic use of policy levers and their impact on mental health policy trajectories and outcomes. Part One examines historical opportunities for change and identifies key policy levers. Part Two discusses the use of policy levers and mental health policy trajectories and outcomes. Part Three compares the use of policy levers across the states to highlight differences in the scale and pace of reforms. The analysis highlights a difference in the scale and pace of mental health policy reforms, with Australia and the UK implementing larger scale and faster paced changes compared to Canada's more conservative

approach. These differences are shaped by the state's institutional frameworks and historical legacies that influence how mental healthcare is governed, financed, and delivered.

The research highlights the imperative to shift from traditional biomedical models to more inclusive, human rights-focused mental health practices. This research improves understanding of the dynamic interplay between policy levers and mental health reforms in varied institutional contexts. It emphasizes that future policies be co-produced with policy communities, prioritizing community-based care and moving beyond traditional biomedical approaches to address broader social determinants of mental health. The research adds to the literature by offering an examination of the intersections between mental health policy, social justice, and institutional change.

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## List of Acronyms and Abbreviations

| | |
|---|---|
| **AHCAs** | Australian Health Care Arrangements |
| **AHPRA** | Australian Health Practitioner Regulation Agency |
| **CAMIMH** | Canadian Alliance on Mental Illness and Mental Health |
| **CBT** | Cognitive Behavioural Therapy |
| **CCACs** | Community Care Access Centres (Ontario) |
| **CCGs** | Clinical Commissioning Groups (England) |
| **CHA** | Canada Health Act (1985) |
| **CIF** | Community Investment Fund (Ontario) |
| **CMHA** | Canadian Mental Health Association |
| **CTO** | Community Treatment Order |
| **CRPD** | Convention on the Rights of Persons with Disabilities |
| **DHCs** | District Health Councils (Ontario) |
| **ECHR** | European Convention on Human Rights (1953) |
| **FFS** | Fee-for-service |
| **GMC** | General Medical Council (UK) |
| **GPFH** | GP Fundholding |
| **HIDSA** | Hospital Insurance and Diagnostic Services Act (1957) (Canada) |
| **HRA** | Human Rights Act (UK) (1998) |
| **IAPT** | Improving Access to Psychological Therapies (UK) |
| **ICSs** | Integrated Care Systems (England) |
| **KPIs** | Key Performance Indicators |
| **LHNs** | Local Hospital Networks (Australia) |
| **LHINs** | Local Health Integration Networks (Ontario) |
| **MBS** | Medical Benefits Scheme (Australia) |
| **MCA** | Medical Care Act (1966) (Canada) |
| **MHA** | Mental Health Act |
| **MHAustralia** | Mental Health Australia |
| **MHCC** | Mental Health Commission of Canada |
| **MHT** | Mental Health Tribunal |
| **MOHLTC** | Ministry of Health and Long-Term Care (Ontario) |
| **NDPP** | New Deal for Disabled People (UK) |
| **NGOs** | Non-Governmental Organizations |
| **NMHC** | National Mental Health Commission (Australia) |
| **OHIP** | Ontario Health Insurance Plan |
| **OHTs** | Ontario Health Teams |
| **PCGs** | Primary Care Groups (UK) |
| **PCNs** | Primary Care Networks (UK) |
| **PCTs** | Primary Care Trusts (UK) |
| **PHNs** | Primary Health Networks (Australia) |
| **PIP** | Practice Incentives Program (Australia) |
| **RCVMHS** | Royal Commission into Victoria's Mental Health System |
| **ROMs** | Routine Outcome Measures |
| **SDoH** | Social Determinants of Health |
| **UN** | United Nations |

| | |
|---|---|
| **WHO** | World Health Organization |

# Introduction

## Statement of Problem

The evolution of public policy is understood through history, particularly the political and institutional circumstances in which decision-making occurs. Change is the product of "strategic judgments" made by policy-makers within these distinctive political and institutional circumstances (Tuohy, 2018, p. 13). The "scale" and "pace" of policy change is determined by the outputs of these strategic judgments (Tuohy, 2018, p. 75). The study of public policy provides insight into the perception of problems and the identification of solutions. Using a critical lens in analyzing policy allows for the exploration of assumptions underpinning "ways of thinking" that "accepted practices are based" (Foucault, 1981, p. 456). Adopting Foucault-influenced post-structural policy analysis, researchers have highlighted how problems are represented and subsequently addressed in governmental policies and practices (Bacchi, 2012, 2016; Hankivsky, 2012). Such study is of importance, as policies are instrumental for advancing socially just practices in mental health. My intent in writing this dissertation is driven by my passion to instill moral transformation for mental health reform. In agreement with Kleinman (2009), I argue, the moral conditions in which people with mental health and psychosocial conditions exist "remain horrendous most everywhere" (p. 603). This dissertation will provide a comparative analysis of mental health system reforms in Canada, the United Kingdom (UK), and Australia. A comparative analysis will identify the differences and similarities in institutional processes these states faced in moving towards system reform. Between the three states, contrasting mental health governance and government structures, service system designs, and policy approaches to public funding offers an interesting perspective.

The growing emphasis on reducing the global burden of mental health and psychosocial conditions has highlighted the role of biomedical systems in responding to inequities and care gaps and has promoted "medical imperialism"[1] (Patel, 2014, p. 783). The biomedical focus on diagnosis and symptom reduction through pharmaceuticalization, however, can mask the complex social realities of mental distress and the pluralistic nature of psychiatry, which is inherently heterogenous. Psychiatry encompasses a multitude of treatment practices, intersecting in complex ways (Rose, 2019). Biomedicalism can also reinforce human rights abuses and coercion through legal mechanisms (i.e., Mental Health Acts) that allow for involuntary detention and treatment (World Health Organization (WHO), 2021). The passive privatization of mental health services and the tendency to shift responsibility of care between institutions[2] (i.e., emergency departments, the criminal justice system, and mental health hospital units) further complicate issues of equity and the invisibility of needs not addressed within the biomedical paradigm. Research priorities of funding agencies, centered on exploring the neurobiological 'brain bases' of mental health and psychosocial conditions, have also protected biomedical psychiatry by producing research on the objective and measurable states of mental distress, shaping public perceptions accordingly (Rose, 2019). The subsequent emergence of a prevalence framing, evident by mental health awareness campaigns that use numerical depictions of distress (i.e., "1 in 5 Canadians will experience a mental health problem each year") to emphasize a problem and need for a solution (Titchkosky & Aubrecht, 2017, p. 325), "normalize" mental distress as a problem while establishing that people experiencing distress are "different from everyone else" (p. 317). Identified as the "prevalence problematic," the framing implies "the

[1] Medical Imperialism is a term coined by Schrieier & Berger in 1974. The term is being used to describe the damage of imposing the western medical model on the rest of the world.
[2] Often coined 'trans-institutionalization.'

presence of a problem and inadequate response" (Titchkosky & Aubrecht, 2017, p. 315). The insinuation is that through education, stigma will be reduced as mental health challenges will be perceived as alike to other medicalized health challenges, enabling more people to be helped (Titchkosky & Aubrecht, 2017). The prevalence framework that has emerged from the biomedical dominance is damaging as mental distress is not viewed as a shared human experience (Davis, 2014) nor is it acknowledged that medical "expert" help is not the only form of care and that "alternative relations to help" exist (Titchkosky & Aubrecht, 2017, p. 326).

Advancing equity and social justice requires revolutionizing the ways we understand and respond to mental distress. Mental health is shaped by social and structural determinants that create disadvantages and inequities pertaining to mental health. The WHO in its *World Mental Health Report: Transforming Mental Health for All* (2022) states "a key requirement for successful mental health transformation … is to reduce or eliminate local and national disparities or inequalities as they relate to mental health" (p. 97). However, financing for mental health services rely on health and social care budgets and often follow "historical convention" or institutions rather than "ongoing evaluation of need" (WHO, 2022, p. 128). Although "mental health and access to mental health care are a basic human right" (WHO, 2022, p. 248), people experiencing mental distress often face discrimination and social exclusion and are "denied basic social and civil rights" (p. 97). The United Nation's (UN) *Convention on the Rights of Persons with Disabilities* (CRPD) (United Nations General Assembly, 2006) represents the first human rights treaty of the 21st century and protects the rights and freedoms of people with disabilities. While 184 countries have ratified the CRPD (WHO, 2022), "rights-based legislation may not necessarily be concordant with reformed mental health laws" (Cronin et al., 2017, p. 261) as "mental health law varies in practice depending on historical and cultural factors" (p. 262).

Rooted in psychiatric deinstitutionalization, calls for mental health reform have been focused on mental health service reorganization with the focus of care shifting from psychiatric hospitals towards community-based services (LaJeunesse, 2002; WHO, 2022). In fact, dozens of government reports (written over the past 90 years in Canada) have produced almost identical recommendations for mental health system change (LaJeunesse, 2002; Canadian Mental Health Association (CMHA), 2010a). Responses for mental health reform have focused on improving vast care gaps and inequities in mental health through scaling-up access to care through increased health coverage and financial protection as well as integrating mental health and physical health to prevent service fragmentation and duplication and better meet care needs (Kaehne & Nies, 2021; WHO, 2022). An "integration paradox" can emerge, however, where need for integration within an adverse financial setting can lead to "a retreat into more "siloed" ways of working" (Erens et al., 2019, p. 24). Implementing mental health policies and legislation aimed at financing mental health through reallocating resources is essential then to transforming mental health services (WHO, 2022).

Many countries have updated and strengthened their mental health policies and plans opening 'windows of opportunity' for mental health reform (CMHA, 2010a; WHO, 2022). The UN CRPD has encouraged countries to "act for mental health" creating "further impetus to transform and improve mental health" (WHO, 2022, p. 2). Advocacy movements that include and are run by people with lived experience strengthen the voices and expertise of people with lived experience and increase understandings of mental distress helping to reduce stigma and discrimination against people with mental health and psychosocial conditions (WHO, 2022). Peer-led networks and organizations also enable people with lived experience to "engage with their care" and help to "inform and influence policy-makers … and fight for improved services

and legal rights" (WHO, 2022, p. 94). In response to the discussion paper, *Every Door is the Right Door: Towards a 10-yr Mental Health and Addiction Strategy* (2009) released by the Advisory Group, selected by the Ministry of Health and Long-Term Care, under the McGuinty Liberal government in Ontario, Canada, the CMHA (2010a) released a review of mental health strategies for reform by the state of Victoria, Australia, and the government of England. The reviewed strategies shared a similar vision for system reform based on a recovery and person-centered approach (CMHA, 2010a). The reform strategies also recognized social determinants of health as "essential to mental health" and requiring a whole government approach beyond the boundaries of mental health service provision (CMHA, 2010a). Other commonalities include the involvement of people with lived experience and engagement of communities in changing and building effective mental health service delivery (CMHA, 2010a). Finally, provision of mental health services within the community was seen as "vital" in all strategies (CMHA, 2010a, p. 35). Despite these similarities, among the reviewed strategies, "the actual approach to system and service change" was found to vary "depending on local factors such as the current state of mental health reform, cultural differences and the preparedness for change" (CMHA, 2010a, para. 4).

**Purpose**

This dissertation explores how broad state-based configurations of institutions shape the causes (policy-levers) and outcomes of mental health reform (policy-trajectories). This is studied by comparing the relationship between institutional processes – government structures and healthcare governance; financing and service system designs; professional regulation and payment – shaping reform and the degree to which policy communities are involved in each state.

**Background**

### *Evolution of Healthcare Systems*

Canada, the UK, and Australia represent "parliamentary democracies with broadly universal healthcare systems" (Bartram, 2019a, p. 63). However, the ways in which their healthcare systems evolved reflect "choices made at critical historical points" (Tuohy, 1999a, p. 114). Canadian medicare was initiated in the province of Saskatchewan by Tommy Douglas, the Premier of Saskatchewan, under the New Democratic Party in 1947 (Martin et al., 2018). Through federal cost sharing first for hospital care, followed by physician services, medicare spread throughout Canada in the 1960s and was protected through standards set in federal law through the Canada Health Act of 1984 (Martin et al., 2018). The expansion of medicare followed "an era of economic growth, high public expectations, and government expansiveness, in which … the model of private insurance … and public underwriting of the costs of universal coverage of medical and hospital services in a professionally dominated system appeared feasible" (Tuohy, 1999a, p. 117). The National Health Service (NHS) in the UK, followed the "wartime legacy of the centralization and expansion of government authority" (Tuohy, 1999a, p. 117), and was established in 1948, under the Labour Party's Health Minister, Aneurin Bevan (Rivett, 2019). The NHS was created in response to a need for an emergency hospital service produced by the Second World War (West, 2022). Medicare in Australia was created in 1975 under the name "Medibank" by the Whitlam Government led by the Australian Labour Party (Jamieson, 2014). Medibank was drastically cut back and abolished in 1981 under the Liberal-National Coalition Fraser Government and reinstated in 1984 under the name "Medicare" by the Hawke Government of the Australian Labor Party (Jamieson, 2014). Medibank was created to extend healthcare coverage and provide competition in the private health insurance industry so to keep premiums at a reasonable level (Reece, 2013; Willis, Reynolds, & Helen, 2016).

***Early Mental Health Policy (up to twenty-first century)***

Across the three states, the progression of mental health policy can be tied to the process of psychiatric deinstitutionalization. In Canada, this connection was readily seen in Ontario, which closed 7000 of its 11000 provincial psychiatric beds between 1959-1979 (Lurie, 2005). Between 1988-1999, Ontario released three prominent policy reports *The Graham Report* (1988), released under the Peterson Liberal provincial party, *Putting People First* (1993), released under the provincial Rae New Democratic Party (NDP), and *Making It Happen* (1998), released under the provincial Harris Conservative Party. These reports supported greater mental health spending, as a proportion of health spending, to support a community mental health system. This period of mental health policy change was significant in changing the ways that people with mental health and psychosocial conditions were seen and legitimizing their voices and provision of supports by people with mental health and psychosocial conditions and their families through funding (Lurie, 2005).

Similar to the Ontario experience, the UK underwent significant psychiatric closures during the 1990s and by 2000 closed 90 of its 120 psychiatric hospitals (Shera et al., 2002). The government released the *National Service Framework for Mental Health* in 1999 following its investment of £700 million to improve mental health services (Lurie, 2005). The Framework set quality standards for mental health services and promoted "partnerships with primary care and social care system" (Lurie, 2005, p. 98). A review by the Commission for Health Improvement in 2003, however, found that despite policy advancements in shifting care to the community, "the historical legacy of the neglect of mental health services … still regrettably evident" (p. 9).

Australia's national government "showed little interest in mental health care until 1992" when it introduced Australia's *National Mental Health Policy* (Lurie, 2005, p. 98). The policy

called for an increase in federal funding, priority for people with serious mental illness, enhanced consumer rights, and new opportunities for the private sector including a strategy to involve general practitioners (GPs) as basic primary care providers (Shera et al., 2002, p. 569). The goal of the policy framework was to create "a seamless set of relationships from inpatient ward to community support" (Healy & Varney, 1995, as cited in Shera et al., 2002, p. 568). To help the states shift care from institutions to the community, "national government funding was provided on a matching basis" and "benchmarking was used to measure progress" (Lurie, 2005, p. 98).

***Policy Change***

Mental health reform and subsequent policy change has developed slowly among the three states. Since mental health reform is "politicized within national governance fora" and "shaped by different historical, institutional and political contexts with divergent allocation of authority" (Wiktorowicz et al., 2020, p. 1). Historical institutionalism views institutions, such as healthcare, as "political legacies of historical struggles" (Thelen & Mahoney, 2015, p. 7). The analytic approach recognizes that "policy decisions cannot be fully understood as the rational choice of policy actors alone … [but] … as products of the institutional parameters of the system in which policy actors make their choices" (Wiktorowicz et al., 2020, p. 2). To maintain power, policy-makers "rely on a coalition of support" and must "accommodate a range of powerful interests" (Wiktorowicz et al., 2020, p. 2). A mental health participation gap in policy representation can therefore not only lead to mental health inequities (Bernardi, 2021) but can reinforce structural stigma through the omission of mental health from healthcare legislation and funding (Wiktorowicz et al., 2020). Research examining the relationship between mental health spending and public preferences for spending on mental health services or policy problems in England, between 1994-2013, reveals a negative relationship between spending and public

preferences, indicating policy misrepresentation, as when the public supported more spending, the local authorities provided less (Bernardi, 2021). While, over the last decade, the UK and Australia have made investments to support mental health reform, through improving access to psychological services (Bartram, 2017), Canada has just begun to catch-up as evidenced by the federal government's 10-year targeted federal transfer of $5 billion in 2017 to support provincial and territorial governments in improving access to services (Government of Canada, 2017).

Lessons can be learned, however, from the UK and Australia as challenges remain with access and outcome inequities of recent mental health service reforms (Mental Health Commission of Canada, 2018). Further research examining the relationship between government structure and capacity for policy reform indicates that the UK should have more capacity for psychotherapy reform than Australia, while Australia should have more capacity than Canada (Bartram, 2020). The UK is argued to be the most centralized, "with a command-and-control health system," while the Canadian federation is decentralized, with federal transfers amounting to only 23 percent of provincial and territorial spending on health (Phillips, 2016). Alternatively, the Australian federation not only has jurisdiction over Medicare but contributes 61 percent of total public spending on health (Australian Institute of Health and Welfare, 2017, as cited in Bartram, 2020, p. 12).

**Terminology**

Before comparing how institutional processes influence policy change for mental health reform, it is important to discuss the significance of terminology referenced throughout the dissertation. These terms and concepts include people with mental health and psychosocial conditions, recovery, neoliberalism, reform, and person-centered care.

This dissertation uses the term **people with mental health and psychosocial conditions** as well as **people experiencing mental distress** and **people with lived experience** to identify a community that is entrusted in my heart. As I am motivated by a personal commitment to address inequities faced by humanity in enduring mental distress throughout the life-span. While mental health is universal, its experiences are personal and intertwined with language and identity. The use of oppressive language and medicalized mental illness labels reinforced through neoliberal risk rationalities created the process of othering (Sharland, Heller, Stanford, & Warner, 2017), which in turn supported the surveillance and control of people associated with risk (Stanford, Heller, Sharland, & Warner, 2017). Drawing on Judi Chamberlin's (1998) "citizenship rights," human rights is inclusive of the right to define and understand oneself in a particular way. My intention with the selected terms is to be inclusive of the diversity of labels selected by people and the ways of being human.

Other labels of identifying may include **psychiatric consumers/survivors/users** referring to people who are in contact, or have been in contact, with psychiatric institutions or the mental health system as a patient, client, or consumer (Usar, 2014). People may also identify as a "mental health services consumer," "person with a psychiatric disability," "service user/client," "Mad," or choose not to identify with any labels (Usar, 2014). People may also switch between labels, (i.e., "user" or "ex-patient") (Corrigan, Roe, & Tsang, 2011). Additionally, certain labels (i.e., ex-patient and survivor) may be used by advocate groups to reflect injustices or express anger (Corrigan et al., 2011). For example, someone may identify as an ex-patient because they feel that "breaking off" from mental health services was critical to their process of recovery (Corrigan et al., 2011). Similarly, someone may associate with the term survivor to reflect the treatment, rather than the illness, they survived (Corrigan et al., 2011).

The concept of **recovery** became prominent in mental health policies during the 1980s and 90s (Morrow, 2013) and has been "taken-up unevenly in policy" (Adams, Daniels, & Compagni, 2009; Piat and Sabetti, 2009, as cited in Morrow, 2013, p. 324), as recovery is conceptualized in "myriad ways with no agreed-upon definition or framework for supporting people" (Morrow, 2013, p. 324). Piat and Sabetti (2012) identify three conceptualizations of recovery. These include recovery as personal empowerment as reflected in the ex-patient movement; personal recovery, emerging from the consumer-narrative literature; and recovery as an issue of social equality (Piat and Sabetti, 2012, p. 20). The dissertation draws on these conceptualizations in exploring how governments utilized the concept of recovery to guide mental health reform.

Following close to the deinstitutionalization of psychiatric hospitals and the shift to community-based models of care, **neoliberalism**, referred to as New Public Management, brought changes to mental health policy, legislation, and service delivery (Sawyer, 2017, p. 103). The political shift introduced market-based principles of efficiency, quality, and performance into the provision of services as well as economic independence (Braithwaite, 1999; Hood, 1995; Osborne & Gaebler, 1992; Stanhope & Solomon, 2008; Yeatman, 2009; as cited in Sawyer, 2017, p. 103). Influenced by private sector models, the logic of these governance systems is driven by the market and their value based on security through the de-regulated economy (Coburn, 2006; Sharland et al., 2017). Consequently, New Public Management focuses on the "forensic functions" of risk or the "protocols used to … establish accountability and [appropriate] blame" when failures to manage risk occur (Douglas, 1992, p. 27, as cited in Sawyer, 2017, p. 104). Structured under a business model, mental health services are driven by performance and efficiency and thus support negative conceptualizations of risk focused on

reducing or eliminating mental distress or risk problems (Sawyer, 2017, p. 104; Sharland et al., 2017, p. 179). Through this model, people identified as experiencing mental distress are ascribed risk identities – "a risk" or "at risk" – while at the same time these risk "categories are moralized and responsibility for occupying them is privatized" (Sharland et al., 2017, p. 179). This objectification of risk and people associated legitimates blame and marginalization (Sharland et al., 2017, p. 179).

The neoliberal concept of recovery, seen through a biomedical lens, is promoted as an individual responsibility requiring restoration from an abnormal state believed to be caused by illness (Bracken & Thomas, 2005). However, in the medical model a patient assumes a passive role, one that fosters dependency (i.e., pharmaceuticalization), contradicting the neoliberal emphasis on self-management approaches in mental health recovery (Bilsker, 2003, as cited in Davis, 2014, p. 21). The biomedical framing of recovery therefore further creates conditions in which neoliberal welfare policies can thrive, as the emphasis on the management of risk through medication, has meant that failures in managing it effectively are blamed on the patient or patient-provider relationship (Kemshall, 2000, p. 99) instead of the "wider political and cultural environments that are responsible for injustice in the first place" (Bracken & Thomas, 2005, p. 235).

The global narrative for mental health **reform** has focused on improving access to services and supports. The response, however, has overwhelmingly concentrated on biomedical systems. The Covid-19 pandemic accentuated inequities in responding to mental distress solely through medicalization and exposed the human rights requirement of governments to provide mental health services that are acceptable to its population. This entails providing a comprehensive continuum of services and supports that acknowledge the context of needs and

are seamlessly delivered between sectors not complicated by fragmented power relations. Reports have consistently advocated that "real investment into community-based care, and not further study, [is] necessary for mental health reform to succeed" (CMHA, 2004). While there has been some progress at improving care coordination, the vision of mental health reform has yet to be attained.

Often conflated with patient-centered care, the concept of **person-centered care** emphasizes the "person behind the patient" (Ekman et al., 2011, p. 249). Patient-centered care is often linked to the medical model which can objectify and reduce the person to their symptoms/a recipient of medical services (Santana et al., 2017; Ekman et al., 2011). Giving primacy to the person, person-centered care, embedded in the human rights model, encompasses the "whole-being, including a person's context" and individual experiences and needs (Santana et al., 2017, p. 430). Embracing a person-centered approach means challenging paternalism in mental healthcare and moving towards integrative, collaborative, and cross-sectoral approaches to service delivery to reduce fragmentations and better co-ordinate care around needs (Kaehne & Nies, 2021). Like the recovery-movement, the concept of person-centered care, through a neoliberal biomedical lens, can lead to a reductionist approach that misses the impact of structural and systemic barriers on mental health. Incorporating institutionalism, which takes a macroconfigurational orientation, person-centered care cannot be understood without acknowledging the macrostructural environment in which the person lives (Thelen & Mahoney, 2015, p. 7). By placing the person at the center of their care, it is important to not responsibilize the person at the neglect of the State and healthcare.

**The Sites**

Canada, the UK, and Australia were chosen for their similarities: historic colonial ties, high-income, and English-speaking. In comparison to Canada's publicly funded healthcare system, the UK has both a publicly funded healthcare sector, the National Health Service (NHS), as well as a private healthcare sector. While every Australian is eligible for Medicare, the country's national universal healthcare, private insurance plans coexist with Medicare to provide access to private hospitals and other services not covered by the public program. Institutional features and comparisons between the province of Ontario, the country of England, and the state of Victoria are also explored. Both transnational and subnational comparisons incorporate variations that occur between states as well as within them. These different methodologies highlight how the role of national settings can shift depending on the approach (Sellers, 2019). Shifting from serving as a baseline control in comparing regional differences within a single country, to being the main focus in traditional national comparisons, to acting as one component in the multi-level framework used in transnational comparisons (Sellers, 2019). These sub-national jurisdictions were selected based on available research (CMHA, 2010a) of recent strategies (from early 2000s) for mental health reform. As well, for assisting in showcasing policy communities connecting with the concept of policy networks (Khaje Naieni, 2014, 2016). The comparisons across the states and sub-states explore the causes or policy-levers for mental health reform and the outcomes or policy-trajectories of mental health reform.

**Methods**

The dissertation draws on primary and secondary research from both peer-reviewed and grey literature. The research methods of an archival policy research and documentary research on contemporary policies were conducted. Collection of policies span from the late 1980s, which roughly follows the process of psychiatric deinstitutionalization amongst the three states, to the

most present policy releases. There is much less available research on policy reform from the 2000s onwards. Archival policy research at the CMHA Archives, and documentary research on policies from community services agencies across the states, including the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), Mind, Centre for Mental Health, and Healthwatch in the UK, and Mental Health Australia allow me to map the outcomes or policy-trajectories of mental health reform from the early 2000s onwards, as well as the distinctive policy logics characterizing the different mental health systems. While the research was searched using these sources, the primary intention of the archival policy analysis was to synthesize policies focused on integrating or expanding community-based mental healthcare across the states and sub-states. While the exclusion of an integration focus did not eliminate policies from the study, the intention was to track the trajectory of mental health reforms and compare the emphasis on integration in mental health policies. Influenced by Tuohy's (1999b) work on *Accidental Logics*, the archival policy research assists in explaining how policy frameworks adopted during windows of opportunity were essentially accidents of history. Documentary analyses of current policies, practices, and the institutional processes shaping mental health policy and practice in each state will supplement the archival research. Drawing on Tuohy's (2018) more recent work on *Remaking Policy*, concerned with "what happens around and within windows of opportunity" (preface), the documentary analyses assist in exploring the policy-levers or the political and institutional circumstances in which decisions that led to policy change were made. These materials are important to understanding "somewhat similar politics in systems of government as different" (Tuohy, 2018, p. 3). Exploring the "scale," "pace," and "drivers" of policy change in answering why policy changes occur "at some times and in some

jurisdictions and not others?" and "what determines the course of policy changes once they are under way?" (Tuohy, 2018, p. 4).

**Additional Value**

Although research has compared elements of the mental health systems in Canada, the UK and Australia (Lurie, 2005; Bartram, 2019a, 2020), the dissertation is unique in providing a comparative study of the mental health policy trajectory for reform through the lens of the theory of historical institutionalism. Research is limited comparing mental health policies over time within the states let alone between the states. Similarly, no previous studies have brought insights of postpsychiatry and Mad activism into study with institutional processes. There is also limited examination comparing feedback from policy communities on the status of mental health reform.

**Summary**

This dissertation offers a comparative analysis of mental health policy change across three states – Canada, the UK, and Australia – highlighting comparisons within the sub-national regions – Ontario, England, and Victoria. Drawing on the theory of institutionalism, I employ a comparative historical approach to understand the importance of context in exploring the policy-levers and policy-trajectories for mental health reform. This dissertation is divided into three parts. The first part explores the institutional processes within and between the three states that guided the circumstances under which policy change occurred. The second part analyzes the outcomes of policy change and trajectories of mental health policy frameworks since the early 2000s within each state. Building on this, the third part compares the scale and pace of policy change across the states, highlighting differences and similarities in their approaches and outcomes.

## Chapter 1: Integrating Institutional Change with Postpsychiatry and Mad Activism

The dissertation draws on the theory of institutional change to surface analyses of power and inequities (Hacker, Pierson, & Thelen, 2015). The theoretical processes of "drift" and "conversion" provide a crucial link between institutional change and institutional reproduction (Hacker et al., 2015, pp. 180, 183) and help to better understand the levers and trajectories of policy in moving towards more equitable mental health. A comparative-historical approach (CHA) assists in explaining "large-scale political and political-economic outcomes" (Thelen & Mahoney, 2015, p. 5). CHA is advantageous for its focus on "macroconfigurational explanation" and "temporal dimensions of politics" (Thelen & Mahoney, 2015, p. 28). Drawing on Esping-Andersen's *Three Worlds of Welfare Capitalism* (1990), broad macroconfigurations of institutions are conceived as being politically created and important for shaping markets and politics as well as power distribution in society (Gingrich, 2015, p. 75). Of particular importance to the dissertation is the perspective of postpsychiatry, which seeks to overcome the reductionist biomedical focus of traditional psychiatry by giving primacy to the meaningful reality of an individual's distress (Bracken & Thomas, 2005). Proposed as an alternative psychiatric biopolitic (Rose, 2019), postpsychiatry relocates forms of mental distress within their social contexts recognizing that multiple perspectives are both possible and valid in framing mental distress. Insights from people with lived experience of mental distress as well as Mad activists not only is critical to the study but benefits institutionalism by making visible the underlying assumptions and frameworks that have led to policy and practice.

### Theory of Institutional Change – Drift and Conversion

Reform is facilitated by factors outside the policy sector that create opportunities for change (Lazar, 2013). Institutions are conceived as "distributional instruments laden with power

implications" (Hall, 1986, 2010, Skocpol, 1995, Mahoney, 2010, as cited in Mahoney & Thelen, 2010, p. 8). They are "fraught with tensions" as they "raise resource considerations and invariably have distributional consequences" (Mahoney & Thelen, 2010, p. 8). As such, "rules … that patterns action will have unequal implications for resource allocation" and formal rules that mobilize highly valued resources (i.e., political-economic institutions [like healthcare]) are "intended to distribute resources to particular kinds of actors and not to others" (Mahoney & Thelen, 2010, p. 8). Institutional change does not occur "just in response to exogenous shocks or shift" (Mahoney & Thelen, 2010, p. 7), but in "gaps" between rule interpretation and enforcement, which create space for existing rules to be implemented in new ways (pp. 4, 14). The type of openings available for institutional change depend on the "mechanisms of reproduction that sustain them" (Thelen, 1999, p. 397) (i.e., "features of the broader political and social context") (p. 384). The theory of institutional change is therefore concerned with "*what specific sorts of institutional changes* pursued by *what kinds of actors* are likely under *what kinds of conditions*" (Hacker et al., 2015, p. 203).

Once formed, institutional characteristics, especially those developed during colonial rule, are difficult to change (Kohli, 2004, as cited in Haggard, 2015, p. 53). For a long time, institutions were viewed as being "fixed," independent of intervening variables used to study cross-national differences (Hacker et al., 2015, p. 180). More recently, institutional scholars have explored "how institutions evolve" (Hacker et al., 2015, p. 180), and the "relationships between institutional change and political outcomes" (p. 182). The theoretical processes "drift" and "conversion" have been used to describe how institutional effects can change over time, despite difficulty in directly altering formal rules or institutions (Hacker et al., 2015). Drift occurs in response to "context discontinuity" (Hacker et al., 2015, p. 183) or when "institutions or policies

… are held in place while their context shifts in ways that alter their effects" (p. 180). By contrast, conversion occurs in response to "actor discontinuity" (Hacker et al., 2015, p. 183) "when political actors are able to redirect institutions or policies toward purposes beyond their original intent" (p. 180). Both drift and conversion "combine elements of constancy in institutional form with changes in institutional impact" (Hacker et al., 2015, p. 185). However, unlike drift, conversion involves the reinterpretation of existing formal rules to serve new purposes; this can be achieved when "institutions or rules are … malleable;" "[their] ends are politically contested;" "political actors are able to redirect an institution or policy;" and when "formal rules [are able to be left] in place" (Hacker et al., 2015, p. 185). The prevalence of drift and conversion is argued to increase with the "strength of a political system's status quo bias" (Hacker et al., 2015, p. 187). While the "status quo bias call[s] attention to the political context of formal rules," the "precision" of an institution or policy "draws attention to the character of the rules themselves" (Hacker et al., 2015, p. 189). As such, policies whose rules are more "unambiguous" or precise are more vulnerable to drift as "what is not in the rule is also not covered by the rule" (Hacker et al., 2015, p. 189). While less precise rules are more vulnerable to conversion, "because they require working out what the rule calls for in a specific situation" (Hacker et al., 2015, p. 189). Understanding the social context of institutions and the organization of political actors, drift arises "when contexts change" while conversion arises "when the players change – when political actors inherit institutions not of their own making and inconsistent with their ends" (Hacker et al., 2015, p. 195). Drift and conversion provide a way of understanding not just the sources of institutional change and institutional reproduction, often regarded as separate, "but also the structure of power in advanced societies" (Hacker et al., 2015, p. 204).

**Main Approaches to Institutional Analysis**

The three main institutional approaches used to perceive institutions and theorize on institutional change are sociological, rational-choice, and historical-institutional (Mahoney & Thelen, 2010). Despite their differences, the idea that institutions are "relatively enduring" is true in each approach such that they tend to focus more on "explaining continuity than change" (p. 4). Sociological institutionalism focuses on "noncodified, informal conventions and collective scripts that regulate human behaviour" (p. 5). The approach emphasizes the "self-reproductive properties" of institutions, as reproduction occurs when people are socialized to follow rules and as actors "carry their existing scripts forward when building new institutions" (p. 5). Sociological institutionalists identify "exogenous" over "endogenous" sources of change, focusing attention on how "new actors" can "unsettle dominant practices or scripts and impose their preferred alternatives" (p. 5). A critique being that sociological institutionalists fail to identify "what properties of institutional scripts make some of them, at some times, more vulnerable than others to this type of displacement" (p. 5).

Similar to the difficulties sociological institutionalism faces in explaining institutional change, rational-choice institutionalists view institutions as "coordinating mechanisms that sustain particular equilibria" and thus make it difficult to theorize on sources of endogenous change (p. 6). The work of Greif and Laitin (2004) focuses on "indirect institutional effects – or feedback effects" that can "either expand or reduce the set of situations in which an institution is self-enforcing" (as cited in Mahoney & Thelen, 2010, p. 6). In theorizing on endogenous change, Greif and Laitin (2004) "redefine (some) of the exogenous parameters as endogenous variables (i.e., quasi-parameters)" to "account for the stability (or breakdown) of different institutional equilibria" (as cited in Mahoney & Thelen, 2010, p. 6). Their work, however, does not identify

how exogenous and endogenous parameters would be distinguished nor which endogenous variables would be affected by the functioning of the institution (Mahoney & Thelen, 2010, p. 6).

Historical institutionalists "view institutions first and foremost as the political legacies of concrete historical struggles" (Mahoney & Thelen, 2010, p. 7). The approach explains "institutional persistence in terms of increasing returns to power" (p. 7). Taking a "power-political view of institutions" the emphasis is on the "distributional effects" of institutions (p. 7). Historical institutionalism explains change through "critical junctures" in which the "constraints on action are lifted or eased" during "periods of contingency" (Capoccia & Kelemen, 2007, as cited in Mahoney & Thelen, 2010, p. 7). Change therefore occurs when "enduring historical pathways are periodically punctuated by moments of agency and choice" (Mahoney & Thelen, 2010, p. 7). Historical institutionalism is criticized for "obscuring endogenous sources of change" and viewing institutional change as the replacement of one set of institutions, that involved a "breakdown," with another (Mahoney & Thelen, 2010, p. 7). While all three approaches can be used to explain exogenous shocks that prompt institutional change, they fail to provide a model that encompasses both exogenous and endogenous sources of change (Mahoney & Thelen, 2010, p. 7).

**Case for Using a Comparative Historical Approach**

The temporal oriented analysis characterizing a comparative-historical approach explores how temporal location can influence the effect of a variable; "the same variable can have different effects depending on when it occurs relative to other processes and events" (Thelen & Mahoney, 2015, p. 20). Understanding political outcomes involves "placing an explanation 'in context'" or "situating variables in a particular temporal setting" (Thelen & Mahoney, 2015, p. 20). Explanations of political outcomes are thus configurational as "they consider combinations

of causes located at different points in time" (Thelen & Mahoney, 2015, p. 20). Central to CHA is the idea that "early events in a path-dependent sequence" apply a "stronger causal impact on outcomes" than later events (Thelen & Mahoney, 2015, p. 20). Research on path dependence draws attention to patterns of institutional change with a focus on critical junctures as a mode of discontinuous change followed by long periods of stability (Thelen & Mahoney, 2015). Further research in CHA, however, has emphasized how gradual change can evoke a mode of "institutional evolution in the political world" (Thelen & Mahoney, 2015, p. 24; see Thelen, 2003, 2004; Pierson, 2004; Hacker et al., 2015). Operating within the "constraints of path dependence" and the "punctuated equilibrium concept of change," CHA scholars can explore how "long-run processes may be marked by incremental change" (Thelen & Mahoney, 2015, p. 24).

**Comparative-Historical Analysis and Three Worlds of Welfare Capitalism**

Central to Esping-Andersen's *Three Worlds of Welfare Capitalism* (1990) is the conception of institutions as being politically created and important for shaping power distribution in society (Gingrich, 2015, p. 75). The welfare regimes of the *Three Worlds of Welfare Capitalism* – Liberal, Social Democratic, and Conservative – vary not in just "how much they spend on social welfare but also in how they spend on it" (Gingrich, 2015, p. 67). The politics of the welfare state is a product of "tension" between "inequality produced by capitalism" and the "equality of parliamentary democracy;" the resolution therefore a result of political struggles (Gingrich, 2015, p. 68). In exploring how "democratic processes modify markets," Esping-Andersen spotlights how "coalitions of actors come together at particular historical moments to construct social policy" (Gingrich, 2015, p. 68). These "macroconfigurations of institutions created by coalitions of particular actors" thus

"institutionalize particular power structures that shape subsequent politics" (Gingrich, 2015, pp. 85-86). Paul Pierson's work on welfare state retrenchment (2001) and path dependence (2004) produces alternative theorizations of institutional reproduction (as cited in Gingrich, 2015, p. 83). Contrary to Esping-Andersen's logic in Three Worlds, regime reproduction does not just occur through "regimes following distinct paths" (i.e., power from the left) but also from "new political mechanisms" (Gingrich, 2015, p. 84). Central to Pierson's work is the idea that "policy creates its own institutional costs (or opportunities) for change" and as such "all policies create a distinct political logic through institutional maturation" (Gingrich, 2015, p. 83). Recent work theorizing on influence in political economies, "trace the link between wealth and power" to expose "whom politicians are responsive, the nature of political accountability for welfare reform" (Gingrich, 2015, p. 92). Ultimately, CHA, guided by Esping-Andersen's work, provides a means for theorizing on "broad links between regulatory, financial, and welfare institutions and the realm of political conflict around them," so to better understand both the "causes and consequences of change" (Gingrich, 2015, p. 92).

**The Role of Postpsychiatry and Mad Studies**

Shifting away from the reductionist medical model in the formulations and interventions of psychiatry can lead to very different approaches to mental health policy and practice. Although the role of adversity in the genesis of mental distress is well-established, the neoliberal framing of the "epidemic of mental ill health" continues to locate its ailments within individuals rather than in societies (Rose, 2019, p. 49). Lanny[3] states, as a result, "people who go crazy can either be given over to psychiatric care, or somehow live in a society that is uncaring and lacks love" (as cited in Shimrat, 1997, p. 57). While the law enables two sides to engage in a

[3] Lanny Beckman, interviewed by Shimrat in 1997, is one of the founders of the Mental Patients Association (MPA), a self-help group formed in Vancouver during the early 1970s.

conversation (Costa, 2013, p. 206), it lacks the capacity to generate mental health reform in the name of civil or human rights (Rose, 2019, p. 175).

Only by looking holistically can we begin to rethink the biopolitics of psychiatry (Bracken & Thomas, 2005, pp. 12, 16). There was a greater prevalence of psychiatric diagnoses among people who had no previous encounters with psychiatry following the Second World War (Rose, 2019, p. 68). This recognition led psychiatrist Karl Menninger (1965) to conclude universality in experiences of mental distress: "some people have some degree of mental illness at some time, and many of them have a degree of mental illness most of the time" (p. 33, as cited in Rose, 2019, p. 68). As a result, more people were encouraged to apply psychiatry to their own lives (Rose, 2019). Not everyone, however, was considered "suitable for treatment" as practices of diagnosis aimed to differentiate "the normal" from "the mad" as well as conditions within the "mad" (Rose, 2019, p. 68). The desire of psychiatry to seek objectivity in diagnoses of mental distress encouraged researchers to discover neurobiological underpinnings for categories of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Rose, 2019, pp. 85-86). Consequently, the "power of biology" (Rose, 2019, p. 86) in disease pathology has strived to confirm the hypothesis that "disease … [can be] found in the tissues" (p. 81).

Discourses of neuroscience and psychopathology, guiding the narrative of psychiatry, continue to separate mental health from its contextual factors (Bracken & Thomas, 2005, p. 10). To demand a radical change in the ways in which research views mental distress, and the ways we address mental distress in societies (Rose, 2019, p. 66), psychiatry must recognize that "formulation rather than, or alongside, diagnosis" captures lived experiences of mental distress (p. 91). If multiple perspectives are possible (Rose, 2019, p. 180), the link between treatment and

coercion must be abolished enabling equal partnerships between medical professionals and people experiencing mental distress (Bracken & Thomas, 2005, p. 12).

Works from Mad Studies scholars challenge the dominance of the medical model in mental health and work towards activism and change through exploration of the history of Mad people and the current lived experience of people labelled "mentally ill" or "Mad" (Menzies, LeFrançois, & Reaume, 2013). Mad studies embrace "holistic perspectives where people are not reduced to symptoms but understood within the social and economic context of the society in which they live" (Menzies et al., 2013, p. 2). Mad Studies is not limited to "people deemed Mad," but is inclusive of "allies, social critics, revolutionary theorists, and radical professionals" (Menzies et al., 2013, p. 2) who distance themselves from the narrative of biomedical psychiatry by protesting structural discrimination produced through societal assumptions of "normalcy" and "madness" along with forms of structural oppression that pathologize and stigmatize people with mental health diagnoses (Diamond, 2013, Perlin, 2003, Liegghio, 2013, as cited in Josewski, 2017, p. 63; Morrow, 2017).

The call for psychiatry to relocate forms of mental distress within their social contexts has been termed postpsychiatry by Bracken and Thomas (2005) and further referred by Rose (2019) as an alternative psychiatric biopolitics. According to Bracken and Thomas (2005) post-psychiatry "means an end to the 'monologue of reason about madness,'" that has been established on the basis of silencing the Mad (p. 2). While it is not "anti-science," post-psychiatry aims to redefine the discourse surrounding "meanings, relationships, and values" (Bracken & Thomas, 2005, p. 5). A "context-centered approach" is central to understanding experiences of distress and madness; as Bracken and Thomas (2005) assert, experiences of psychiatric symptoms can not only be understood "in terms of what is happening in the

individual at one moment in time but in terms of other dimensions of the person's reality" (p. 14). As such, Bracken and Thomas (2005) argue going beyond reductionism towards hermeneutics in medical understandings of madness and distress. Accordingly, the reductionist approaches of traditional psychiatry are criticized for ascribing "meaningful human experiences" to "non-meaningful entities" (i.e., genes, neurotransmitters, molecules, etc.) (Bracken & Thomas, 2005, p. 14). In contrast, hermeneutics, or "the process of interpretation to make sense of things" (Bracken & Thomas, 2005, p. 15), is argued to resist such reductionism by insisting that "meaning cannot be fixed" (p. 16). Therefore, the impact of the interplay of biological, psychological, social, and cultural forces on people's lives is what gives them meaning (Bracken & Thomas, 2005, p. 16). Accordingly, psychiatry is a world of meaning and thus context; forms of distress can mean different things depending on the contexts in which they occur (Bracken & Thomas, 2005, p. 109).

Postpsychiatry seeks to overcome the individual biomedical focus in modern psychiatry by giving primacy to the meaningful reality of the individual's distress (Bracken & Thomas, 2005, pp. 107, 133). Rethinking the role of science and expertise in mental health, postpsychiatry explores a different way of understanding priorities and the values we attach to states of mental distress (Bracken & Thomas, 2005, p. 189). The role of medical professionals in the new biopolitic of psychiatry is therefore to support the demedicalization of mental distress and challenge the increasing long-term use of psychopharmaceuticals (Rose, 2019, pp. 191-192). Citizenship, which is bound to hegemonic judgements of what is and what is not normal (Foucault, 1980, as cited in Bracken & Thomas, p. 255), must also be inclusive, allowing space for difference in experiences of reality (p. 257). Ultimately, another psychiatric biopolitics is possible if psychiatry can move beyond the conflict between the biomedical and the social to

embrace pluralism and thus "abdicate … responsibility to those whom … [it] claim[s] to serve" (Rose, 2019, p. 198).

**Comparative Method of Analysis**

Tuohy (2012) states that "the comparative study of health policy is a dance," involving "explanation and prescription," "inductive and deductive analysis" and "attention to converging elements and attention to the continuing distinctiveness of each nation" (p. 23). Furthermore, that "comparisons across time within nations can marry well with cross-national comparison" (Tuohy, 2012, p. 22). The institutional processes and features: government structures and healthcare governance, financing and service system designs, and regulation and payment were selected as they shape healthcare laws and policies. Having cross-national and nation-specific indicators enable a more reliable and valid measurement of the same phenomenon (mental health reform) between the states (Przeworski & Teune, 1966).

**Conclusion**

The chapter reviews literature on the theory of institutional change to analyze its application in understanding power dynamics and inequities in mental health reform. Concepts such as "drift" and "conversion" are explored to understand how institutional change either coincides with or diverges from institutional reproduction. This approach allows for a deeper understanding of the complexities involved in leveraging policy for equitable mental health improvements. A comparative-historical approach (CHA) aids the study in examining large-scale political and socio-economic forces on mental health policies. This methodology emphasizes the role of historical contexts and macro-configurational factors in shaping contemporary institutional practices and policy outcomes. Drawing on Esping-Andersen's research on welfare capitalism, the chapter examines how political agendas and power distributions impact mental

health reforms. The chapter incorporates perspectives from Postpsychiatry and Mad activism to critique the dominant biomedical approaches in mental healthcare. This integration advocates for a shift towards more inclusive, human rights-focused practices that fully consider an individual's social context and experiences. The methodology outlined in this chapter provides a foundation for examining the interplay between policy levers and mental health reforms across different institutional contexts. By examining historical opportunities for change and current policy trajectories, the research highlights the strategic use of policy levers and their varying impacts across the states studied. The comparative analysis emphasizes the urgent need for global mental health policy reform, promoting person-centered and recovery-oriented approaches that integrate social and structural determinants of health.

## Chapter 2: Government Structures and Healthcare Governance

This chapter explores the dynamic shifts of power between governments and their effects on the governance of (mental) healthcare. This is the first chapter comprising Part One of the dissertation. Each chapter, making up Part One, examines a different policy lever(s) and its impact on mental health reform among the three states until roughly the 2010s. Part Two of the dissertation will explore further the policy-levers and policy-trajectories, within each state, throughout the most recent past decade. While the focus of this dissertation is on policies from the 2000s onwards, chapters in the first part of the dissertation will often highlight earlier windows of opportunity that were critical in shaping governance and reform trajectories in each state. The policy lever of organization is explored in its use by governments to implement change. Drawing attention to narratives of care integration, policies reflect openings that occurred in political arenas for change. Finally, exploring historical deliberations surrounding decentralized versus centralized governance, a new role for accountability within a networked model of governance is revealed.

### Integration as the Key Response

The rhetoric of mental health reform has been focused on shifting the locus of mental healthcare away from an "institutional-medical approach" towards a "community-based approach" (Nelson et al., 2001, p. 77). The WHO in its *World Mental Health Report: Transforming Mental Health for All* (2022) states, "at the heart of mental health reform lies a major reorganization of mental health services" (p. xix). Emphasis on strengthening community-based care is evident in numerous government reports including the Canadian Tyhurst Report, *More for the Mind*, (a CMHA document), published in 1963, that documented psychiatric services between 1939-1963 to show that the "continuity of care extending into the community,

had simply not developed adequately" (Griffin, 1989, p. 249; Lurie & Goldbloom, 2016). During this time, participation of people with mental health and psychosocial conditions in mental health policies, also began to grow across Canada,[4] the UK,[5] and Australia.[6] Their voices echoed need for community investment, to address critical social determinants that impact mental health (i.e., job insecurity or unemployment, isolation, lack of access to housing, social safety nets, and health services) (WHO, 2021). Investing in community mental health has been shown to produce greater supportive housing and crisis intervention, diverting emergency department mental health visits, and producing less reliance on the medical system and the police – often the default service for mental health crisis (Auditor General of Ontario (AGO), 2016; CMHA, 2020; Lurie, 2021). Research has also linked community resources with improved health outcomes, responding to poverty, inequality, discrimination, and violence (WHO, 2021).

Governments rely on policy levers or "control knobs" to implement mental health reform (Roberts et al., 2008, p. 7). The choice of lever is dependent on the "political climate" and "constitutional and legal restrictions on government authority" (Howlett, 2011, as cited in Grace et al., 2015, p. 3). While more than one lever may be used concurrently to implement a strategy (Grace et al., 2015), for the purpose of this chapter, and the subsequent chapters making up Part One of this dissertation, the dominant lever will be separated from the others in attempt to draw

[4] The Canadian National Committee for Mental Hygiene, later becoming the Canadian Mental Health Association (CMHA), founded in 1918, is one of the earliest voluntary health organizations in Canada (Griffin, 1989). In 1985, The CMHA published *Listening to people wo have directly experienced the mental health system*. The Graham Report published in 1988 in Ontario is also of significance in fostering a partnership with the policy community.
[5] "User involvement" (as used in the UK) has been central to NHS policy since the establishment of Community Health Councils in 1973; the NHS and Community Care Act in 1990 made it a legal requirement for user involvement in service planning; other key policies include the Patient's Charter (Department of Health, 1991) and the plans set in *Local Voices* (NHS Management Executive, 1992) (as cited in Tait & Lester, 2018).
[6] The first "consumer organisation" in Australia (terms consumer and carer are used in Australia) – Campaign Against Psychiatric Injustice and Coercion (CAPIC) was formed during the 1970s (VMIAC, 2023). The Burdekin Report released in 1993 was the first report to consult with and recognize "roles to be played by consumers and 'carers'" (as cited in Epstein, 2013, p. 11).

better comparisons between the three states. However, at times, it will be difficult to parse one lever without another (i.e., between the levers of organization (government and governance), finance and service system design, and regulation and payment). Policy levers represent an aspect of the health system's structure or function and are different from causal factors, which are outside of the health sector's control, that can affect health system performance (Roberts et al., 2008). Unlike causal factors, policy levers can be adjusted by governments through public policy to influence the health system's functioning (Roberts et al., 2008). While there is no agreed upon definition for policy levers (Grace et al., 2015), the policy lever of organization identified by Roberts et al. (2008) is used in this section. Organization refers to "macro-level changes in the location, magnitude and diversity of capital and human resources" and includes "the degree of vertical integration" between services (Grace et al., 2015, p. 3). The lever will be used to explore how policies influence the "degree of integration and/or centralization … or … type(s) of ownership of [mental] health facilities" (Grace et al, 2015, p. 3).

Contrary to the "one-size-fits all" approach "offered by many health services," integrated care aims to design services specific to individual needs (Kaehne & Nies, 2021, p. 2). Care integration can be defined as "an emergent set of practices intrinsically shaped by contextual factors, and not as a single intervention to achieve predetermined outcomes" (Greenhalgh, Shaw, & Hughes 2020, as cited in Kaehne & Nies, 2021, p. 2). Integration, "from an operations management perspective," is needed as a response to service differentiation and fragmentation (Lillrank, 2012, p. 7). A problem faced by many with concurrent disorders who are four to seven times more likely than someone with one mental health or substance use problem to report unmet need (Urbanoski et al., 2007). As Fleury & Mercier (2002) state, "the purpose of integration is to avoid service duplication, to enhance accountability, and to allow clients to move among

agencies without having to repeat their history, to be unrestricted by interorganizational barriers" (p. 57). Integration takes place at the policy level "to ensure eligibility criteria, financial incentives, and workforce requirements … are in place to support the other [levels] of integration," including functional (service delivery integration) and clinical (client service integration) (CMHA, 2010b, pp. 2, 3). The success of macro-level integration (systems-level) is revealed by its ability to support micro-level integration (organizing services around individual needs) (Lillrank, 2012).

Three main types of integration exist: linkage, coordination, and full integration (Leutz, 1999, as cited in Kaehne & Nies, 2021, p. 8). Linkage involves arranging services with "existing divisions of labour divisions in the health system," typically through referral routes between services (Kaehne & Nies, 2021, p. 8). Coordination includes "more shared responsibilities and resources than linkage" and aims to "share clinical information," "optimize service use," and "manage transitions of patients between settings" (Kaehne & Nies, 2021, p. 8). Full integration draws on multiple care systems to "pool organizational resources" to develop comprehensive care (Kaehne & Nies, 2021, p. 8). Fully integrated services typically "transform professional practices and delivery," "define new tasks," and are governed by new structures that "cut across previously distinct organizations" (Kaehne & Nies, 2021, pp. 8-9). Coordination and integration are "inversely related;" "need for coordination decreases" as "services become more integrated" (Poku, Kagan, & Yehia, 2019, p. 1906). The main difference between care coordination and (full) integration is that coordination involves arranging existing services "into an organized whole," while integration "implies a fusion of components into something new" (Lillrank, 2012, p. 8).

Inadequate integration is a barrier to providing a continuum of care (Wiktorowicz et al., 2020, p. 2). Integration in mental healthcare is therefore intended to produce a more "accessible and flexible" system that meets the "bio-psychosocial and persistent needs" of people (Fleury & Mercier, 2002, p. 57). The WHO (2022) declared mental health integration "a crucial ingredient of mental health reform" (p. 211). Integration creates more cost-efficient services by preventing acute crises that develop in response to unmet needs and result in hospitalization (Fleury & Mercier, 2022). Integration, however, entails political leadership at the macro-level in policy making and management to support system integration (Dickinson & Smith, 2021).

## Organizing Health Governance

### *Roles of Governments and Health System Governance*

To contextualize international comparisons, it is important to briefly overview health system organization and governance in Canada, England, and Australia. In Canada, both the federal and provincial/territorial levels of government "share responsibility for the regulation and financing of health care" (Flood, 2014, p. 83). However, due to significant decentralization, most of the responsibility for the organization and delivery of healthcare is assigned to the provinces and territories, as outlined in the Constitution Act (1867) (Flood, 2014, p. 83). In many provinces and territories, regional health authorities have been established to plan and deliver public health insurance, medicare (Mossialos, Wenzl, Osborn, & Sarnak, 2016). Medicare provides "medically necessary" hospital care and "medically required" physician services (Flood, 2014, p. 79). However, there is no legal definition for deciding what constitutes "medically necessary" care (Flood, 2014, p. 79). Consequently, provinces and territories "determine standards of care and decide what services will be covered" under medicare (Hartford, Schrecker, & Wiktorowicz, 2003, p. 65). To receive federal co-financing for medicare, the provinces and territories must

adhere to the five principles of the *Canada Health Act* (1984). These principles are to ensure that provincial/territorial healthcare insurance plans are (1) publicly administered; (2) comprehensive in coverage; (3) universal; (4) portable across provinces; and (5) accessible (Government of Canada, 1985).

Health Canada, responsible to the federal minister of health, contributes to promoting "overall health, disease surveillance and control, food and drug safety, and reviewing medical devices and technology" (Mossialos et al., 2016, p. 25). The department is also responsible for other federal health agencies including the Public Health Agency of Canada, which oversees public health, emergency readiness and response, and management of infectious and chronic disease control and prevention. Nationally, various intergovernmental non-profit organizations work toward enhancing governance "by monitoring and reporting on health system performance; disseminating best practice in patient safety (the Canadian Patient Safety Institute); providing information to the public on health and healthcare and standardizing health data collection (Canadian Institute for Health Information); and providing funding and support for provincial health information systems (Canada Health Infoway)" (p. 25). Other nongovernmental organizations that play significant roles in system governance include the Canadian Medical Association, provincial regulatory colleges, which are "responsible for licensing professions and developing and enforcing standards of practice," and Accreditation Canada, a non-profit organization providing "voluntary accreditation services … across Canada, including regional health authorities, hospitals, long-term care facilities, and community organizations" (p. 25). Under provincial and territorial laws, most healthcare providers are self-governing and registered with professional associations that oversee adherence to education, training, and quality-of-care standards. Physicians' professional associations also negotiate with provincial ministries of

health over fee schedules. Patient advocacy often occurs through ombudspersons in most provinces.

Since the devolution of responsibility for healthcare services in the UK in the late 1990s, "the respective governments in England, Scotland, Wales and Northern Ireland have been responsible for organizing and delivering health care services" (Anderson et al., 2022, p. xviii). In England, "health legislation" and "general policy" is overseen by Parliament, the Secretary of State for Health, and the Department of Health (Mossialos et al., 2016, p. 49). The Secretary of State for Health is obligated by law, the Health Act (2006), to endorse a "comprehensive health service, providing services free of charge, except for those with charges already in place" (Mossialos et al., 2016, p. 49). The rights of people eligible for National Health Service (NHS) care are outlined in the NHS Constitution (2013) and include non-discriminatory access to care and delivery of care within specific timelines for some services including emergency and planned hospital care (Department of Health, 2013, as cited in Mossialos et al., 2016, p. 49). While "the Department of Health provides stewardship for the overall health system … day-to-day responsibility for running the NHS belongs to a separate public body, NHS England" (Mossialos et al., 2006, p. 49). This body manages the NHS budget, supervises 209 local Clinical Commissioning Groups (CCGs),[7] and ensures that the goals put forth in the annual mandate issued by the Secretary of State for Health are met (Mossialos et al., 2016). These goals include both efficiency and health-related targets (Mossialos et al., 2016). Local government authorities manage budget allocations for public health and are "required to establish "health and well-being boards" to improve coordination of local services and reduce health disparities" (Mossialos et al., 2016, p. 49).

[7] Replaced by Integrated Care Systems (ICSs) under the *Health and Care Act* in 2022.

The Department of Health and the Secretary of State for Health are responsible for the entire health system (Mossialos et al., 2016). The *Health and Social Care Act* (2012) transferred significant functions to NHS England, including budget control, CCGs and Monitor, "an economic regulator of public and private providers" (p. 52) supervision, and "responsibility for setting [diagnostic-related groups] DRG rates for provision of NHS services" (p. 53). NHS England is also responsible for commissioning "some specialized low-volume services, national immunization and screening programs, and primary care" as well as "setting the strategic direction of health information technology" (p. 53). For instance, initiatives such as the creation of online appointment booking services, standards for quality in electronic medical record-keeping and prescription practices, and the infrastructure of the NHS information technology. The National Institute for Health and Clinical Excellence (NICE) is responsible for setting guidelines for treatments deemed clinically effective and evaluating new health technologies for efficiency and cost-effectiveness. The Care Quality Commission (CQC) oversees provider registration to ensure basic standards for safety and quality of care are achieved and has the authority to mandate the closure of services if standards are not met. The role of Monitor[8] is to license all healthcare providers receiving NHS funding and "may investigate potential breaches of NHS cooperation and competition rules and mergers involving NHS foundation trusts" (p. 53). At the national level, Healthwatch England advocates for patient interests. Within local communities, Healthwatch organizations receive quality concern reports and can also support people in making service complaints. Healthwatch England can also advise the CQC to act in such quality concern reports. Local NHS bodies, including general practices, hospital trusts, and

[8] Starting in April 2016, Monitor became part of NHS Improvement (UK Government, 2016). NHS Improvement consolidates the functions of Monitor, the NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team, and the Intensive Support Teams into a single entity (UK Government, 2016).

CCGs, are also responsible for fostering their own patient engagement groups and initiatives. NHS choices, owned by the Department of Health, is a website for "public information about health conditions, the location and quality of health services, and other information" (p. 53). The website also serves as a platform for user feedback.

Australia has a federated system of governance, characterized by "a complex division of responsibilities between federal and state/territory governments" (Grace et al., 2015, p. 1). Through intergovernmental agreements, the federal government, or Commonwealth government, regulates and funds health services while the states and territories are primarily responsible for delivering and managing services and hold "some additional regulatory and funding responsibilities" (Grace et al., 2015, p. 1). The federal government "subsidiz[es] primary care providers through the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Schemes (PBS) and provid[es] funds for state services" (Mossialos et al., 2006, p. 11). States are primarily responsible for "public hospitals, ambulance services, public dental care, community health services, and mental health care" (Mossialos et al., 2016, p. 11). In addition to federal funding, states provide their own funding (Mossialos et al., 2016). Local governments also participate in the delivery of community health and preventive health programs (Mossialos et al., 2006).

Other "key entities for health system governance" include the Council of Australian Governments (COAG), at the federal level, comprising the Prime Minister and the first ministers from each state, the Council focuses on "highest-priority issues, such as major funding discussions and the interchange of roles and responsibilities between governments" (Mossialos et al., 2016, p. 15). The Australian Ministers Advisory Council supports the COAG Health Council, which is "responsible for more detailed policy issues" (p. 15). National policies and programs

such as the MBS and the PBS are overseen by the federal Department of Health and the Department of Human Services administers payments within these schemes. Multiple national agencies and state governments are responsible for ensuring quality and safety of care and key health data is provided by the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS). Workforce registration and accreditation is overseen by the Australian Health Practitioner Regulation Agency in collaboration with National Boards, and the Australian Prudential Regulation Authority oversees private health insurance. Competition among private health insurers is promoted by the Australian Competition and Consumer Commission and as of July 2016, the Australian e-Health Commission governs electronic health data. State governments manage their own health departments and have decentralized hospital management to Local Health Networks (LHNs) that work collaboratively with Primary Health Networks (PHNs). As well, "patient-consumer organizations and groups operat[e] at the national and state level" (p. 15).

### *The Healthcare State*

The "health care state" (Moran, 1995, p. 15) and its governing structures "have existed in tension with democratic ideas and institutions" (Tuohy, 2003, p. 204). For instance, parts of the health system such as the medical profession "are in large part pre-democratic creations," while "some systems of consumption politics originated explicitly as anti-democratic creations" (Moran, 1995, p. 15). As such, "the government of the health care state has had to adjust to institutions of democratic politics for which it was never designed" (Moran, 1995, p. 15). Evident in Canada, during the late 1990s, where "health care issues had come to define the climate of federal-provincial relations rather than vice versa" (Tuohy, 2003, p. 213). Due to the previous four decades (1945-1985) where governance of the Progressive Conservative Party in

the province of Ontario "barred rather than eased the way for mental health issues to become an important part of Progressive Conservative ideology" (Simmons, 1990, p. 255). Different institutional factors also influence the distribution of authority among jurisdictions which impact trajectories in healthcare laws, policies, and systems (Wiktorowicz, Di Pierdomenico, Buckley, Lurie, & Czukar, 2020). Up until the 1990s, "formal accountability relationships in the health care arena" were based in the hierarchy of the NHS in the UK (Tuohy, 2003, p. 206). The "internal market reforms of the 1990s," split the "purchasing and providing functions"[9] within the NHS system so to create a "market" enhancing accountability among different stakeholders "requiring them to bargain explicitly with each other and to monitor compliance with the specific contracts struck through this process" (Tuohy, 2003, p. 206). Similarly, in Australia, the National Mental Health Strategy (1992) supported the transition "from a reliance on government services to the use of private, for-profit services" (Henderson & Roberts, 2020, p. 177). This movement towards a market model of care was based in a view of people with mental health and psychosocial conditions as consumers who have control and choice in their care by deciding between services (Henderson & Roberts, 2020).

### *Managerial Discourse and Modes of Governance*

The concept of managerialism is linked to the dominance of neoliberalism and can refer to the use of market values in the governance of healthcare (Gavin, 2020). The widespread use of managerial discourse in health services is attributed to the financial crises and increasing healthcare demands of the 1980s and 1990s (McCabe & Sambrook, 2019). Managerial discourse underpins the need for mental health outcome measures, benchmarking, and key performance

[9] The purchaser/provider split refers to the creation of an internal market within the NHS during the 1990s (Patients4NHS, 2017). This separated organizations into service providers (such as hospitals) and service purchasers. The result required NHS hospitals and other service providers to generate their own income and engage in competition among themselves for business.

indicators as the problem representations relating to public mental health services (Oster et al., 2023). Evident in the *No Health Without Mental Health* (2011) strategy in England, where the government set out six objectives to improve mental health and parity with physical health, the implication is that for the strategy to be effective the objectives must be fully integrated into the "outcomes frameworks" that "hold the NHS, public health and social care professionals to account for the results they achieve" (Naylor, 2011, para. 5). Similar accountability issues occurred in the implementation of the Canadian national mental health strategy, *Changing Directions, Changing Lives* (Mental Health Commission of Canada (MHCC), 2012), where the MHCC operating at the federal level "can only attempt to foment change through national consultations and moral suasion" (Morrow, 2013, p. 324). Managerialism also coincided with conceptions on the right to healthcare that emphasized the market or purchasing of private health insurance over the collective good (Wiktorowicz et al., 2020). Accordingly, people experiencing mental distress are costly as customers of mental health services and are labelled as either "good/responsible" or "deviant/irresponsible" based on their ability to recover and maintain "economic prudence and responsibility" (Sharland et al., 2017, p. 179). While, Canada, the UK, and Australia ratified the UN CRPD, incorporating a human rights-based model to mental health, mental health laws, "except those that contain or are under a primary capacity gateway criterion," are incompatible with Article 12[10] of the CRPD (Davidson et al., 2015, p. 39).

**A History of Health Policy Logics and Mediated Reforms**

[10] Article 12 of the CRPD requires States to: "recognize that persons with disabilities enjoy legal capacity on an equal basis with others" (12.2); that States "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity" (12.3); and States should "ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards" (12.4). Much debate exists over what 'exercising legal capacity on an equal basis with others' means (Davidson et al., 2015).

The "logic of decision-making within the health care system" is important to understanding mental health policy and opportunities for reform (Wiktorowicz et al., 2020, p. 2). Mental health policy reform has developed incrementally despite decades of state commissioned policy reports endorsing a continuum of care (Wiktorowicz et al., 2020). However, "forces in the broader political arena have periodically opened windows of opportunity for major policy change in the health care arena" … the health systems that have resulted in each nation are "largely, if not entirely accidents of the timing of their birth" (Tuohy, 1999, p. 239). Consequently, health systems have been "shaped by their own internal logics" between these windows of policy change (Tuohy, 1999, p. 239). Tuohy (1999) argues that political will, or the willingness of political actors to change a health policy framework, and political capacity, or favourable institutional and electoral conditions that enable political actors to assert their authority to enact a change, are needed to create a window of opportunity for change. However, decision-makers may still pursue change incrementally despite having the political will and capacity to make discontinuous change (Tuohy, 2018). Accordingly, Tuohy (2018) has classified four strategic outcomes in which policy change occurs based on the scale, "changes of degree and scope in the logic established by the policy framework governing decision-making over the allocation of resources" (p. 9), and pace, "a spectrum from fast to slow" distinguishing the "pace of enactment and the pace of implementation" (p. 11), of change. The four strategic types of policy change – big-bang, blueprints, mosaics, and incremental – and strategic domains can be seen in Figure 1 in Appendix B.

Big bang policy change occurs "where the leadership of the coalition has the political and institutional resources to command support for a centrally driven agenda," producing strategies of large-scale change and rapid enactment and implementation (Tuohy, 2018, p. 15). Big bang

strategies usually occur in conditions where control is centralized, such as Westminster parliamentary systems (Tuohy, 2018). In the Westminster systems of Canada, the UK, and Australia, universal health coverage was created through a big bang change (Tuohy, 2018). The impetus for big bang change was "less obvious" in Canada during the mid-1960s (Tuohy, 2018, p. 30) given the federal minority Pearson Liberal government. However, a "rare instance" of an "all-party consensus at the federal level" led to the enactment of the Medical Care Act in 1966, a cost-share agreement between the federal and provincial governments for physician services "drawing the medical profession into a bilateral monopoly with the state" (Tuohy, 2018, p. 30). The election of the Attlee Labour government in the UK in 1945, considered a "political earthquake"[11] (Brown, 2001, para. 1), introduced several reforms aimed at improving social services and the public sector including the creation of the NHS in 1948 (Touhy, 2018). While the Beveridge Report (1942) proposed a universal system of social insurance, the "people did not trust [Churchill] to deliver the brave new world of Beveridge" (Brown, 2001, para. 5). In Australia, the role of the Commonwealth government in health matters was limited up until the establishment of a federal health department in 1921 with a directive to deliver health services in collaboration with the states (Philippon & Braithwaite, 2008). In 1922, the Hughes Nationalist party, the main non-labor party, lost its majority (Barber & Johnson, 2014). The opposition Labor party led by Charlton did not take office, instead the Nationalists sought a coalition with the two-year-old Country party and Hughes was replaced as Nationalist leader by Stanley Bruce (Barber & Johnson, 2014). In 1946, a coalition[12] was formed between the new Liberal party and

[11] The then leader of the Conservative Party and Prime Minister of a Coalition Government, Winston Churchill, called the election just 12 weeks after the surrender of Nazi Germany confident that he would be supported and wanting to continue his wartime coalition (Brown, 2001).

[12] The Liberal-National Coalition, referred to as the Coalition, is made up of the Liberal party of Australia and the National Party of Australia (previously known as the Country Party and the National Country Party); both parties occupy positions on the centre-right of the political spectrum ("Coalition (Australia)," 2023).

National party (Barber & Johnson, 2014), during this time the constitution[13] was amended to give the Commonwealth "wide concurrent powers in health policy" (Philippon & Braithwaite, 2008, p. 172). Consequently, the Commonwealth government became the "dominant player on matters pertaining to physicians and pharmaceutical policy" (Philippon & Braithwaite, 2008, p. 171).

During the "millennial reform era" (1981-1996), the UK experienced another big bang change through the internal market reforms to the NHS in 1990 by the Thatcher Conservative government (Tuohy, 2018). The majority government in its third successive term replaced "managerial authority between Health Authorities" with "a relationship of contracting between independent "purchasers" and "providers" represent[ing] a pronounced shift from hierarchical to market-type mechanisms in the design of decision-making structures" (Tuohy, 1999, p. 241). Canada experienced a period of "structural and institutional stability" (Tuohy, 1999, p. 245) during the 1990s as the *Canada Health Act* (CHA) (1984), which set the criteria for provincial medicare plans to receive federal financing, "constrained the role of private finance in the medical and hospital sectors, as well as the extent to which any market mechanism based on price competition could be put in place" (Tuohy, 1999, p. 246). Consolidation of federal and provincial authority needed to renegotiate the terms of the CHA was unlikely, despite the Conservative and then Liberal (1993) majority government having the "consolidated authority to act unilaterally" (Tuohy, 1999, p. 246), given the debates surrounding degree of centralization/decentralization within the federation and the 1995 Quebec referendum for independence (Tuohy, 1998). The logic of the Canadian system therefore maintained "collegial mechanisms and medical influence" through "agency relationships between individual patients

[13] The *Commonwealth of Australia Constitution Act* (1901) provides the basis for Australia's federal system of governance (Parliamentary Education Office, 2023).

and professionals" (Tuohy, 1999, p. 247). In 1976, the Liberal-Country party in Australia made significant changes to Medibank by creating competition between private and public insurance schemes with the aim to reduce overall health expenditures (Philippon & Braithwaite, 2008; Boxall 2010). However, the impact shifted more people from the public to private sector and increased service inflation (Boxall, 2010). In 1981, under the same Fraser Liberal-Country government, Medibank was abolished with the rational that the mix of public and private insurance was confusing and would complicate economic policy (Boxall, 2010). With a change of government in 1984, the Hawke Labor party reintroduced universal health insurance through the name Medicare as part of its Accord[14] it "had negotiated with unions and employers while in opposition" (Boxall, 2010, p. 529). Another example of big bang policy change occurred in 1997 under the Howard Liberal-National coalition government which implemented the Medicare levy surcharge that financially penalized people earning above a certain threshold that chose not to purchase private insurance (Boxall, 2010). Baum and Dwyer (2014) argue that health policy in Australia has been guided by challenges in how to "maximise health outcomes" while ensuring "equity in access to health care" and an "effective health care delivery system within constrained resources" (p. 187). Consequently, the logic of the health system surrounds an ideological debate about a "subsidized market system underwritten by government" versus a "government-controlled system incorporating universal coverage" (Philippon & Braithwaite, 2008, p. 175).

Incremental change dominated the early 2000s despite opportunities for major change in each state. Given a window of opportunity, incrementalism can be a "strategic choice" not just a "default position" and occurs when "there is a coalition of support for change … to reach an

[14] The 1983 Prices and Incomes Accord made between the Hawke Labor Party and the Australian Council of Trade Unions acted on "social wage" – to minimize government inflation, unions agreed to restrict wage demands (Boxall, 2010, p. 529). The Accord aimed to combine the Labor party's economic reforms with social equity policies.

agreement rather than retain the status quo" (Tuohy, 2018, p. 529). Incrementalism was evident in the UK during the second Blair Labour government's term (2001-2005) (Tuohy, 2018). The government gradually took steps to undo certain elements of the previous Conservative reforms, while maintaining the purchaser/provider split but reinforcing the centralization of the NHS as a hierarchy for setting targets and performance standards (Tuohy, 2018). The UK also experienced the conditions for a mosaic strategy during the unprecedented formation of a Conservative/Liberal Democrat Coalition following the 2010 general election (Tuohy, 2018). A mosaic is characterized by "fast-paced change involving multiple adjustments to existing arrangements" (Tuohy, 2018, p. 32). In seeking to change the NHS's policy framework the coalition built on the previous Labour government's platform. The result was a series of convoluted amendments "that maintained the logic of the purchaser/provider split by reconfiguring the "purchasers" to invert the formal relationship between physicians and managers" (Tuohy, 2018, p. 527). Another example of incremental change occurred in Canada during Martin's leadership of the Liberal party (2003) where the provinces recognized the opportunity for significant increases in federal funding and initiated negotiations for the federal acquisition of provincial drug insurance schemes (Tuohy, 2018). What ensued was the federal-provincial First Ministers Health Accord that resulted in a $16 billion federal investment in the Health Reform Fund, which "targeted primary health care, home care, and catastrophic drug coverage" (Hutchison et al., 2011, p. 262). Given the opportunity to change the policy framework for healthcare, Martin's government instead aimed to reach an agreement with the provinces over healthcare spending, setting his government apart from the "more confrontational stance of his predecessor" (i.e., Jean Chrétien of the Liberal party) (Tuohy, 2018, p. 531), and reinforcing the "existing design and boundaries of the single-payer framework with increased

funding" (p. 32). Incrementalism also defined Australia during the Rudd Labor government in 2007, which established the National Health and Hospitals Reform Commission in 2008 to advise on health system reform (Boxall, 2010). The resulting 2010 release of the reform plan, *A national health and hospitals network for Australia's future*, was accompanied by a $16 billion guarantee from the Commonwealth to cover hospital services up until 2019 (Wells, 2013). The Labor government proposed becoming the major funder of Australian public hospitals, funding 60 percent of all public hospital services delivered to public patients (Wells, 2013). The resulting reform plan, however, lacked comprehensive details including how the responsibility for running hospitals would be devolved to the proposed Local Hospital Networks (LHNs) (Van Der Weyden, 2010). Another challenge was the Reform Commission was not given directive to examine the relationship between Medicare and private health insurance (Boxall, 2010). The next section will explore how governance logics influenced the vision for mental health reform as outlined in mental health policies.

**Vision Guiding Mental Health Reform**

Despite the different logics governing the healthcare systems, the mental health reform strategies put forth in Canada, the UK, and Australia during the first decade of the twenty-first century shared a common vision for change though the scale and pace may vary (refer to Table 1 in Appendix A).

In 2011, Ontario's comprehensive mental health and addictions strategy, *Open Minds, Healthy Minds*, was released under Liberal party governance. The 10-yr strategy outlined a plan to provide integrated mental health supports and services to all Ontarians (MOHLTC, 2011). The following year, the MHCC, operating at the federal level under the Conservative party governance, released *Changing Directions, Changing Lives* (2012) the first national mental

health strategy. Areas of action include reducing disparities, promoting access to services, recovery, and rights, and increasing the proportion of health spending on mental health (MHCC, 2012).

In 2009, England under the Labour party governance, released *New Horizons: A Shared Vision for Mental Health*, and the *Future Vision for Mental Health* by the Future Vision Coalition (FVC) of the National Health Service England (both in July) (CMHA, 2010a). The *New Horizons* program recognizes "mental health is about equality and justice" (p. 16) framing mental health as a social issue and highlighting the importance of recovery as being both based in "personalisation and self-determination" (p. 24). The FVC further endorsed a recovery-based, person-centered approach emphasizing prevention and early intervention (CMHA, 2010a).

In 2009, the state of Victoria, under the Brumby Labor government, released *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019* (in February) while at the federal level, the government of Australia, under the Rudd Labor party, released the *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014* (in November). The 10-yr Victorian strategy centered around prevention, early intervention, recovery and social inclusion, with the vision that "all Victorians have the opportunities they need to maintain good mental health, while those experiencing mental health problems can access timely, high quality care and support to live successfully in the community" (Mental Health and Drugs Division, 2009, p. 21). Building on the National Mental Health Policy released in 2008, that endorsed a mental health system enabling recovery, the *Fourth Plan* emphasized the need for performance indicators to monitor change and improve accountability (AIHW, 2009).

The strategies shared many similarities in key areas for system reform. Including a "whole of government approach" articulated in each strategy to "achieve population mental health" (CMHA, 2010a, p. 5). However, the ways in which the approach was to be implemented differed across the states (i.e., through policy integration, funding mechanisms, or structural changes).

In Canada, the MHCC, argued for integration of mental health policies into public health and social policies across all government levels (CMHA, 2010a). The MHCC emphasized need for a broad network of services accessible to individuals that include primary care, specialized hospital and community care, housing, employment, education, and family and community development and that these services be supported by policies that are comprehensive (CMHA, 2010a).

NHS England encouraged a "cross-sectoral" approach to mental health (Department of Health, 2009, p. 101). The government held that local governments played a critical role in developing effective and "value for money" services spanning multiple sectors (CMHA, 2010a, p. 6). To achieve this, the government introduced a "Payment by Results" funding system in the *Health and Social Care Act* 2012 (CMHA, 2010a). The incentives for cross-sector collaboration are therefore financial not structural (CMHA, 2010a). A Mental Health Ministerial Board was also established to oversee progress of the *New Horizons* program as well as a *New Horizons* Ministerial Advisory Group for Inequalities and Mental Health to advise and monitor the program's mental health strategies (CMHA, 2010a). The FVC further recommended a Cabinet Minister of mental health to "oversee all government activities … determining their impact on mental health" and an Interdepartmental Coordinating Committee to "support linked policies and integrated services across government" (CMHA, 2010a, p. 7). The FVC also advocated for a new

"Public Service Agreement" for mental health to incentivize collaboration between local health and social care organizations and suggested the pooling of resources for these services "to permit flexible resources across a range of services" (CMHA, 2010, p. 7).

The government of Australia identified that governance of health and social services must be "structured around the needs of the individual, rather than those of the service" (CMHA, 2010a, p. 5). The government proposed "new governance and funding models at the local delivery level" (CMHA, 2010a, p. 5) including integrated care centers guided by regional health authorities that receive additional funding to foster partnerships between health and social service providers. The state of Victoria viewed "collaborative governance structures and common accountability frameworks" as key to system reform (CMHA, 2010a, p. 5). The Victorian strategy proposed a new Mental Health Reform Council, which reports to the Minister for Mental Health and is composed of stakeholders from government and non-government sectors with a five-year mandate to bring sectors together in progressing reform (Mental Health and Drugs Division, 2009; CMHA, 2010a). The Victorian Strategy also proposed the establishment of Mental Health Boards (MHBs) operating under regional Health Service Boards with the responsibility of developing Community Mental Health Plans (CMHA, 2010a).

The strategies agree that a whole of government approach is also needed to address the social determinants of mental health and promote recovery (CMHA, 2010a). The provision of mental health services within the community was seen as pivotal in facilitating a comprehensive mental health system (AIHW, 2009; MOHLTC, 2011). While all the reports emphasized a recovery or person-centered approach to care, some "took a stronger position on the recovery principle, while others advocated person-centered care which incorporated the recovery principle" (CMHA, 2010a, p. 9). The MHCC (2012) acknowledged that "the concept of recovery

is built on the principles of hope, empowerment, self-determination and responsibility" (p. 16). The MOHLTC (2011) argued that a recovery approach means the "consumer is at the centre" (p. 19). The Department of Health (2009) in England identified personalized care "ensuring that care is based on individuals' needs and wishes, leading to recovery" as one of its guiding themes (p. 3). In Australia, the *Fourth National Plan* identified social inclusion and recovery as one of its five priority areas (AIHW, 2009) applying the approach "to clinical staff in the private and public sectors" (CMHA, 2010a, p. 10). The state of Victoria identified the need for "social and economic policies and services to support recovery" identifying a platform for recovery that includes coordinated support for people with opportunities for stable housing, employment, and participation (Mental Health and Drugs Division, 2009). Both Australia and England have also included performance indicators and outcome measures related to recovery. In Australia, performance indicators and target status relate to participation of people with mental health and psychosocial conditions in employment and in education, percentage living in stable housing, and rates of community participation (AIHW, 2009, p. 9). Similarly in England, the "Recovery Star" tool enables people to "rate 10 domains (including work, social networks, living skills and managing mental health) with a score of 1-10, according to where they feel they are in their journey towards recovery" (Department of Health, 2009, p. 61). The government also highlighted the importance of including views of "service users" and "views of carers" in shaping outcome measures and performance frameworks (Department of Health, 2009, p. 23).

The concept of mental health recovery is relevant across the mental health continuum (i.e., service planning and delivery, implementation, evaluation, and governance) thus involving people with lived experience in all facets of change (CMHA, 2010a). Themes related to "equality of voice," and "partnership in decision-making" were therefore present in each strategy (CMHA,

2010a, p. 9). Specifically, the strategies emphasize the need to improve opportunities for people with lived experience in leadership roles (MHCC, 2012, p. 111); that people with lived experience "must have a voice as essential partners" (MOHLTC, 2011, p. 9); demonstrate the representation of people with lived experience on Health Ministers' Advisory Councils as in the Mental Health Standing Committee in Australia (AIHW, 2009); and importance of supporting service user-led initiatives and partnerships between service users and health practitioners (Department of Health, 2009, p. 24). The state of Victoria also promoted "consumer and carer peer worker roles" to assist in navigating the mental health system in primary and specialist care settings (CMHA, 2010a, p. 10). While the FVC of NHS England endorsed "Quality of Life" packages that would provide personal health budgets allowing people choice in their services and enabling personalized recovery (CMHA, 2010a, p. 10).

**Challenges with Newer Modes of Governance**

Adopting a whole-of-government approach in promoting personalised recovery results in greater integrated community-based care models (CMHA, 2010a). Integrated care refers to care delivered through a team of care providers, working together with the person receiving care and their families, within the same environment (Kates et al., 2018). It involves reconfiguring how services are distributed, delivered, managed, and organized with the aim of creating a "comprehensive continuum of services to improve access, quality, efficiency and user satisfaction" (Kates et al., 2018, p. 3). Central to recovery-oriented service delivery is that services must adapt to individual needs rather than expect individuals to conform to service requirements (Penzenstadler, Khazaal, & Fleury, 2020). Collaboration and coordination between care providers has developed to "minimize the risk for cost-shifting from the private sector to the public sector" (Diminic & Bartram, 2018, as cited in Bartram, 2019a, p. 65). There has also been

considerable attention to “structural elements” that can enhance collaboration including centralizing patient-information systems and pooling resources (Kee Nies, van Wieringen, & Beersma, 2021, p. 75). Improving care outcomes, however, also requires actions outside of the health sector to address critical social determinants that impact mental health (WHO, 2021).

Challenging the hegemony of psychiatric hospitals, psychiatric deinstitutionalization promoted the development of decentralized mental health services that could be accessed in the community and linked with primary healthcare. Represented by the mantra “every door is the right door,” decentralized models of care support access from “multiple locations” with the intention of similar standards of care at each location (Rush & Saini, 2016, p. 78). However, more recent policy documents (since the 2010s), consistent with government directives, have highlighted the need for a coordinated/centralized approach in response to challenges that resulted from the decentralization of mental healthcare including variations in “quality of care,” “fragmented services,” “difficulty in navigating the system,” “barriers in accessing timely services,” and “inconsistent data reporting” (Rush & Saini, 2016, p. 48). Government structures in Canada, the UK, and Australia, also reflect different degrees of centralization in healthcare governance with the UK being the most centralized, Canada the least, and Australia falling in between (Bartram, 2020). The Canadian federal government “does not have either jurisdiction over medicare as does the commonwealth government in Australia or full jurisdiction over healthcare as does the United Kingdom government” (Bartram, 2019a, p. 65). Philippon and Braithwaite (2008) argue that the “robust nature of the five-year Health Agreements”[15] between the Commonwealth and the states has “influenced healthcare decision-making considerably” (p.

[15] The Australian five-year Health Care Agreement (2003-2008) between the Commonwealth government and all states and territories “increase[d] accountability on the states, requiring states to match increases in Commonwealth funding, and de-emphasize the prospects for further reform in Commonwealth-state relations during the course of the Agreements” (Duckett, 2004, p. 1).

182). Accountability within a decentralized system "where no one level of government has full responsibility for all aspects of health policy" is challenging (Bartram, 2019a, p. 65). Regionalization policies were therefore put forth to better administer integration of healthcare services (Ramos et al., 2020). The goal of regionalization is "to decentralize resources and decision-making" (Ramos et al., 2020, p. 2).

The process of regionalization and decentralization of healthcare governance is evident across the three states. Marchildon (2006) argues that an objective of regionalization in Canada was to improve public participation in healthcare decision-making. In Ontario, the District Health Councils (DHCs) later replaced by the Local Health Integration Networks (LHINs) in 2004 under the McGuinty provincial Liberal leadership, were designed as regional planning agencies (Wiktorowicz, 2005) based on the belief that local authorities could better integrate and coordinate services (Born & Sullivan, 2011). While the DHCs lacked fiscal authority over service delivery (Wiktorowicz, 2005), the LHINs were equipped to administer healthcare though lacked capacity as well as say in how funds would be distributed (i.e., shifting budgets from hospitals to the community) (Wiktorowicz, 2005; Born & Sullivan, 2011). Without management of hospital boards and other local health organizations, LHINs were challenged to integrate health planning (Born & Sullivan, 2011). In 2001, the UK devolved responsibility for healthcare to England, its constituent country (Saltman, Busse, & Figueras, 2006). In 2002, England abolished district health authorities and "devolved purchasing responsibilities" to Primary Care Trusts (PCTs),[16] "local organizations … responsible for managing health services in the community and for commissioning all but highly specialist services" (Saltman et al., 2006, p.

[16] PCTs were established in the *Health Act* 1999 (under the Blair Labour party) which aimed to improve the quality of care provided by the NHS and coordination of care between local authorities and the NHS (The Health Foundation, 2023a).

288-289). PCTs were also given a mandate to oversee "the integration of health and social care, ensuring that local health organizations work together with local authorities" (Saltman et al., 2006, p. 288). While different forms of regionalization emerged in Australia, Victoria "never embraced a full regional system" but instead "developed a series of service networks in the mid-1990s" (Philippon & Braithwaite, 2008, p. 177). In 2000, the service networks were restructured into metropolitan health services (Philippon & Braithwaite, 2008).

Expanding healthcare regionalization without implementing coordination strategies can negatively impact system integration (Wiktorowicz et al., 2020). Accountability and governance becomes more "diffuse" as the number of integration strategies and models increase among organizations (Fleury & Mercier, 2002, p. 69), making it more difficult to know who is accountable for services "provided by a variety of different bodies, which vary by jurisdiction" (Flood & Thomas, 2016, p. 69). Strengthening "ties between organizations in local districts" (Fleury & Mercier, 2002, p. 66) can "reshape" and "reorganize" (WHO, 2021, p. xx) complicated mental health systems into integrated networks of services. Integration has thus been proposed as the response to healthcare silos and "involves formally linking organizational administrations into a cohesive network" (Wiktorowicz, 2005, p. 401). The aim of networks is then to provide health services that "work seamlessly with social and other sectors" (WHO, 2021, p. 188). Networks "offer a means to develop a system of coordinated care" (Wiktorowicz et al., 2010, p. 2), in relation to the "socioeconomic and cultural healthcare environment" (Fleury & Mercier, 2002, p. 58). Structuring the mental health system through integrated service networks replaces "vertical coordination of activities (hierarchical or bureaucratic governance) or horizontal coordination (governance by the market)" (Fleury & Mercier, 2002, p. 60). As network structuring enables organizations to "carry out more complex and wide-ranging

operations, without minimizing the benefit of small-scale intervention" tailored to local needs (Fleury & Mercier, 2002, p. 60).

Networks of integrated care do not have a "formal hierarchy" (Zonneveld, Nies, Wijk, & Minkman, 2021, p. 102). The "central problem" for governments in a networked governance model is "the location of responsibility in order to ensure accountability" (Tuohy, 2003, p. 204). Given the absence of "formal hierarchy" within these networks, "top-down governance is often not appropriate" so instead "leadership, accountability and supervision" is organized horizontally referred to as "shared governance" (Zonneveld et al., 2021, p. 102). Drawing on Whetten's (1981) framework for network governance with three forms of coordination: "mutual adjustment," "alliance," and "corporate structure," urban networks in Ontario, Canada, reflect "mutual adjustment" governance based "largely on voluntary exchanges between organizations, but no formal mechanism of coordination" (as cited in Wiktorowicz et al., 2010, p. 2). Extending Whetten's framework to England, "corporate structure governance" (involving "overarching formal authority") may best describe its mode of network coordination, as the NHS outsources development to healthcare organizations but maintains their management as in the case of the e-health consumer portal "NHS Choices" (Christensen & Hickie, 2010). Victoria's mode of network governance may be attributed to an "alliance" model, depicted by its blending of agencies with no hierarchical functions but share cooperatively in decision-making (Fawcett & Marsh, 2017). Wiktorowicz et al., (2010) found that ensuring that budget and service planning decisions do not occur at different jurisdictional levels is also important for effective governance in mental health networks. Alternative accountability mechanisms may include "direct federal oversight" or "entrusting monitoring to provincial and territorial auditors general" as was recommended by the Standing Senate Committee on Social Affairs, Science and Technology in

Canada in 2006 (Bartram & Lurie, 2017, p. 14). Consequently, in a network governance framework, public policy is no longer viewed as the product of governments but rather of a network of various actors that converge through expertise, information sharing, and political support (Khaje Naieni, 2014, 2016).

**Conclusion**

This chapter introduced the policy-lever of organization, exploring government structures, shifting political contexts, and forms of healthcare governance across the three states up until roughly 2010s. The second part of the dissertation will expand on this policy-lever (over the most recent past decade) applying the lever in understanding outcomes of mental health reform or the policy-trajectories within each site. While the states share a common vision for mental healthcare integration, the policy logics governing their healthcare systems resulted from different types of policy change produced in windows of opportunities for reform. Consequently, the ways in which a whole of government approach to care integration is to be implemented varied among the policies reviewed based on the internal logics governing their healthcare systems. Though networks have been supported as a way of coordinating integrated care, their success depends on how they will be governed within these three healthcare systems and the extent to which they will involve community members in re-designing mental healthcare. The next chapter will explore the policy-lever of financing and service-system design that has supported the process of mental health reform in each site up until roughly 2010s.

## Chapter 3: Financing and Service System Designs

The focus on reforming mental healthcare has been accompanied with changes in financing and service system designs, all aimed at creating a more integrated system of care. This chapter explores the application of the policy lever of finance to changes to service system designs. The "control knob"[17] of financing refers to the methods of mobilizing funds for healthcare operations and how those funds are allocated and utilized (Roberts et al., 2008). The effectiveness of a healthcare system is contingent upon its financing, which is typically, derived from its citizens, either directly or indirectly (Roberts et al., 2008). States are responsible for determining the sources of financing to employ and to what degree (Roberts et al., 2008).

Experiences of psychiatric deinstitutionalization are similar across the three states reviewed. The closure of psychiatric hospitals outpaced the allocation of new resources into the community (Kirby & Keon, 2004a). This led to many negative consequences for people with mental health and psychosocial conditions and their families. The CMHA (2001) summarized in its report to the Commission on the Future of Health Care in Canada:

> For many former hospital residents, the new system meant either abandonment, demonstrated by the increasing numbers of homeless mentally ill people; trans-institutionalization: living in grim institution-like conditions such as those found in the large psychiatric boarding homes; or a return to family who suddenly had to cope with an enormous burden of care with very little support (p. 8).

The vision to normalize mental health and psychosocial conditions and transition into community-based care was flawed by insufficient resources and compounded by resistance

[17] Roberts et al. (2008) refer to "control knobs" as the options available to reformers in shaping health system performance (p. 7).

within communities themselves, where discriminatory attitudes regarding risk and danger proved slow to change (CMHA, 2001; Kirby & Keon, 2004a).

According to Esping-Andersen's (1990) three-fold typology of welfare state regimes, the states (Canada, the United Kingdom, and Australia) fall into the liberal regime category. These regimes are distinguished by reduced decommodification, increased social stratification, and a stronger emphasis on market mechanisms for distributing economic and social resources as opposed to the family or state (Esping-Andersen, 1999; Raphael & Bryant, 2015). Although classified as liberal regimes, Bartram (2020) notes the states feature "highly redistributive universal healthcare systems" that are distinguished by the services covered and the extent of coverage (p. 13). Canada provides first dollar coverage, exclusively for physician and hospital services; Australia offers more comprehensive coverage with significant copayments; the UK coverage falls somewhere in the middle (Bartram, 2020). Health reforms are "strongly aligned with the policy levers that are available in each government context" (Bartram, 2020, p. 15).

The next chapter will build on the policy lever of finance, exploring the levers of regulation and payment utilized in mental health reforms up until roughly the 2010s. These levers will be studied together to examine how states use their power to restrict or prohibit the behaviour of individuals and organizations in the healthcare sector, while also providing incentives through disbursement of financial resources (Roberts et al., 2008). The subsequent chapter will complete Part One of the dissertation.

**Changes Created by Policy Logic Governing Decisions over Resource Allocation**

> If you want to see where the government's heart and soul is and if you want to really check out where government's commitments are policy-wise, don't listen to the words,

look at where they spend the money. (Excerpt from a psychiatric survivor, cited in Poole, 2011, p. 76).

Tuohy (2018) argues that "the scale and pace at which such change is pursued are inherently political decisions" (p. 5). Political actors must evaluate their "political capacity and prospects" before deciding on the scale and pace to implement change especially in healthcare where political risks are high in the "context of an overarching agenda and/or a threatening competitive challenge" (p. 5). The scale of change in healthcare embodies changes in the "degree" and "scope" in the policy logic governing decisions over resource allocation (p. 9). The logic guiding the policy framework is determined by who is in control of allocating resources, the information they are presented with, and how their decisions are justified. Policy frameworks endorse "the winning coalition of interests at the time of its establishment, and reinforce that balance of interests through its effects on decision-making logics" (p. 37). Within the context of a democratic capitalist political economy, the balance of interests derive from the policy arena's "intrinsic characteristics" (p. 37). These structures of interest within the healthcare arena are the "state, private finance, and the medical profession" (p. 37). Whose power is argued to be rooted in "authority, capital, and knowledge respectively" (p. 37).

The "direction" of change is affected by the perception of problems and the identification of policy solutions (Tuohy, 2018, p. 5). Discontinuous policy change involves "disrupting established balances of power, sets of sanctions, and legitimating principles" (p. 5). Financial changes constitute what Hall (1993) has termed "first-order" change, impacting the quantity of resources but not the logic governing their allocation. Resource allocation "depends on the relationships among interests and the mechanisms of control that the policy framework ordains" (p. 9). The "market-oriented" reforms to policy-making, starting in the mid-1980s, opened a

window of opportunity for a new interest in the healthcare arena; entrepreneurs who merge "public mandates with private sector resources to create new hybrid public/private entities that shape the course of policy change" (p. 34).

Healthcare systems are defined by the balance between public and private finance despite ongoing rearrangement of "affinities between state and hierarchy and between private finance and markets" (Tuohy, 1999, p. 268). Fundamental to policy frameworks is an understanding of the role of government and degree of state influence (Tuohy, 2018). Governments may provide services, as in the case of national health services where "facilities are owned and providers are employed by the state" (Tuohy, 2018, p. 49). They may also purchase "in-kind benefits from private sector providers," such as "single-payer health insurance" (Tuohy, 2018, p. 49). In its role as payer, governments may also subsidize the "private market on either the demand or supply side" (Tuohy, 2018, p. 49). Governments may assume a regulatory role over private activity by issuing "authoritative rules" (Tuohy, 2018, p. 49). The government can also delegate its authority to private actors with mandates to fulfill public objectives, as in "professional or industrial self-regulatory bodies" (Tuohy, 2018, p. 49). Governments may also act as "market participants" or economic actors as demonstrated by state-owned enterprises (Tuohy, 2018, p. 49).

**Direction of Change**

Managerial discourse spread throughout health services during the 1980s and 90s and is linked to the emergence of neoliberalism in the Western countries (Gavin, 2020). Neoliberalism involves a collaboration between the government and the market, where market values are applied to healthcare and welfare governance (Gavin, 2020). The shift from institutional to community mental healthcare placed emphasis on both community care and supports (Kirby &

Keon, 2004a). Advocates of community care were pitted against medical professionals due to a perception that interests of professionals sometimes diverged from people experiencing mental distress and their families (Kirby & Keon, 2004a). Hospitals were also perceived as part of the problem rather than the solution (Kirby & Keon, 2004a). Over time, governments began prioritizing voices from people experiencing mental distress and their families becoming more responsive to this community than to professional advice (Kirby and Keon, 2004a). This shift brought about a "significant change in the boundaries of medical autonomy" (Flynn, 2002, p. 155). While mental health services and supports existed by the late 1980s they were not well integrated; the situation was often described in Ontario, Canada, as the "three solitudes" of mental health – comprising psychiatric hospitals, psychiatric units in general hospitals, and community mental health supports and services (Kirby & Keon, 2004a; Lurie, 2005).

The shift from the dominance of medical expertise and competing demands for health and social resources led to the proliferation of managerialism in mental healthcare (Oster et al., 2023). The problem became the "(potential) lack of high standards or quality of mental health care, situated within the broader concern about variability in service demands" (p. 4). The solution to improve the quality of care was proffered as collecting and reporting on outcome measures. Reporting outcome measures across services was endorsed as a way to enhance "consumer and carer choice" in accessing quality mental healthcare (p. 6). By the late 1990s, routine outcome measures (ROM), "intended to act as a key driver of reform," were implemented to evaluate mental health services (p. 1). However, in choosing outcomes measures, a transition from a managerial discourse to a biopsychosocial discourse is often present, underpinned by a deficit model of mental health. The problem representation for choice of outcomes measures is that first mental distress is situated within the individual, as "represented

by a specific range of deficits as defined in the chosen outcome measures" (p. 10). Second, that the role of quality mental healthcare is to address individual deficits rather than "examining and addressing issues in health services of the broader socio-political context of mental health" (p. 11). Consequently, despite decisions for using ROMs in mental health for funding allocation and to improve experiences of quality mental health, the "(unintended) consequences of the problematization underpinning their use" must be considered "to ensure mental health services are in fact meeting the needs of the communities they service" (p. 13).

**Comparative Overview of Health Financing and Service System Designs**

This section will broadly overview how healthcare is organized and financed across the states. The sections to follow will provide a historical review of the policy lever financing and its influence on reforms to service system designs in each state. This exploration draws on the work of the Standing Senate Committee on Social Affairs, Science & Technology, which will be referred to by its authors Kirby and Keon. In 2003, the federal government of Canada established the Standing Senate Committee on Social Affairs, Science and Technology to provide a three-year study of "mental health, mental illness, and addictions in Canada" (White & Pike, 2013, p. 243). As part of its study, the Committee released four reports based on consultations with the policy community. The first two provide an overview of policies and services in Canada and in four selected countries, respectively. The third report explores issues facing the provision of mental health services in Canada and presents policy options, while the fourth, and last report, provides recommendations for reform (Kirby & Keon, 2024b).

In Canada, the organization and delivery of health services, as well as supervision of providers, is mainly under the responsibility of provinces and territories (Mossialos et al., 2016). Beginning in the mid-1990s, many provinces and territories established regional health

authorities to help reduce costs and decentralize healthcare delivery decision-making (Government of Canada (GoC), 2019). These authorities usually oversee the funding and delivery of hospital, community, long-term care, and mental and public health services (Mossialos et al., 2016). Healthcare is primarily funded by provinces and territories (through general tax revenue); the federal government provides financial support to the provinces and territories based on a per capita arrangement through the Canada Health Transfer (Mossialos et al., 2016). Physician-provided mental healthcare is universal covered through medicare (Mossialos et al., 2016). Mental healthcare is provided in hospitals, either through specialty psychiatric hospitals or general hospitals that offer adult mental health inpatient services (Mossialos et al., 2016). Community-based mental health services, including case management, crisis response, and supported housing is offered by provinces and territories (Goering, Wasylenki, & Durbin, 2000). About two-thirds of Canadians have private insurance and most insurers are for-profit (Mossialos et al., 2016). Psychologists can work privately and receive payment either out-of-pocket or through private insurance, or through a salary in publicly funded organizations (Mossialos et el., 2016). This patchwork of public and private insurance coverage, created from the exclusion of mental health services from medicare, has created a two-tiered system of care (Flood & Thomas, 2016). People without private insurance, often of lower-socioeconomic status, are unable to access the mental health and supports they needs (Anderssen, 2015).

The government in England is responsible for the financing, management, and delivery of health services (Kirby & Keon, 2004b). Similar to medicare in Canada, all UK residents qualify for health coverage through the NHS (Kirby & Keon, 2004b). Compared to Canadian medicare, however, the NHS coverage is more comprehensive encompassing physicians, hospitals,

prescription drugs, dental care, and optical services (Kirby & Keon, 2004b). Although user charges may be applicable to prescription drugs, dental care, and optical services (Kirby & Keon, 2004b). Unlike Canada, people in the UK are eligible to purchase private health insurance that covers the same benefits as the NHS but is provided by professionals that work outside the NHS (Kirby & Keon, 2004b). A greater share of healthcare spending is funded by the public sector (82 percent) in the UK compared to Canada (70 percent)[18] (Kirby & Keon, 2004b). User charges are less than 3 percent of NHS financing (Kirby & Keon, 2004b).

The NHS is primarily financed through general taxation from the central government and is supplemented by national insurance contributions from employers and employees (Kirby & Keon, 2004b). Mental healthcare, through the NHS, is provided by GPs (Mossialos et al., 2016). Mental health and hospital trusts, within the NHS, provide inpatient care and more advanced mental health services (Mossialos et al., 2016). Community-based providers also deliver some of these services (Mossialos et al., 2016). The private sector provides about a quarter of hospital-based mental health services funded by the NHS (Mossialos et al., 2016). The NHS covers some talk or psychological therapies, however, waiting times are long (Mossialos et al., 2016).

Similar to Canada, responsibility for healthcare is shared between the national (Commonwealth) government and sub-national governments (six States and two Territories) in Australia (Kirby & Keon, 2004b). The Commonwealth government plays a stronger role in healthcare compared to Canada, as the Australian states and territories rely more on the Commonwealth for healthcare funding than provincial governments do in Canada (Kirby & Keon, 2004b). In contrast to Canada, user charges may be required for publicly insured health services in other jurisdictions, and it is permissible for doctors to bill patients for amounts

[18] Percentages based on the Standing Senate Committee on Social Affairs, Science & Technology second report released in 2004.

exceeding the scheduled fees (Kirby & Keon, 2004b). The Commonwealth government manages Medicare and oversees the private healthcare insurance sector (Kirby & Keon, 2004b). Healthcare funding from the Commonwealth is derived from general taxation and is supplemented by a dedicated healthcare levy of 1.5 percent on taxable income (Kirby & Keon, 2004b). State and territory governments oversee and deliver publicly insured services within their jurisdictions, including acute mental health and psychiatric hospital services and a range of community services (Kirby & Keon, 2004b). Regulating healthcare providers as well as the licensing and approval of private hospitals also falls under the responsibility of state and territory governments (Kirby & Keon, 2004b). Funding for healthcare by states and territories is derived from the Commonwealth government's general revenue and specific purpose grants and is supplemented by general taxation and user charges from the states and territories (Kirby & Keon, 2004b). Public health insurance is more extensive in Australia than in Canada, as Medicare in Australia offers comprehensive coverage to all its citizens, encompassing physicians, hospitals, prescription drugs, as well as community-based and home care services (Kirby & Keon, 2004b). However, unlike Canada, user charges for publicly insured health services and extra-billing by doctors is allowed (Kirby & Keon, 2004b). Australian Medicare is comprised of the Medical Benefits Scheme (MBS), the Australian Health Care Arrangements (AHCAs), and the Pharmaceutical Benefits Scheme (PBS) (Kirby & Keon, 2004b). The MBS provides access to a range of physician services outside of hospitals; each service has a specified fee known as the "scheduled fee" and the MBS only reimburses 85 percent of the schedules fee (Kirby & Keon, 2004b, p. 4). The Commonwealth government provides funding to the states and territories for hospital services through the AHCAs so to permit user charges for public hospital services (Kirby & Keon, 2004b). The funding mechanism involves annual block grants, the amounts are

negotiated in five-year agreements with the states and territories (Kirby & Keon, 2004b). The PBS subsidizes access to drugs prescribed outside of public hospitals (Kirby & Keon, 2004b). Private healthcare insurance can both "complement and compete" with Medicare (Kirby & Keon, 2004b, p. 4). Individuals cannot opt out of the publicly-funded system as they continue to pay for it through their taxes; however, they can enhance their Medicare benefits through private healthcare insurance as private insurers can offer coverage for the same benefits as Medicare (Kirby & Keon, 2004b). There is a limited number of private for-profit hospitals, managed by private firms, that offer public hospital services under arrangements with state and territorial governments, though most provide non-emergency care such as elective surgeries (Kirby & Keon, 2004b). Similar to Canada and the UK, Medicare provides mental healthcare by GPs, specialists, and community-based services (Mossialos et al., 2016). The MBS and PBS subsidizes specialist care and pharmaceuticals (Mossialos et al., 2016). Mental health is also provided in both public and private hospitals through inpatient and outpatient services with public hospital free for public patients (Mossialos et al., 2016). About a half of the Commonwealth government's support for mental health is allocated to people with disability, while the remaining support is directed towards payments to states, allowances for caregivers, and subsidies offered through the MBS and PBS (National Mental Health Commission, 2015).

## Historical Overview of (Mental) Health Financing and Organization of Service System Designs

### *Canada*

#### Federal

The federal government's role in mental health is essentially fiscal, based on its constitutional spending power (Kirby & Keon, 2004a). Ambiguity regarding the role of mental

health services within a national healthcare system persisted for many years (Kirby & Keon, 2004a). The National Health Grants Program of 1948 considered "the first stage in the development of a comprehensive health care insurance plan for all Canada," led to the expansion of healthcare services including services for mental health (see Table 2.1. in Appendix A) (Department of National Health and Welfare, 1950, p. 77). The program was designed to assist provinces and territories in developing and strengthening public health and hospital services through the provision of federal grants (GoC, 2019). In the program's final year (1960-1961), approximately 53 percent of the funds were allocated to institutions, 23 percent to clinics and psychiatric units, 13 percent to training, and 8 percent to research (Kirby & Keon, 2004a). The *Hospital Insurance and Diagnostic Services Act* (HIDSA) in 1957, however, omitted coverage of psychiatric hospitals although it did include psychiatric services within general hospitals (Kirby & Keon, 2004a). This was due to the fact that psychiatric hospitals provided custodial care and therefore were ineligible for federal cost-sharing (Kirby & Keon, 2004a). However, in 1966, the *Medical Care Act* (MCA) extended public coverage for physician services, including services offered by psychiatrists regardless of setting (Kirby & Keon, 2004a). In 1977, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* granted each province "block-funding;" a federal transfer payment was distributed partly in cash and partly in tax points according to population size (Kirby & Keon, 2004a, p. 197). The Act included coverage for psychiatric hospitals (Kirby & Keon, 2004a). While the *Canada Health Act* (CHA) (1984), consolidated most of the provisions of the two previous insurance Acts, psychiatric hospitals were not included in its coverage for extended care services (Kirby & Keon, 2004a). During the 1990s,[19] the influence of the Chrétien Liberal federal government in national healthcare and

[19] Throughout the 1990s, public pension plans and social security programs saw tightened conditions for eligibility and benefits as a measure for cost containment (Prince, 2016).

consequently in mental healthcare diminished as transfer payments to provinces and territories were scaled back (Kirby & Keon, 2004a). This resulted in the provinces insisting on the replacement of unilateral federal decisions about transfers with mechanisms that incorporate involvement from provincial and territorial governments (Kirby & Keon, 2004a). In 1996, the Canada Health and Social Transfer (CHST) combined the *Established Programs Financing Act* and the Canada Assistance Plan; the restructuring granted provinces autonomy in determining the distribution of their block funding among healthcare, post-secondary education, and social programs (Kirby & Keon, 2004a). Federal spending power still influences medicare, as the amount of money transferred under the CHST can be reduced if a province permits extra-billing or user charges and if health insurance plans do not adhere to the criteria of the CHA (1984) (Kirby & Keon, 2006).

The creation of Health Canada in 1996, through departmental legislation, entrusted the Minister of Health to oversee "the promotion and preservation of the physical, mental, and social well-being of the people of Canada," as outlined in the *Department of Health Act* (1996, sect. 2a.1). This encompassed tasks such as monitoring mental health programs; conducting research and investigations in mental health and other public health issues; and collecting and publishing statistics on mental health (Kirby & Keon, 2004a). The Federal Health Care Partnership, formerly known as the Health Care Coordination Initiative, was established in 1994 between federal departments that were separately providing healthcare services to Canadians (Kirby & Keon, 2004a). The partnership was based on the belief that through collaboration health costs could be reduced and service delivery improved (Kirby & Keon, 2004a). Between 2002-2003, the partners engaged in joint negotiations for fees, bulk purchases, and collaborative policy development, resulting in $11.6 million in cost savings (Kirby & Keon, 2004a). In 1999, the

Social Union Framework and related Health Accord was significant as it committed the federal government to increase funding for healthcare through the CHST (First Ministers' Meeting, 1999). This ensured funding predictability from the federal government and commitment to work collaboratively with provincial and territorial governments to establish nationwide health priorities and objectives (First Ministers' Meeting, 1999). The First Ministers' Meeting Communiqué on Health in 2000 pledged a commitment to "promote those public services, programs and policies which extend beyond care and treatment and which make a critical contribution to the health and wellness of Canadians" (First Ministers' Meeting, 2000, sect. 2). In the 2003 Health Accord, the First Ministers agreed to provide first dollar coverage for portable home care services for community mental health services, with access provided by need (Kirby & Keon, 2004a). The goal was to ensure a range of services, such as case management, professional services, and prescribed drugs, would be accessible by 2006 (Kirby & Keon, 2004a). As part of the Accord, cash transfers from the federal government increased, and the CHST was split, creating the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) for post-secondary education, social services, and social assistance (GoC, 2019). In 2001, the federal government also established the Commission on the Future of Health Care in Canada to review medicare (GoC, 2009). The resulting (Romanow) report, *Building on Values: The Future of Health Care in Canada*, released in 2002, "provided a roadmap … to reform and renew the health care system" (2002, p. xxiii). The 2002 Romanow report examining Canada's healthcare system highlighted the marginalization of the mental health system, often referred to as the "orphan child" within healthcare, due to the segregation of mental health programs from other healthcare services (Ontario Human Rights Commission, 2012).

The federal government, in addition to supporting health-related services, has provided access to other programs aimed at assisting individuals with mental health and psychosocial disabilities (Kirby & Keon, 2004a). Examples include its Office for Disability Issues, Social Development Canada, which works on the participation of Canadians with mental health and psychosocial conditions in learning, work, and community life (Kirby & Keon, 2004a). In 1999, the federal government introduced the National Homelessness Initiative (NHI), a community-based strategy aimed at alleviating and preventing homelessness (Kirby & Keon, 2004a). The initiative involved partnerships with governments, the private sector, and the voluntary sector (Kirby & Keon, 2004a). It recognized the diverse needs of people without homes and the importance of tailored responses and solutions for specific communities (Kirby & Keon, 2004a).

In 2004, the First Ministers released a *10-Year Plan to Strengthen Health Care* (GoC, 2019). Federal, provincial, and territorial governments committed to the plan, focusing on reforms in areas such as wait times management, health human resources, primary healthcare, and enhanced reporting on progress made in these reforms (GoC, 2019). The plan was supplemented by increased federal funding in healthcare cash transfers, including annual increases to the Canada Health Transfer from 2006-07 until 2013-14 (GoC, 2019). In 2006, the Standing Senate Committee on Social Affairs, Science and Technology released their findings from their three-year study in the (Kirby) report entitled *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada* (White & Pike, 2013). The Kirby report recommended a Canadian Mental Health Commission be developed as well as a Mental Health Transition Fund to aid in the shift from an institution-based to a community-based mental health system over the next 10 years (Kirby & Keon, 2006). The transition fund would support a “Mental Health Housing Initiative” and a “Basket of Community

Services" (Kirby & Keon, 2006, sect. 5.6). While the transitional funding did not occur, the federal government invested $110 million in At Home/Chez Soi[20] a "Housing First" study aimed at housing individuals in need of mental healthcare (MHCC, 2014a). Had the Mental Health Transition Fund been enacted, the federal government would have transferred over $530 million annually to provincial budgets, representing only a small fraction of the federal government's yearly healthcare expenditure, and would have bolstered funding for mental health services (Lurie, 2014). The Kirby report provided 118 recommendations, including the development of a national mental health strategy, a national anti-discrimination strategy, and a Knowledge Exchange Centre that "would facilitate the exchange of the best available knowledge between mental health services knowledge producers and users across Canada" (Kirby & Keon, 2006, sect.16.4.3). In 2008, the Harper Conservative federal government provided funding for the Mental Health Commission of Canada (MHCC), with a mandate to provide a national mental health strategy, a 10-year anti-stigma strategy, and a knowledge exchange centre (CMHA, 2013).

**Provincial (Ontario)**

The Ministry of Health and Long-Term Care (MOHLTC)[21] is responsible for the planning, organizing, funding, managing, monitoring, and delivering of mental health services in Ontario (Kirby & Keon, 2004a). Federal transfers to the provinces and territories for healthcare are provided under the CHT (Kirby & Keon, 2004a). The CHT, through the 2003 Health Accord, offers funding for "acute community mental health care" but no portion of the transfer is designated for this purpose (Kirby & Keon, 2004a, p. 202). The Ontario Health Insurance Plan

[20] Despite the cost-offsets associated with Housing First programs (i.e., reductions in health and social services and reduction of involvement in the judicial system), the randomized design of the study was controversial as people without homes were either randomized into housing or to continue with 'treatment as usual,' which did not include housing.

[21] Referred to as the Ministry of Health throughout the dissertation. On June 20, 2019, the Ministry of Health and Long-Term Care was split into the Ministry of Health and the Ministry of Long-Term Care.

(OHIP)[22] is the health plan administered by the government for Ontario and is funded by taxes paid by Ontario residents (MOHLTC, 2008). Over the last three decades, healthcare expenditure in Ontario has mirrored the national trend of "fluctuating peaks and troughs" and is linked to economic activity and variations in federal funding (see Figure 2.1. in Appendix B.) (Institute of Fiscal Studies and Democracy (IFSD), 2017, p. 3). The cost-sharing arrangement between the federal and provincial governments during the establishment of medicare for physician and hospital services was initially a 50/50 split (Canadian Health Coalition & the Ontario Health Coalition, 2017). However, by the late 1990s, the federal contribution significantly declined (Canadian Health Coalition & the Ontario Health Coalition, 2017). The cash transfers from the federal government for healthcare, as stipulated by the CHA (1984) decreased to below 15 percent (Canadian Health Coalition & the Ontario Health Coalition, 2017). There was gradual increase in federal transfers by the start of the 2000s with a slight dip in 2006 (see Figure 2.2. in Appendix B.) (Wiktorowicz et al., 2020).

Despite increased funding for healthcare beginning in the 2000s, only a small portion of the increase was allocated to mental health (Lurie, 2014). In 1979, the mental health share of health spending was 11.3 percent (Ontario Ministry of Health,[23] 1980). The Graham Report (1988) revealed that the mental health share spending had decreased to less than 10 percent by 1985 (Lurie, 2014). A follow-up analysis conducted four years after the report's publication indicated a continued decline in mental health spending to 8.2 percent, despite governmental support for the Graham Report and the introduction of a new mental health reform policy

[22] OHIP was established in 1972 and was initiated by the *Hospital Services Commission Act* of 1957, which advocated for a plan of hospital insurance for Ontario that would be universally available (Simner, 2020). OHIP covers health services that are deemed medically necessary, such as physician services, emergency room visits, and medical testing and surgeries (DelSignore, 2023).

[23] Prior to 1990, the Ministry of Health and Long-Term Care was referred to as the Ontario Ministry of Health.

(*Putting People First*) that aimed to increase community mental health spending to 60 percent of the mental health budget by 2003 (MOHLTC, 1993; Lurie, 2014). While investments in community mental health spending increased, the proportion of mental health spending relative to health spending in Ontario in 2014 was less than the national average of 7.2 percent (Lurie, 2014). Despite Ontario receiving an additional $2.9 billion in federal health transfers between 2005 and 2011, only 1.2 percent of this allocation was directed toward community mental healthcare (Wiktorowicz et al., 2020). The contrast in funding is significant, with healthcare receiving $1361 compared to $16 per capita for mental health (excluding funding for addiction programs) (Wiktorowicz et al., 2020). The modest increases in community mental healthcare spending during the 2000s produced "wait-lists that reflected high unmet needs that new funding helped uncover but did not really address" (Wiktorowicz et al., 2020, p. 6).

### Sociopolitical Context of Mental Health Service Delivery Reform (1985-2010)

In 1985, the Peterson Liberal government replaced the Conservative government in Ontario that had been in power for forty-two consecutive years (Nelson et al., 2001). The Rae New Democratic Party (NDP) succeeded the Liberals in 1990 (Nelson et al., 2001). Throughout the Liberal and NDP governance, policies began to incorporate views from psychiatric consumers/survivors and their families, a new group of mental health stakeholders, that became politically active in the mental health field during the early 1980s (Nelson et al., 2001). In 1982, Health Minister Larry Grossman, along with mental health advocates and community-based professionals, inspected boarding homes in Parkdale, Toronto (Nelson et al., 2001). This led to the formation of the Supportive Housing Coalition of Metropolitan Toronto, which partnered with Grossman's Conservative government to increase supportive housing in Ontario (Nelson et al., 2001). Grossman's leadership with the Coalition highlighted the growing interest among

political leaders to collaborate with community groups (Nelson et al., 2001). Following the shift away from institutionalized psychiatric care, there was an increased public awareness of caregiver needs, leading to the formation of self-help groups like Friends of Schizophrenics (Nelson et al., 2001). Community mental health professionals also gained prominence as a new stakeholder group as government funding for community mental health programs increased (Nelson et al., 2001). Additionally, On our Own[24] was developed in the late 1970s, by a group of Toronto based psychiatric consumers/survivors (Weitz and Lumsden, 1984). This movement marked a significant shift, positioning psychiatric consumers/survivors as active participants in shaping policy, challenging the traditional medical hegemony in mental health, and promoting community empowerment (Nelson et al., 2001). The views of these new stakeholder groups were evident in the Graham Report, *Building Community Support for People: A Plan for Mental Health in Ontario*, which represented a new era in mental health policy (Mulvale, Abelson, & Goering, 2007). The Graham Report fostered a partnership between psychiatric consumers/survivors, their families, services providers, and the government thus enabling participation of the new mental health stakeholders into the "inner circle of political decision making" (Everett, 2000, p. 65). The report reiterated challenges identified with the mental health system, such as gaps in service availability and poor continuum of care (Everett, 2000). In 1993, the Ontario Ministry of Health under the NDP government, released its policy statement, *Putting People First: The Reform of Mental Health Services in Ontario*, which outlined a 10-year strategy for mental health reform (Hartford et al., 2003). The policy called for new linkages to support integration and a continuum of care and that new mental health services be confined to

[24] On our Own was modelled after the Vancouver Mental Patients' Association (MPA), a psychiatric survivor led self-help organization, and was named after a book written by the MPA founder, Judi Chamberlin (Nelson et al., 2001).

case-management, 24-hour crisis intervention, housing and supports, and programs led by people experiencing mental distress and their families (Everett, 2000). The policy also called for the reallocation of funds to promote a "comprehensive human resources strategy" (MOHLTC, 1993, p. 14). However, unlike the Graham Report, the Ontario Ministry of Health did not consult the policy community before releasing Putting People First (Wiktorowicz, 2005). Consequently, the policy was criticized as an "administrative document concerned mainly with system management and cost-effectiveness, relegating … how services are to be delivered to a secondary status" (Everett, 2000, p. 184). The NDP government was further criticized for not wanting to "antagonize" labour unions and medical professionals, their "traditional supporters," in reallocating resources (Nelson et al., 2001, pp. 82-83).

Between 1995-2003, the Harris Conservative political party governed Ontario (Everett, 2000). Its platform, the "Common Sense Revolution," blamed public services for the fiscal debts of the former governments (Everett, 2000, p. 219). In its first term, the Conservative government cutback welfare payments by 21.6 percent and reduced personal income tax by 15 percent (Everett, 2000). The government also implemented a new Workfare program, where people on social assistance were expected to remain active in the labour market (Nelson et al., 2001, p. 89). However, these welfare-to-work policies disregarded the lack of employment initiatives for people with mental health and psychosocial conditions and did not consider the challenges faced by people experiencing severe mental distress who may be unable to sustain employment or only able to secure part-time or short-term contracts (Galvin, 2006). The provincial government's new "business-oriented" approach redirected the focus of mental health reform away from a model centered on empowerment and community integration (Nelson et al., 2001, p. 89). With the election of the Conservative government in 1995, the Ministry of Health requested that DHCs

include Assertive Community Treatment (ACT) teams in their mental health system designs (Wiktorowicz, 2005). Under the previous NDP government, DHCs were asked to "reconfigure the mental health system" by developing plans for mental health service delivery specific to the population needs within each region (Wiktorowicz, 2005, p. 390). DHCs acted as "regional advisory and planning agencies without fiscal authority" (Wiktorowicz, 2005, p. 390). The decision to incorporate ACT teams was faced with much opposition from mental health stakeholders as they viewed the teams as having a "biomedical basis," emphasizing "social control" rather than "natural supports" (Nelson et al., 2001, pp. 92-93). In 1996, the DHCs released their plans for the mental health system (CMHA, 2024a). The plans incorporated perspectives from the Ministry of Health and the policy community to improve coordination between mental health services (CMHA, 2024a). While the DHC in Toronto advocated for regional mental health authorities, the Ministry of Health "resisted devolving power" and instead aimed to create a "systems" approach to mental healthcare through the Community Investment Fund (CIF) (Wiktorowicz, 2005, p. 391). The CIF aimed to integrate services between "community service agencies" and "general hospitals," by making funding for their programs dependent on their ability to coordinate services, i.e., "client assessment, intake and referral" (Wiktorowicz, 2005, p. 391). The Ministry of Health also established the Health Services Restructuring Commission (HSRC) (Nelson et al., 2001). The Commission did not include members from the policy community, nor did it engage in community consultation (Nelson et al., 2001). In 1996, the Conservative government enacted the Ontario Savings and Restructuring Act (Bill 26) granting the HSRC authority to "close, amalgamate, and transfer programs among general hospitals" (Wiktorowicz, 2005, p. 391). Subsequently, in 1999, the HSRC released recommendations to the Ministry of Health in its report, *Building a Community Mental Health*

*System in Ontario: Report of the Health Services Restructuring Commission* (CMHA, 2024a). The HSRC did not include recommendations for community care, however, it did encourage the Ministry to provide transitional funding and establish Mental Health Implementation Task Forces (MHITFS), that would provide recommendations to the Ministry concerning "priority areas for reinvestment in the community" (Wiktorowicz, 2005; Hartford et al., 2003, p. 70). In 2001, the Ministry of Health implemented nine MHITS and seven regional ministry offices (Wiktorowicz, 2005). In 1998, during the HSRC's mandate, Dan Newman, a member of provincial parliament, led a five-week consultative review of mental health reform (Hartford et al., 2003). The resulting (Newman) report, *2000 and Beyond: Strengthening Ontario's Mental Health System*, found that although the Conservative government supported a vision for community-focused care, the government "failed to provide the necessary dollars" to implement reform (Newman, 1998, p. 29). The Newman Report (1998) also insisted that the government review the Mental Health Act (Everett, 2000). Bill 68, referred to as "Brian's Law," amended the Mental Health Act and the Health Care Consent Act by removing the word "imminent" in the phrase "imminent harm to self and others" from the involuntary examination, thereby enabling "health professionals to initiate the committal process at an early stage" (Wiktorowicz, 2005, p. 394). The revisions also provided for "compulsory outpatient treatment" (Hartford et al., 2003, p. 70). Community Treatment Orders (CTOs) were to facilitate involuntary treatment outside of the hospital (Hartford et al., 2003). The revisions to the Act were viewed as a "significant defeat" for psychiatric consumers/survivors because they enhanced psychiatrists' authority to treat patients on an involuntary basis and to write CTOs (Everett, 2000, p. 220) reasserting medical power in community mental healthcare. In 1999, the Ministry of Health released *Making It Happen*, its implementation plan and operational framework for mental health reform (Hartford et al., 2003).

The plan outlined the Ministry's strategy "to increase the capacity" of the mental health system "for comprehensive and integrated treatment" (MOHLTC, 1999a, p. 3). The Ministry in the operational framework committed to "a comprehensive continuum of supports and services" (MOHLTC, 1999b, p. 8). In 2000, *Making It Work*, a policy framework for employment supports for people experiencing mental distress was released (CMHA, 2024a). The report emphasized the need for employment initiatives, which were not adequately provided in the 10-year plan outlined in *Putting People First* (1993) (CMHA, 2024a). In 2002, the MHITFS submitted their recommendations for a reformed mental health system (CMHA, 2024a). The final report, *The Time is Now*, supported an increase in mental health funding and a range of community-based supports encompassing the broader determinants of health (Wiktorowicz, 2005). However, when the Liberals came to power, the government "essentially set the reports aside" (Wiktorowicz, 2005, p. 396). Instead, the McGuinty Liberal government announced its platform to "transform the health sector through local health integration networks (LHINs)" (Wiktorowicz, 2005, pp. 396-397).

By 2003, the government's commitment to invest 60 percent of mental health spending in community programs was not realized (CMHA, 2024a). The conservative neoliberal cost-cutting agenda had already swept through the province with the aim of creating a systems approach to mental healthcare. Consequently, the Conservatives, resistant to devolve control to local authorities, established "successive arms-length governance processes," which were rarely given the power to act on their recommendations (Wiktorowicz, 2005, p. 386). Three important sets of studies, however, were released during the McGuinty Liberal leadership in Ontario: the Provincial Psychiatric Hospital and Community Comprehensive Assessment Projects (CAPs), the Community Mental Health Evaluative Initiative (CMHEI), and the Systems Enhancement

Evaluative Initiative (SEEI) (CMHA, 2011). The CAP (1998-2002) was the first study to collect data on community mental health services and supports in Ontario (CMHA, 2011). The main findings from the CAP projects were that hospital and community systems lacked the capacity to meet the intensity of provincial needs; an increase in community-based services and support would allow for a larger number of hospital patients to be treated within the community; and that more intensive community supports were needed (Koegl, Durbin, & Goering, 2004). The CMHEI (1998-2004), was the first "multisite evaluation of community mental health programs in Canada" (CMHA, 2011 p. 11). The results indicated that community mental health services and supports were cost-effective, as researchers found that it "could cost up to five times less to provide an individual with community-based services, than to keep them in the hospital for the same length of time" (Goering, 2004, p. 6). As well, that peer support could reduce symptom severity and rates of hospitalization (Goering, 2004). Additionally, that Intensive Case Management (ICM) and ACT programs reduced dependency on institutional care (Goering, 2004). In 2004, due to some extent from the CAP and CMHEI findings, the MOHLTC provided a 52 percent increase in funding for certain mental health community supports and services (CMHA, 2011). The investments came from the two provincial initiatives: Federal Health Accord for Home Care, which provided $117 million over four years for ICM, ACT, crisis intervention, and early intervention services; and the Service Enhancement Initiative, which provided $50 million from 2005-2006 for court support programs, ICM, crisis intervention, supportive housing, and safe beds (CMHA, 2011, p. 12). The SEEI (2005-2009), comprised of "nine research studies in two phases," that assessed the impact of these new government investments ($167 million) in Ontario's community mental health sector (CMHA, 2011, p. 12). The SEEI also led to the creation of the Ontario Mental Health and Addictions Knowledge

Exchange Network (OMHAKEN) (CMHA, 2011). The SEEI found that additional services and supports were needed, as "expanded services in one part of the system increased case finding, and ultimately identified client needs for other services" (CMHA, 2011, p. 12). Subsequently, from 2010-2011, OMHAKEN, in collaboration with 17 mental health and addictions organizations, led the initiative *Creating Together* (CMHA, 2011). Creating Together consulted with the policy community to identify six priorities for mental health in Ontario: "social determinants of health; risk and resilience; health promotion and prevention; stigma and discrimination; continuity of care; and vulnerable populations" (OMHAKEN, 2011, pp. 6-7). In 2008, the Ministry of Health established an Advisory Group to develop a 10-year strategy for mental health in Ontario (Minister's Advisory Group, 2009). In 2009, the Advisory Group released their discussion paper, *Every Door is the Right Door* (CMHA, 2024a). The Advisory Group stated that it was critical to make every door the right door, as Ontario's fragmented system of services caused many people to "struggle" to find appropriate services (Minster's Advisory Group, 2009, p. 11). In 2009, the Legislative Assembly of Ontario, appointed a Select Committee on Mental Health and Addictions to provide recommendations for a "comprehensive provincial mental health and addictions strategy" (Select Committee on Mental Health and Addictions, 2010a, p. 2). From 2009-2010, the Committee consulted with mental health stakeholder groups to address provincial mental health needs (Select Committee on Mental Health and Addictions, 2010a). In 2010, the Committee released their *Interim Report* (2010a), which outlined major issues with the mental healthcare system as identified through the Committee's public hearings (CMHA, 2024a). Significant issues raised were long wait times in the emergency department and less than ideal treatment settings; inappropriate incarceration; poor service integration (i.e., transitioning from: children, youth, and adult services; adult and

senior services; addiction and mental health services; and addiction and mental health and the healthcare system in general) (Select Committee on Mental Health and Addictions, 2010a). In 2010, the Committee released their *Final Report* (2010b). The Committee stated that "radical transformation of mental health and addictions care" was necessary to ensure that Ontarians get the "care they need and deserve" (Select Committee on Mental Health and Addictions, 2010b, pp. 1-2).

### *Prospects for Future Reform*

The Romanow Commission on the Future of Healthcare advised that the CHA's (1984) principle comprehensiveness in coverage (within the medicare system), is not "a description of existing coverage, but a continuing goal" (2002, p. 62). By the end of the first decade of the twenty-first century (2010), the mental health system was criticized as being fragmented, lacking integration, and operating in silos making it difficult to navigate (2004a). Structural discrimination was identified as creating "undesirable conditions in treatment settings" (Kirby & Keon, 2004a, p. 51). Additionally, structural stigma, reflected in "levels of funding" for mental health (Kirby & Keon, 2004a, p. 51) and "constraints on federal funds" (Wiktorowicz et al., 2020, p. 7) was found to be present. In its final report, the Standing Senate Committee on Social Affairs, Science and Technology (Kirby & Keon), advised the federal government to create a Mental Health Transition fund to accelerate the vision for a community-based mental health system (2006). The proposed fund, which was ultimately not created, was intended to be a targeted federal investment to the provinces and territories on a per capita basis, with oversight by the Canadian Mental Health Commission (Kirby & Keon, 2006). The Committee also stressed the need for a national action plan or strategy to outline the roles and responsibilities of governments in providing mental healthcare (Kirby & Keon, 2006). This was endorsed by the

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)[25] (Kirby & Keon, 2004a). The Canadian government, however, refrained from this step until 2012, and the provincial Ontario government until 2011. While the MHCC was given a mandate to develop the national strategy, it was argued that the MHCC, operating at the federal level, would be unable to direct provinces and territories in the resourcing of mental health services as rooted in federalism and the constitutionally-based division of powers (Teghtsoonian, 2009). The Committee also emphasized improving the social determinants of mental health in adopting a "population health approach" in all provinces and territories (Kirby & Keon, 2004a, p. 209). The development and implementation of collaborative care initiatives aimed at supporting an integrated community-based continuum of mental healthcare were encouraged (Kirby & Keon, 2006). Furthermore, enhancing mental health human resources and increasing access to psychological therapies was identified as essential for people experiencing mental distress (Kirby & Keon, 2006).

***England***

This section will focus predominantly on mental healthcare in England, though it is important to reference the evolution of the NHS. While the UK shares the same parliamentary system as Canada, it functioned as a unitary state until the devolution of Parliaments in the 1990s (Kirby & Keon, 2004b; Anderson et al., 2022). The National Health Service (NHS) is one of the "more centrally managed and financed health care systems in the world" (Kirby & Keon, 2004b, p. 37). The NHS was created in 1948 under the newly-elected Atlee Labour government (Greengross, Grant, & Collini, 1999). The core principles that defined the NHS, and continue to do so, were that healthcare services be free, comprehensive, and accessible to everyone and

[25] CAMIMH, established in 1998, is an alliance of mental health groups comprised of healthcare providers and organizations that represent people experiencing mental distress and their families (2022). Its mission is to support timely access to mental healthcare and support in parity with other health conditions (CAMIMH, 2022).

funded primarily through general taxation (Greengross et., 1999). While privately-funded healthcare systems existed alongside the NHS, until the 1990s, the British population were able to access the majority of their healthcare publicly (Greengross et al., 1999). The three main components of the NHS were state owned hospitals; a network of GPs; and community health services (Greengross et al., 1999). These three components were funded centrally but managed separately (Greengross et al., 1999). In the early 1970s, the Heath Conservative government initiated research into the poor service-coordination of the NHS (Greengross et al., 1999). The 1974 reorganization of the NHS took place under the Wilson Labour government and involved the formation of 14 Regional Health Authorities and implementation of the Resource Allocation Working Party (RAWP) formula (Greengross et al., 1999). The 1946 *National Health Service Act* first established "the regional tier in the NHS as regional hospital boards" (Edwards & Buckingham, 2022). These boards were reorganized into the regional health authorities, which were responsible for the planning and allocation of resources to newly established Area Health Authorities (Greengross et al., 1999). These regional tiers were overseen by boards "primarily of lay members, appointed by the Secretary of State for Health" (Greengross et al., 1999, p. 9). The regional health authorities used "historical year-on-year funding[26] of services" as the primary funding allocation method to the area health authorities (Greengross et al., 1999. p. 9). The RAWP formula aimed to move away from "supply-driven funding" that "enshrined geographical inequalities," by applying mortality data to weighted regional populations to establish "a fair-share funding target" (Greengross et al., 1999, p. 9). RAWP aimed to allocate more funds to regions that faced greater deprivation but had historically received less funding (Greengross et al., 1999). Until its discontinuation in 1991, RAWP produced highly debated funding reductions

[26] Referring to funding based on historical patterns.

and increases in certain regions (Greengross et al., 1999). In 1979, the Thatcher Conservative government came into power with an agenda to radically change the public sector (Greengross et al., 1999). New District Authorities were established and comprised of local government members (Greengross et al., 1999). Regional and area health authorities were now expected to "stand back from day to day operations and concentrate on recurrent and capital resource allocation" (Greengross et al., 1999, p. 10).

Significant reforms to the NHS were made during the 1990s. These include the creation of an internal market, which applied market-oriented principles into the NHS; a purchaser-provider split that divided the planning of healthcare from its delivery; and implementation of GP fundholding, which made changes to the way that general family practices were organized (Greengross et al., 1999; Kirby & Keon, 2004b). In 2002, existing regional health authorities were merged to create Strategic Health Authorities (SHAs) (Edwards & Buckingham, 2022). The SHAs were responsible for implementing health policy developed by the Department of Health and managing performance of healthcare services at the regional levels (Kirby & Keon, 2004b). SHAs were also responsible for Primary Care Trusts (PCTs) (Kirby & Keon, 2004b). In the early 2000s, PCTs received about 75 percent of the NHS budget, and were involved in providing primary and community healthcare services and commissioning services from care providers, including mental health services (Kirby & Keon, 2004b). While the NHS is similar throughout the UK, it is managed separately by each jurisdiction (Kirby & Keon, 2004b). The following section will review the changing landscape of mental health financing and service system design as it pertained to the NHS in England.

## Sociopolitical Context of Mental Health Service Delivery Reform (1984-2010)

In February of 1983, the Thatcher Conservative government commissioned Roy Griffiths, a prominent businessman, to lead an investigation into the management of the NHS (Turner et al., 2015). The (Griffiths) *Community Care Agenda for Action: A Report to the Secretary of State for Social Services*, released later that year, found that the NHS lacked management and recommended the implementation of regional and district managers within the NHS; implementation of a Health Services Supervisory Board (HSSB), chaired by the Secretary of State for Health; along with decentralizing healthcare decision-making to the hospital level (Turner et al., 2015; The Health Foundation, 2023b). The recommendations were accepted by the government and marked an important power shift from consensus management to general management, increasing the power and salary of general managers while reducing the power of other groups (i.e., public health doctors and nursing managers) (The Health Foundation, 2023b). The 1988 Griffiths (second) report that led to the 1990 *National Health and Community Care Act* increased managerialism within the NHS, establishing the NHS purchaser/provider split and assigning responsibility for community-based care to local authorities (Turner et al., 2015). These changes to responsibility for community-based care did not reduce frustration over inadequate community funding (Turner et al., 2015). The Griffiths reports also advocated for the use of the "independent sector," referring to private medicine (Turner et al., 2015, p. 608). In support of general management principles, operational units within districts (i.e., hospitals and community health services) were allocated budgets that covered all aspects of their operations as opposed to budgets segmented into functions (Greengross et al., 1999). Financial information systems were introduced, allowing costs to be allocated to clinical activities (Greengross et al., 1999). Since the NHS, historically, did not invoice patients, it now needed to calculate costs of individual treatments; management information systems therefore focused on managing staff and

resources, resulting in low costs (Greengross et al., 1999). NHS Trusts, including separate Mental Health Trusts, established under the *National Health and Community Care Act* (1990), accountable to the central government, were to assume responsibility for the ownership and management of hospitals or other facilities that were formerly managed or provided by regional, district, or special health authorities (The Health Foundation, 2023c). Despite being non-profit entities, trusts were able to generate income form alternative sources like private beds and were also accountable for employing their own staff (Greengross et al., 1999). Trusts were to function as semi-autonomous organizations, "run in a more business-like manner" than the facilities they replaced (Greengross et al., 1999, p. 14). This approach aimed to enhance efficiency and quality of NHS services, while also increasing accountability to purchasers thus providing more choices for them (Greengross et al., 1999).

In 1998, under the new Blair Labor government, a First Minister for Public Health was appointed and was to report to the Secretary of State (Greengross et al., 1999). The New Deal for Disabled People (NDPP) initiated under Blair's government aimed to integrate individuals into society via employment (Roulstone, 2000). The welfare-to-work approach adopted the Labour party's slogan "no rights without responsibilities," enforcing tighter conditions for claiming unemployment benefits, all in the pursuit of fostering an active welfare system (Swain et al., 2003). Part of the government's agenda was to better understand health inequalities (Hunter, Fulop, & Warner, 2000). The new Minister for Public Health was commissioned by the government to evaluate the former health strategy, *Health of the Nation* (HOTN), released in 1992 (Hunter et al., 2000). HOTN, developed under the previous Conservative government, was the first attempt to developing a strategy aimed at improving the health of British people (Hunter et al., 2000). It focused on five key areas, including mental health, and established health targets

(Hunter et al., 2000). The strategy, however, was criticized for not acknowledging the socio-economic determinants of health (Hunter et al., 2000). In 1999, *Saving Lives: Our Healthier Nation*, the successor to the HOTN strategy was released (Hunter et al., 2000). The revised strategy acknowledged the "association between inequality, poverty, and ill health" and proposed "national contracts for health" for which the government and local authorities were to assume responsibilities (Greengross et al., 1999, p. 27). At the same time the health strategy was being written, the White Paper,[27] *Modernising Mental Health Services*, was published in 1998 (Greengross et al., 1999; Turner et al., 2015). Recognized as the new mental health strategy for England, *Modernising Mental Health Services: Safe, Sound, and Supportive*, proposed a vision of creating 'safe,' 'sound,' and 'supported' mental health services (Marshall, 1999). The mental health strategy proposed an increased investment of £700 million over three years towards beds (in hostels and secure units); outreach teams and 24 hour access; new treatments; and staff training (Marshall, 1999). The strategy also proposed amendments to the *Mental Health Act* (1983), to "ensure compliance with the appropriate treatment" in the community (Marshall, 1999, p. 3). The strategy was criticized for failing to recognize disparities between the supply and demand for mental health services and the failure of successive governments in establishing priorities for mental health (Marshall, 1999).

In 1999, that *National Service Framework (NSF) for Mental Health* (NSF-MH) (see Table 2.2 in Appendix A) produced detailed objectives and targets for mental health services for adults between 18-65 (Kirby & Keon, 2004b). The NSH-MH framework, a 10-year agenda, set out seven standards that focused on mental health promotion, access to services, reducing suicide rates, and improving services and supports for caregivers (Kirby & Keon, 2004b). Accordingly,

[27] White Papers are policy documents produced by the government that usually set out proposals for future legislation (UK Parliament, 2024a).

mental health was “one of the three declared clinical priorities alongside cancer and heart disease” in the 2000 *NHS Plan* (Turner et al., 2015, p. 604). The *NHS Plan* built on the standards and targets set by the NHS-MH by outlining new services for assertive outreach, crisis resolution, and early intervention in psychosis treatment (Kirby & Keon, 2004b). The Plan also introduced more mental health staff and introduced care trusts (Kirby & Keon, 2004b). In 2005, *Everybody’s Business: Integrated Mental Health Services for Older Adults*, built on the NSF-MH to secure better health for older adults (Turner et al., 2015). As previously mentioned, PCTs, were to now receive NHS funding directly through the government instead of health authorities (Kirby & Keon, 2004b). PCTs served as the primary funding source for mental healthcare and “in theory can redirect resources between services and providers according to local priorities” (Kirby & Keon, 2004b, p. 44). In 2002, specialist mental health trusts began to emerge, replacing services previously managed and provided by acute trusts and community trusts (Kirby & Keon, 2004b). Several providers had been established as health and social care trusts, consolidating budgets that include both health and social service funding along with shared staffing facilities (Kirby & Keon, 2004b). The NHS Plan was accompanied by £300 millions of new funding for mental health (Kirby & Keon, 2004b). The Secretary of State for Health informed the Standing Senate (Kirby) Committee on Social Affairs, Science & Technology that mental health services made up 12 percent of the 2000 hospital and community health service budget: rising to 13 percent between 2001-02 (Kirby & Keon, 2004b). The yearly average spent on mental health in England (between 1994-2013), was indicated to be £940 million (Bernardi, 2021). Mental health expenditure grew throughout this time, experiencing a decline beginning in 2010 (Bernardi, 2021).

### Prospects for Future Reform

The implementation of the NSF-MH in 1999, along with its ten-year planning initiative, prompted targeted reforms in the provision of NHS services. Especially noteworthy, was the establishment of Local Implementation Teams, aimed at adapting the NSF-MH to local conditions, and the emergence of mental health trusts designed to consolidate mental health services into a single local provider (Kirby & Keon, 2004b). However, there remained concerns whether the standards outlined in the NSF-MH would be met (Kirby & Keon, 2004b). In 2000, the House of Commons Select Committee on Health characterized the NHS system as a "patchwork quilt," highlighting disparities in service standards and delivery across the country (Kirby & Keon, 2004b, p. 52). Reports also highlighted concern regarding the priority of mental health within the overall health system (Kirby & Keon, 2004b). Mental health expenditure had increased at a slower rate compared to overall NHS expenditure (British Medical Association, 2023). Greater priority seemed to be placed on the acute sector through minimizing wait times and expanding patient choice rather than implementing the targets outlined in the NSF-MH and NHS Plan (Kirby & Keon, 2004b). Shortages in human resources also posed a challenge to implementing the reform plans (Kirby & Keon, 2004b). The initiative to train graduate mental health workers to support service delivery at the primary care level, as outlined in the NHS Plan, was considered important in tackling challenges related to the recruitment and retention of mental health staff (Kirby & Keon, 2004b).

### *Australia*

#### Federal

Although the responsibility for public mental healthcare is shared between the Commonwealth and state governments, it was not until 1992 that the Commonwealth demonstrated interest in mental healthcare with the announcement of the National Mental Health

Policy (Lurie, 2005). The Commonwealth's decision to develop a mental health policy was influenced by the findings of two previous inquiries into the human rights of people with mental health and psychosocial conditions. The 1983 (Richmond) report of the *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*, conducted by David Richmond, commissioned under the Hawke Labor government for New South Wales, strongly advocated for deinstitutionalization through a decentralized and integrated community-based system of mental healthcare (Mental Health Commission of New South Wales, 2014). In his role as a public administrator, David Richmond had worked closely with community-based psychiatrists and social workers providing services to public housing residents (Mental Health Commission of New South Wales, 2014). Through this experience, Richmond emphasized the significance of funding and providing services that enabled people to remain in their "normal community environment" (1983, sect. 2i). A decade later, in 1993, under the Keating Labor government, the first Australian human rights commissioner Brian Burdekin released the *Report of the National Inquiry into the Human Rights of People with Mental Illness* (Mental Health Commission of New South Wales, 2014). The Inquiry revealed that new investments into community health, outlined by the Richmond report, had not been materialized (Mental Health Commission of New South Wales, 2014). Additionally, insufficient collaboration between government and non-government agencies and the private sector, had limited the availability of services (Mental Health Commission of New South Wales, 2014). The Burdekin report also stressed the need for mental health legislation grounded in the human rights of people with mental health and psychosocial conditions (Mental Health Commission of New South Wales, 2014). Subsequently, in 1992, the goal of the first National Mental Health Policy, released under the same Keating Labor government, was to "mainstream" and "integrate" mental health services

into general health services to create “a seamless set of relationships from inpatient ward to community support” (p. 568).

All Australian states, territories, and the Commonwealth government unanimously adopted the National Mental Health Policy in April of 1992 (Kirby & Keon, 2004b). The Policy, implemented through a series of five-year National Mental Health Plans (refer to Table 2.3 in Appendix A) became recognized as the National Mental Health Strategy (Kirby & Keon, 2004b). Of the four National Mental Health Plans that ensued; the first (1993-98) was developed through the National Mental Health Strategy, with transitional funding provided by the Commonwealth to states and territories to redirect mental health services from institutions to local communities (Rosen, 2006). Mobile community-based crisis intervention services and assertive community treatment teams were introduced, as well as initiatives to promote community participation in policy and planning (see Figure 2.3 in Appendix B) (Rosen, 2006). To ensure that additional funds from the Strategy would not be offset by state and territory funding, all levels of government committed to sustaining the current level of expenditure on mental health services and reinvesting any resources resulting from the closure of psychiatric hospitals into mental health services (Kirby & Keon, 2004b). The Second National Mental Health Plan (1997-2003), released under the Howard Liberal-National Coalition, introduced new reform priorities such as promotion and prevention; partnerships in service reform and delivery; and quality and effectiveness of service delivery (Kirby & Keon, 2004b). Between 1999-2000, expenditures on community-based mental health services grew from 29 percent at the start of the Strategy to 49 percent (see Figure 2.4. in Appendix B) (Kirby & Keon, 2004b). Australia now spent $778 million more on public mental health services or $33 more per person per year than it did as the start of the Strategy (Kirby & Keon, 2004b). The Third National Mental Health Plan (2003-

2008), released under the Howard Coalition government, prioritized workforce improvement and integration across all care systems including legal, emergency, and substance use services (Grace et al., 2015). However, without additional Commonwealth funding, many argued that the Plan "spread available resources too thinly" (Grace et al., 2015, p. 2). The Fourth National Mental Health Plan (2009-2014), under the Rudd Labor government, sought to enhance workforce agreements, accreditations, and reporting standards, as well as provide resource packages and outcome targets to minority groups, including Indigenous Australians (Grace et al., 2015). The Plan did not receive significant resource allocation as it was superseded by the *National Action Plan on Mental Health* released in 2006 by the Council of Australian Governments (COAG) (Grace et al., 2015). The COAG Plan (2006-2011), outlined nine individual implementation plans, including one for the state of Victoria, along with key reform strategies and outcome measures (Grace et al., 2015). The COAG also promised new Commonwealth mental health funding of $1.9 billion over a five-year period; these funds were in addition to existing Commonwealth funding (2006).

**State (Victoria)**

About 70 percent of healthcare expenditures are financed by the public sector (46 percent by the Commonwealth government and 24 percent by state and territory governments) and 30 percent by the private sector[28] (Kirby & Keon, 2004b). This is in contrast to the national figure in 2021-22 where public funding was 72.9 percent, with the Commonwealth government providing $105.8 billion and state and territory governments, including Victoria, contributing $70.2 billion, and private sector contributions of 27.1 percent, with individuals providing over half of this amount (AIHW, 2023). During the 1990s, mental health services in Victoria underwent

[28] Percentages are taken from the second report by the Standing Committee on Social Affairs, Science and Technology released in 2004(b).

significant transformation (Gerrand, 2014). The adoption of the National Mental Health Strategy (1992) required each state to go through its own implementation of the Strategy's framework for service reform (Meadows & Singh, 2003). The structural changes that were produced aimed to create a "community-oriented mental health system under general health, instead of one based on psychiatric institutions" (Gerrand, 2005, p. 255).

### Sociopolitical Context of Mental Health Service Delivery Reform (1992-2010)

Between 1992-1999, Premier Jeff Kennett's "radical reformist Conservative government" secured power in Victoria (Meadows & Singh, 2003, p. 63). Victoria's public mental health system, upon the election of the new Conservative state government, was characterized as not only insufficient but also harmful to the wellbeing and recovery of people (Gerrand, 2005, p. 258). Recent investigations conducted by the Health Department in Victoria (1991a; 1991b) had brought to light "unacceptable staff practices," revealing a "deliberate disregard for patient rights" (Gerrand, 2005, p. 258). These findings prompted a statewide clinical audit of all inpatient services (including services located in general hospitals, long-term care facilities, and in psychiatric hospitals) (Office of Psychiatric Services, 1992). The audit report, published in 1992, showed "uneven quality" of inpatient care that "fell below required standards in many adult extended care wards" (Gerrand, 2005, p. 258). By 1992, inpatient mental health services were largely geographically inaccessible from the communities they were meant to serve (Gerrand, 2005). Inpatient and community mental health services were also fragmented and lacked continuity of care (Gerrand, 2005). The newly elected Conservative government, however, sought to cut back on public expenditures in response to the "perilous" financial situation in Victoria considered at the time (Meadows & Singh, 2003, p. 63).

Despite this policy agenda, the government was tasked with reducing the state health budget while adhering to the commitments outlined in the National Mental Health Plan (Meadows & Singh, 2003). Consequently, in 1994, a new framework for service delivery was implemented (see Figure 2.5. in Appendix B) (Gerrand, 2005). The new service framework required the delivery of services within a local catchment area (Gerrand, 2005). The model was designed to service catchment areas, with an average adult population of 215,000 (Meadows & Singh, 2003). Victoria was the first state in Australia to replace its institutional mental health service system (Gerrand, 2005). By December of 1999, all Victoria's psychiatric institutions, which had received most of the state psychiatric service budget in 1992, were closed (Meadows & Singh, 2005). Table 3 (in Appendix A) illustrates savings from the closure of psychiatric hospitals that supported new investments in community mental health between 1993-1998 (Meadows & Singh, 2005). During this period, there was also a notable development of an internal market within Victoria's mental health system, where general hospitals were contracted to provide mental health services (Meadows & Singh, 2003). Furthermore, the state government enforced the mandatory involvement of consumers, as stipulated under the National Mental Health Plan, by requiring the paid employment of consumer consultations (Meadows & Singh, 2003; Gerrand, 2005).

Although the vision for service reform was initially defined by the Commonwealth Labor government, it was the radical conservative agenda that pursued service reform in Victoria (Meadows & Singh, 2003). Between 1999-2010, a Labor state government assumed control with a policy agenda of creating a more inclusive mental health system (Meadows & Singh, 2003). In 2009, following extensive consultations with 1200 stakeholders and 240 written submissions commissioned by the Minister of Mental Health, *Because Mental Health Matters: Victorian*

*Mental Health Reform Strategy (2009-2019)* was released (Mental Health and Drugs Division, Department of Human Services). The Strategy (2009) set out a vision for a "new era" (p. 3) in mental health reform advocating for a "holistic approach" to address the individual range of mental health needs (p. 8). The Strategy identified four key elements for reform, including prevention; early intervention; recovery; and social inclusion (Mental Health and Drugs Division, Department of Human Services, 2009). The Strategy also highlighted Victoria's commitment to "achieve better social and economic outcomes" for people experiencing mental distress as well as their families and carers (Mental Health and Drugs Division, Department of Human Services, 2009, p. 2). The reforms were supported through a financial commitment of $128 million spread across four years, as outlined in the 2008-09 budget (Mental Health and Drugs Division, Department of Human Services, 2009).

### *Prospects for Future Reform*

By the end of the first decade of the twenty-first century, four National Mental Health Plans had been released with the fifth Plan set for 2017. The Plans underscored the crucial importance of ensuring sufficient funding for mental health services (Kirby & Keon, 2004b). The Commonwealth government's "ring fencing"[29] of mental health funding enabled the proportion of mental health financing to increase thereby supporting service delivery to shift into the community (Kirby & Keon, 2004b). Victoria's adoption of a statewide service framework enabled new investments from the closure of psychiatric institutions to be reinvested into comprehensive and locally accessible mental health services (Gerrand, 2005). Following the release of both national and state mental health strategies, future goals for mental health reform

[29] The concept of ring-fencing as discussed by Kirby & Keon (2004b) refers to the practice of securing budgetary funds specifically for mental health so to prevent them from being diluted into the general healthcare budget.

focused on implementing a holistic approach to care through shared care initiatives creating a more integrated mental health system.

**Similarities in the Direction of Change Across the Three States**

Funding arrangements and service delivery mechanisms of healthcare systems are rooted in history and politics. While directly applying reform measures from one state to another in making comparisons is not feasible, there have been shared challenges faced by the mental health systems and policymakers (Kirby & Keon, 2004b). Perhaps the most apparent similarity among the three states was the recognition of the need to shift the focus of mental healthcare from institutions to the community so to improve care quality and individual rights. This transition highlighted the insufficiency of community level resources to meet care demands (Kirby & Keon, 2004b). The result was an emphasis on decentralizing funding decisions, aiming to bring these decisions closer to the communities they served (Kirby & Keon, 2004b). Evident through service delivery models that aimed to regionalize care.

The need to deploy national resources towards mental health was prevalent across all three states. While this led to England and Australia developing national mental health strategies, Canada refrained from this step, until 2012, due to structural stigma that historically omitted mental health from health legislation as evident by the CHA (1984). The development of national mental health strategies correlated with increased funding for mental health (Kirby & Keon, 2004b). Further initiatives, such as ring-fencing mental health spending by the Commonwealth government in Australia ensured that its transfers led to increases in mental health expenditures. Without measures to protect specific funding for mental health, increased investments may be used elsewhere. Similarly, across the states, only Australia guaranteed consumer participation, as mandated by its National Mental Health Plan. Nearing the second

decade of the twenty-first century, the focus developing across the states became determining how best to deliver mental healthcare to meet needs and that is integrated at regional levels.

**Conclusion**

This chapter introduced the policy-lever of finance, exploring its shaping of service delivery designs as the states shifted towards community-based mental healthcare. This lever will be further explored in the second part of the dissertation to highlight changes that have occurred since roughly 2010, impacting the delivery of mental healthcare. Comparisons across the three states illustrate similar challenges in transitioning toward a continuum of mental healthcare. However, by the end of 2010, both England and Australia implemented distinct financial targets for mental health and outlined standards for a community-based mental health system, whereas Canada had not. The next chapter will explore the lever of regulation and payment to better understand how initiatives for shared care between providers were introduced by governments to provide comprehensive mental healthcare.

## Chapter 4: Regulation and Payment

This chapter explores the policy levers of regulation and payment in directing mental health reforms and represents the last of three chapters in the first part of the dissertation. Part One of the dissertation investigates the trajectory of mental health policies up to around the 2010s, delving into several policy levers: (1) organization of healthcare delivery influenced by government structures and managerial practices; (2) financing and changes to service system designs; and (3) regulatory frameworks and payment strategies – explored in this chapter – which together shaped the "scale"[30] and "pace"[1] of reforms in the mental health systems.

Despite a narrative across the states for integration, the overarching policy logics governing funding mechanisms up to the 2010s still backed the medical model, perpetuating traditional biomedical psychiatric approaches. The introduction of Routine Outcomes Measures (ROMs) in the 1990s to evaluate mental health services further centered mental health issues within individuals and healthcare settings, diverting attention from wider determinants of mental health and mental healthcare (Oster et al., 2023). Nonetheless, the Australian (1992) and English (1999) mental health strategies advocated for the mainstreaming of mental health services with general services and integration of the various components of mental health services (Australian Health Ministers, 1992; NHS, 1999). This chapter examines the roles of regulation and payment in actualizing these policy goals across the states.

### Overview of the Levers

#### *Regulation*

[30] Tuohy (2018) conceptualizes policy change through the dimensions of "scale" and "pace." The "scale" pertains to the extent and depth of change within policy "instruments," "organizing principles," and "logics" (p. 7), while "pace" denotes the speed at which these policy changes are "enacted" and "implemented" (p. 11).

The control knob of regulation refers to the state's use of "coercive power" to influence the behaviours of individuals and organizations within the healthcare arena (Roberts et al., 2008, p. 247). Governments may implement regulatory actions to promote "moral norms" that markets may not ensure (p. 247). Governments use regulations to define the duties of both patients and providers in healthcare to ensure that "agreed-upon transactions are honest, transparent, and reliably executed" (p. 249). Regulation is a "major control knob" for improving health system performance and often works reciprocally with other control knobs (p. 248). This section is largely concerned with the regulating frameworks governing GPs, who often serve as gatekeepers for mental healthcare within public healthcare systems (Steele et al., 2009). GPs are responsible for assessing mental health needs and referring patients to specialized, psychiatric care (Steele et al., 2009). Regulation of psychiatrists fall under broader medical regulation, reflecting their medical credentials and the medical model under which they operate. Clinical psychologists, while sometimes part of the public healthcare system, predominantly practice in private settings and are thus subject to distinct regulatory standards. Acknowledging the wide scope of mental health professionals regulated outside public healthcare systems and operating in private healthcare is important. When comparing mental health access in public healthcare systems, the focus is on individuals who are unable to access private mental healthcare modalities through mechanisms such as employment. Health outcomes and patient satisfaction can be improved by setting standards for what health services insurance plans must include. These standards or regulations, however, are most effective when they include appropriate incentives, such as payment schemes, to shape behaviour.

### Regulation of Healthcare Inputs

#### *Health Professional Regulation*

Health professional regulation includes a variety of approaches, though typically in Western countries it involves laws that manage entrance into and practice within professional fields (Adams, 2020). Professions use their regulatory framework to maintain control over a specific field of work, typically through self-governance, selective recruitment, and legal boundaries for the profession (Bourgeault & Grignon, 2013). Regulatory approaches initially aimed at managing "tasks" or "titles" are evolving, with authority shared across professional and state lines, spanning from full professional autonomy to complete state control (Leslie et al., 2021, p. 1). The concept of occupational imperialism highlights how professions can monopolize specialized skills to maintain intra-domain exclusivity and forge beneficial alliances (Larkin, 1983). This trend in which medical professions encroach into territories traditionally occupied by allied health disciplines enables ancillary medical fields to advance within the medical labour hierarchy without overtly challenging the entrenched hierarchal superiority of physicians (Larkin, 1983). Such regulatory practices solidify medical dominance and establish monopolies over services, reflecting the complex interplay between professional autonomy and governmental oversight (Leslie et al., 2021). Flexibility and accountability in professional responsibilities are crucial in regulatory bodies (Nelson et al., 2014).

The goal for health professional regulatory frameworks is quite similar across the three states, (i.e., protection of the public), while regulatory approaches differ according to historical policy legacies and cultural norms (Leslie et al., 2021). In Canada, health professional regulation is a provincial/territorial responsibility and as such regulatory regimes vary across the country (Leslie et al., 2021). Most professions are self-regulated through regulatory colleges that govern respective professions (Leslie et al., 2021). Therefore, changes to scopes of practice or

introduction of new regulated health professions require legislative or regulatory amendments (Leslie et al., 2021).

In the UK, many organizations and "colleges" once regulated medical member-practitioners (Adams, 2020, p. 2). This changed with the creation of the General Medical Council (GMC) in 1858, which introduced a unified regulatory authority for medical practitioners (Adams, 2020). This legislative milestone was reached after extensive negotiations and collaboration between various medical bodies and government officials (Adams, 2020). There are currently twelve statutory regulators called councils, including the GMC, that regulate health and social care professionals in the UK (General Medical Council, 2024). These councils provide practice standards and regulatory frameworks though differ in their legislation and approach (Leslie et al., 2021). The councils are overseen by the Professional Standards Authority for Health and Social Care (coined the Authority) (Leslie et al., 2021). The Authority conducts research, shares good practice, and promotes "right-touch regulation," which ensures that the degree of regulation matches the level of risk to the public (Leslie et al., 2021, p. 7). Across the councils, there is no unified method for defining professional scope of practice, leading to a "crowded" regulatory environment, with scopes of practice shaped by "local and institutional factors" (Leslie et al., 2021, p. 7). This creates the challenge of ensuring governance that effectively minimizes the risk of professionals working beyond their expertise (Leslie et al., 2021). The UK has also revamped its regulatory councils, ensuring public participation in health professional oversight by mandating that at least half of the members of each regulatory council consists of public members as stipulated by the *Health and Social Care Act* of 2008 (Leslie et al., 2021).

Historically, health professional regulation in Australia involved statutory models that were predominantly specific to each profession (Leslie et al., 2021). Regulatory legislation for health professionals was not only tailored to individual professions but was also replicated across the six states and two territories, resulting in a system that was "highly fragmented and duplicative" (p. 6). In 2010, Australia transitioned to the National Registration and Accreditation Scheme, created through the implementation of the National Law.[31] The National Law encompasses fifteen profession-specific boards that set practice and registration standards for their respective fields, and a single regulatory agency, the Australian Health Practitioner Regulation Agency (AHPRA), is responsible for administering the scheme. The National Boards do not exercise regulation by defining restricted acts; instead, they "maintain the outer boundaries of practice" (p. 6). The Boards also have the responsibility of "endorsing the registration of certain professionals," which involves approving additional qualifications of health professionals and recognizing their extended scopes of practice (p. 6). However, legislation at the federal, state, and territory levels around funding and prescription medications may impede professionals from practicing to the full extent of their scope. Echoing the UK's approach, in 2013, AHPRA formed a community reference group to enhance public engagement in the regulation of professions and serve as a "conduit between communities and AHPRA and the National Boards" (p. 10).

### *Licensing*

Licensing safeguards both healthcare professionals and their patients by mitigating the potential harm from "asymmetrical" knowledge between providers and receivers of healthcare services (Bourgeault & Grignon, 2013, p. 203) which could lead to misuse of power,

[31] The National Law originating from the *Health Practitioner Regulation National Law Act* **(**2009) was enacted in each state and territory to create a national registration and accreditation scheme for registered health providers.

misinformed consent, and suboptimal care. The processes of licensing and accreditation for physicians are frequently carried out separately (Roberts et al., 2008). Usually a government body oversees licensing, while a system of professional peer review often manages accreditation (Roberts et al., 2008). For instance, in Canada, an independent board, comprising less than half of individuals from the medical profession, carries out the accreditation process (Roberts et al., 2008). Such a structure is linked to enhancing "education and self-development" (Roberts et al., 2008, p. 262). The accreditation of organizations is typically structured in one of two ways: it might be government-led, with the state setting and enforcing standards as a condition for the organization's ongoing operation and eligibility for funding; or it could be industry-led, where a self-regulatory organization sets the standards and supervises voluntary compliance by participating institutions (Kohn et al., 2000). For instance, the United Kingdom maintains separate regulatory frameworks for its private and public healthcare sectors (Roberts et al., 2008). Licensing and accreditation processes are designed to ensure a fundamental standard of quality (Roberts et al., 2008). However, with a primary focus on inputs (i.e., educational credentials and investment expenditures), these regulatory mechanisms "do not guarantee that the inputs in question will be properly utilized" (Roberts et al., 2008, p. 262).

The Medical Council of Canada, operating at the national level, is responsible for evaluating medical candidates, administering examinations, and awarding the Licentiate of the Medical Council of Canada – a prerequisite for obtaining an independent practice license within Canada (Bourgeault & Grignon, 2013). Certification of specialists is conducted nationally by the Royal College of Physicians and Surgeons of Canada and by the College of Family Physicians of Canada for family physicians. Despite being colleges, these bodies do not hold regulatory authority. Rather, it is the provincial/territorial colleges that issue medical practice licenses

within their jurisdictions. In the UK, the certification and regulation of health professionals are overseen by government-led bodies through (as previously mentioned) separate organizations or councils. The GMC is responsible for the regulation and registration of physicians. The GMC manages admissions to the medical register, establishes guidelines for professional conduct, and oversees practicing physicians. Since April 2010, after merging with the Postgraduate Medical Education and Training Boards, the GMC has extended its regulatory scope to include all medical education in the UK. Before 2010, medical licensure in Australia was under the governance of state and territory medical boards, which handled registration decisions. The Australian Medical Council oversaw the education standards and accreditation of medical schools and specialist medical education. The establishment of the AHPRA in 2010, created a centralized approach for regulating health professionals through national legislation. The Australian Medical Council is still focused on maintaining national education, training, and assessment standards for the medical profession through accreditation.

The traditional "social closure strategies" used by the medical profession are being contested in each of the three states to varying extents (Bourgeault & Grignon, 2013, p. 217). The essence of the credentialing system for closure employed by the medical profession is to control and oversee the supply of new practitioners into the field, thereby preserving the profession's economic worth. A growing demand for the portability of qualifications[32] not only within nations but also for physicians trained internationally exists. Also, a significant shift toward dismantling the regulatory barriers that hinder inter-professional cooperation; this includes broadening nursing scopes of practice to encompass areas traditionally reserved for medicine. Consequently, increasing fluidity and permeability of professional boundaries has

[32] Demands for the portability of medical licenses focus on enhancing healthcare delivery by addressing deficits in the availability of physicians (Chaudhry, 2022).

begun to emerge, both between different professions and within the same profession. The influence of medical professionals continues to be significant in the English NHS, in spite of repeated calls for primary care reform and a shift towards patient-centered care. The strategy to navigate limitations around scopes of practice within a centralized, universally accessible, and publicly funded healthcare system – facing a perceived shortage of healthcare providers and limited patient choice – has been to strengthen the medical profession's dominance and mandate collaboration or shared care practices under physician oversight. Similar patterns are observed in the healthcare systems of Canada and Australia, which like the UK, provide public universal coverage for medical services.

This suggests that differences in professional regulation are determined by the interplay between state governance and market forces. Across the states, professional regulation has been characterized by exclusive scopes of practice and inter-professional tensions over jurisdictional boundaries and practice domains (Adams & Wannamaker, 2022). In the Western healthcare framework, professional regulation has been traditionally organized in siloes, with each profession governed by its own distinct regulatory body (Adams & Wannamaker, 2022). Such practices face criticism "for being cumbersome, inflexible, and vulnerable to special interests" (Adams & Wannamaker, 2022, p. 1). Professional self-regulation has been described as a result of a governance compromise in which states conferred privileges to professional groups, who in turn pledged to use these privileges in the public's interest (Adam & Wannamaker, 2022). This governance compromise has an economic dimension: it offered financial relief to governments by having professions assume the cost of their own regulation, in exchange for granting them a degree of autonomy (Adams & Wannamaker, 2022). When intervention from external forces is required – whether from market or state entities – to influence the relationship between health

professionals and patients, or in organizing the delivery of care to control costs while maintaining quality, market forces tend to be more adept at diminishing professional autonomy than state mechanisms due to their aggressive strategies (Bourgeault & Grignon, 2013). In the United States, this is exemplified by the "managed care" movement (Bourgeault & Grignon, 2013, p. 218). When care is overseen or managed, it imposes a limitation on the healthcare professional's autonomy in care provision. The manager steps in to ensure that services are provided at the minimum cost for an acceptable quality level, which in turn leads to a more flexible interpretation of practice scope regulations and supports the roles of allied health professionals (Bourgeault & Grignon, 2013). Conversely, states often depend on the medical profession to lead primary care reforms, which has the effect of perpetuating the medical profession's governance and dominance (Bourgeault & Grignon, 2013).

### Regulation of Process

#### *Patient Assessments/Service Quality*

Regulation of process in healthcare involves three dimensions of medical quality – clinical, service, and quantity (Roberts et al., 2008). Patient satisfaction is a critical element of quality evaluations, although patient assessments are often more concerned with the service than the clinical component of health services (Roberts et al., 2008). The aim of ROMs is to assess whether the treatment provided is having the intended benefits for the patients and to facilitate ongoing planning and management of services (Oster et al., 2023). Australia was at the forefront of implementing ROMs into mental health services, beginning with the Mental Health Policy in 1992 (Oster et al., 2023). This practice has been consistently integrated into subsequent policy and Mental Health Plans, leading to ROMs becoming a mandatory requirement across the nation in 2000 (Oster et al., 2023). The need for mental health outcome measurement is based on the

issue surrounding the "lack of high standards or quality of mental health care" (Oster et al., 2023, p. 4). The issue is situated within discussions on the variability of service standards and the quality of care, as outlined in Mental Health Plans since 1992 (Oster et al., 2023). For instance, the Fourth Mental Health Plan highlights the importance of developing Key Performance Indicators (KPIs) and a benchmarking framework for "enable[ing] comparison between services and within services over time," and as "a key tool for promoting quality improvement" and for "build[ing] a culture of continuous quality improvement" (Australian Health Ministers, 2009, p. 52). The "service drift" occurring in policy leads to an emphasis on enhancing the quality of and accessibility to health services, despite recognizing that broader Social Determinants of Health (SDoH) concerns are not being sufficiently addressed (Osteer et al., 2023). Focusing policy initiatives on the performance of clinicians and services, with the aim of improving outcomes, neglects the broader social factors that impact health and forces that occur outside the confines of clinical settings (Oster et al., 2023). For instance, socio-economic factors are believed to explain over 40 percent of the health outcomes within a given health authority in the UK (Greener, 2003, p. 244). The framing of the issue assumes that people can influence outcomes by comparing the performance of different services and opting for those that deliver the highest quality of care (Oster et al., 2023). This choice, however, is dependent on the availability and accessibility of multiple service options, which may not always be present (Oster et al., 2023). Furthermore, the categorization of mental health services as "good" or "bad" based on their adherence to KPIs associated with outcome measures (Oster et al., 2023, p. 8), may inadvertently shift the use of these measures for "cost containment and service eligibility" rather than for enhancing the quality of services (Gelkopf et al., 2022, p. ii13).

***Payment***

The control knob of the payment system functions as a financial incentive mechanism to regulate the "quantity and quality of services provided by health professionals" (Grace et al., 2015, p. 4). This lever establishes the basis for professional remuneration and corresponding rates of pay (Grace et al., 2015). Organizations that allocate funds within the health sector, including governments, social and private insurers, and community financing bodies, must decide which service providers to fund, what services to pay for, and the amount of payment (Roberts et al., 2008). These financial choices create incentives that shape both organizations and individuals within the healthcare system (Roberts et al., 2008). The payment system selected is influenced by the "organization and mode of delivery of a service," which involves the number of available providers and the range of alternative services (Grace et al., 2015, p. 4). The choice of payment system also reflects the value assigned to various forms of service provisions (Grace et al., 2015). Payment operates differently from regulation in shaping behaviour as it uses monetary rewards as incentives – a "carrot" to promote changes in behaviour – rather than using the state's authority and the "stick" of punitive threats to enforce compliance (Roberts et al., 2008, p. 190). Payment not only shapes how the healthcare system is organized, but the structure of the system also affects the types of payment methods used (Roberts et al., 2008). When financing organizations, such as governments or insurance plans, have direct ownership and control over service providers, including hospitals, common payment models can include "global budgets for hospitals or having doctors on salary" (Roberts et al., 2008, p. 191). In contrast, where financing organizations and service providers function independently and interact at "arm's length," payment models like fee-for-service or capitation tend to be more suitable (Roberts et al., 2008, p. 191). Policy decisions regarding payment are profoundly political (Roberts et al., 2008). The negotiation of payment rates is often a major point of contention

between the organizations paying for services and those providing them (Roberts et al., 2008). Providers want to maximize their income aiming for the highest possible payment rate while payers seek to keep payments low to reduce their expenditures (Roberts et al., 2008).

### Health Professional Payment

Healthcare professionals, who mainly work in the not-for-profit sector, are subjected to a "particular power relationship between labour and capital" (Bourgeault & Grignon, 2013, p. 203). They may receive compensation through various payment structures: wages (i.e., payment for the time worked); fees (i.e., payment for each service delivered); or capitation (i.e., payment for each patient enrolled) (Bourgeault & Grignon, 2013). In both Canada and Australia, healthcare providers are largely paid through the fee-for-service (FFS) payment scheme. This form of remuneration encourages providers to increase the volume of services they perform (Roberts et al., 2008). It does not incentivize providers to select "healthier patients," rather it may incentivize the selection of patients requiring more care (Roberts et al., 2008, p. 197). With FFS, providers are not at financial risk for the costs of treatment; instead, the financial burden falls entirely on the payer (i.e., the insurer or patient) (Roberts et al., 2008). The establishment of the NHS in England divided the medical profession into two groups: salaried employees, including hospital specialists and doctors in training, and independent contractors, such as GPs (Greengross et al., 1999). In England, capitation payments represent the majority of funding received by general practices (L'Esperance et al., 2019). Capitation payments are determined on a per-person basis (Roberts et al., 2008). It involves a set fee[33] paid to a GP for each patient enrolled with them for the month, irrespective of the amount or type of services the patient may need or receive (Roberts et al., 2008). Capitation payments shift the majority of financial risk

[33] This fee can be adjusted based on factors such as patient's age, gender, and overall health condition (Roberts et al., 2008).

onto the providers (Roberts et al., 2008). Subsequently, providers might opt to take on only healthier and less complex patients, a process referred to as "risk selection" to reduce their risk exposure (see Table 4 in Appendix A) (Roberts et al., 2008, p. 199).

**Evidence for Integrated Care**

Need is the strongest predictor of mental health service use, with the primary care medical system being the most frequently accessed service (Vasiliadis et al., 2005). While other community-based mental health services and supports are available, the lack of adequate coordination and integration across health sectors and between health services presents obstacles to their accessibility (Rush & Saini, 2016). Access to services is therefore more than just ability to "enter the healthcare system" but includes dimensions of approachability, acceptability, availability and accommodation, affordability, and appropriateness, all from a person-centered perspective (Rush & Saini, 2016, p. 14). Central to a person-centered approach to care and support is co-design between healthcare providers and the individual so to ensure the delivery of personalized care that meet the needs of the individual while improving system efficiency and effectiveness (Santana et al., 2018). Collaboration, in its most basic sense, has naturally existed between GPs and specialists via communication over patient consultations (Lesage et al., 2006).

The prevailing perspective on integration emphasizes person-centered care, focusing on addressing the "whole-person needs" (Lillrank, 2012, p. 9). Needs, however, can be shaped by personal preferences, resource availability, and expectations (Lillrank, 2012). Fulfilling all needs is infeasible due to constraints like financial resources, limited clinical understanding, and willingness of patients (Lillrank, 2012). Still, the foundation of integrated care should be centered on the person or community group, around which a tailored and coordinated micro-system of care is developed (Lillrank, 2012). Globally, health systems are perceived as being in a

state of crisis, facing several constraints (Lillrank, 2012). Constraints include limited resources where more funding does not necessarily resolve issues; a heightened demand for equitable access, which has turned healthcare into a "high-volume industry" in need of "mass production efficiencies;" and advancements in clinical medicine that promote increased specialization, resulting in further fragmentation of services (Lillrank, 2012, p. 9). While coordinated access does not "create new resources or address the potential problem of inadequate capacity" it can improve "understanding among partners of what resources are available" (Rush & Saini, 2016, p. 85). In 2005, shared care in Canada, involving collaboration between a mental health specialist and a family physician accounted for 31percent of Medicare usage (Vasiliadis et al., 2005, p. 617). Collaborations between family physicians and psychologists have also been linked with high satisfaction rates among patients and family physicians and have led to improvements in patient care and reductions in mental health billing by family physicians (Chomienne et al., 2011).

The integration of care is critical in addressing the differentiation and fragmentation that stem from advancements in medical science and the diversification of health needs (Lillrank, 2012). Integration involves combining various inputs to gain an "understanding of a patient's situation, which enables the development, coordination, monitoring, and re-integration of a care plan" (Lillrank, 2012, p. 11). Some contributors in the care process may need to adjust and align with the collective goal (Lillrank, 2012). However, efforts to integrate can sometimes devolve into struggles for organizational dominance (Lillrank, 2012). Care integration at varying levels thus requires distinct leadership styles and tasks (Dickinson & Smith, 2021). System-level integration involves political leadership, as leaders must navigate through a complex network of diverse organizations and institutional agencies with differing goals and motivations (Dickinson

& Smith, 2021). At the meso-level, which centers on professional and organizational integration, leaders must advocate for integrated work practices, motivating various professionals to collaborate in new ways that also serve their interests (Dickinson & Smith, 2021). At the micro-level, the aim is clinical integration, organizing services around the specific needs of individuals (Dickinson & Smith, 2021). The success of care integration is evaluated based on its impact on health outcomes, while the effectiveness of organizational integration at a broader scale is measured by how well it fosters and maintains integration at the individual care level (Lillrank, 2012).

### *State of Integrated Care Across States (up to roughly 2010s)*

#### Canada

In Canada, the structure for coordinating health and social care services is established by each individual province and territory (Mossialos et al., 2016). For example, in Ontario, a single ministry was responsible for the administration of health and long-term care, with funding allocations distributed to the regional level (Mossialos et al., 2016). The Ministry of Health and Long-Term Care (MOHLTC) established LHINs under the *Local Health Systems Integration Act* (2006), to enhance the coordination of healthcare and service accessibility (Office of the Auditor General of Ontario (AGO), 2008). The MOHLTC, beginning in 2007, also provided funds for Community Care Access Centres (CCACs),[34] responsible for coordinating in-home and community-based care, such as supportive housing, community support workers, psychiatric nurses, occupational therapists, and case managers (SeniorAdvisor, 2022; eMentalHealth, 2015). LHINs oversaw various health sectors, including CCACs and community mental health agencies (AGO, 2015). However, the 2015 annual report by the Auditor General of Ontario, found that,

[34] CCACs are now known as Home and Community Care Support Services (since April 2021); services previously provided by CCACs stayed the same.

since their inception in 2006, LHINs "have not been consistently assessing" whether their services have been effective in promoting a more efficient and integrated health system (p. 317).

The Standing Committee on Social Affairs, Science, and Technology (2004a) observed that current reforms in primary healthcare were happening separately from the changes being made to the mental health systems within communities throughout Canada. The lack of seamless integration with primary care obstructs physicians' ability to facilitate access to a comprehensive system of community-based mental healthcare (Wiktorowicz et al., 2020). The Committee was informed about shared mental healthcare initiatives throughout the nation, originating from collaborations between the College of Family Physicians of Canada and the Canadian Psychiatric Association, which have been demonstrated to be successful (Kirby & Keon, 2004a). Additional findings suggest an income-based inequity in accessing psychiatrists, with the highest usage rates within the highest income quintile in Toronto, compared to elsewhere in Ontario, where psychiatric access is generally more common among lower income levels (Bartram, 2019b). The push for healthcare regionalization without a corresponding strategy for mental healthcare negatively impacted the integration of the system (Wiktorowicz et al., 2020). Decentralizing the management of mental healthcare services to regional authorities was considered a "missing critical step in the formation of Ontario LHINs" (Wiktorowicz et al., 2020, p. 7).

**England**

GPs have a contractual obligation to coordinate care and work in multi-partner practices that include nurses and other clinical care providers (Mossialos et al., 2016). These practices function similarly to a "medical home"[35] by directing individuals to appropriate specialists in hospitals or to community-based health professionals, such as community nurses and

[35] The medical home model describes a model of primary care that is patient-centred, team-based, coordinated, and accessible (primary care collaborative, 2022).

occupational therapists, and by maintaining comprehensive treatment records (p. 55). The 2012 *Health and Social Care Act*, mandated NHS England, Monitor, and CCGs to foster integrated care, by strengthening connections between hospital-based and community-based services, including primary care and social services. The health and well-being boards set up within local authorities, are also tasked with fostering integration between NHS services and local authority provisions, particularly at the juncture of hospital and social care services.

#### Australia

Integration within the National Mental Health Policy (1992) relates to the connections between mental health services within the broader healthcare system (Whiteford et al., 1993). The concept of integration, together with the mainstreaming approach, promotes the establishment of comprehensive services that are regionally based to ensure that individuals have access to necessary care within their communities (Whiteford et al., 1993). Similar to Canada, state governments in Australia manage their own health departments and have delegated the management of hospitals to Local Hospital Networks (LHNs) (Mossialos et al., 2016). LHNs have a mandate to collaborate with Primary Health Networks (PHNs) (Mossialos et al., 2016). PHNs were established, under the Turnbull liberal and national coalition federal government, in 2015, and are overseen by a board of medical professionals and advised by both a clinical council and a community advisory committee (Healthdirect, 2024a). PHNs aim to foster care integration by improving links between local health services and hospitals (Healthdirect, 2024a).

### Use of Levers to Improve Primary Mental Healthcare Integration (up to roughly 2010s)

#### *Canada*

The traditional model of professional regulation in healthcare is based on "separate statutes and exclusive scopes of practice for each profession" (Leslie et al., 2021, p. 5). However,

"there has been a trend to move away from this model towards umbrella frameworks characterized by overlapping scopes of practice" (Leslie et al., 2021, p. 5).

In 1996, the DHCs in Ontario offered a set of strategic recommendations to reform the mental health system, drawing insights from both the Ministry of Health and broader policy community (CMHA, 2004; Wiktorowicz, 2005). The DHCs proposed strategies such as "joint networks," "joint protocols," and "tracking with a clear point of access into the system" (CMHA, 2004). The DHCs also recommended that the mental healthcare system offer a "continuum of services" and provide models of service delivery based on "best practices" (CMHA, 2004). Ontario's Ministry of Health, reluctant to relinquish control to regional health bodies, preferred instead to incentivize system integration through financial mechanisms like the CIF (Wiktorowicz, 2005). Although the CIF incentivized inter-organizational collaboration, without a regional governance structure, the outcomes varied; smaller urban networks experienced some development, while rural and larger metropolitan networks did not progress as much in the absence of unified leadership (Wiktorowicz et al., 2010).

In 1997, the College of Family Physicians of Canada and the Canadian Psychiatric Association released their vision for shared mental healthcare within the nation (Kates et al., 1997). This vision laid the groundwork for further collaborative activities, including the establishment of the Canadian Collaborative Mental Health Initiative, which received funding through Health Canada's Primary Health Care Transition Fund (Kates et al., 2011). Integration of mental health services into primary care became an integral component of service design, endorsed as a means to improve access to person-centered care (Kates et al., 2011). In Ontario, legislative revisions were made to the *Regulated Health Professions Act* (RHPA)[36] (1991) to

[36] The *Regulated Health Professions Act* (RHPA) (1991) is the legislation that governs Ontario's regulated health professions' colleges (Government of Ontario, 1991).

facilitate interprofessional collaboration, evidenced by the *Health System Improvements Act* of 2007 and the *Regulated Health Professions Statute Law Amendment Act* of 2009 (Government of Ontario, 1991; 2007; 2009). This latter Act (2009), concerning the "performance of shared controlled acts,"[37] allowed scopes of practice to overlap, thereby promoting interprofessional collaboration by enabling different professions to perform shared controlled acts (Kates et al., 2011, p. 1). Despite the existence of some collaborative practices on shared controlled acts among health regulatory colleges in Ontario, pre-existing legislation like the *Public Hospitals Act*[38] of 1990 posed barriers to the full realization of collaborative care models (Kates et al., 2011). The gap between the intention of the amended legislation and the government's expectations from regulatory colleges was marked by a lack of clear, quantifiable goals related to the sharing of controlled acts (Kates et al., 2011). Furthermore, Ontario's mandate in legislating the regulatory bodies' to collaborate was criticized as being superficial, creating "the form" of collaboration without "the substance" (Kates et al., 2011, p. 5). As a result, the revisions to the RHPA were perceived as a "missed opportunity" to foster collaborative care (Kates et al., 2011, p. 5).

Primary care settings, within the framework of OHIP, have been purposively restructuring their care systems to better align with local health needs. In Thunder Bay, Ontario, the introduction of a shared care model, co-located at a primary care site, led to a significant reduction in wait times for mental health services, offering services more than 40 days sooner than the four pre-existing care sites (Haggarty et al., 2011). Compared to the non-shared care sites, the shared care site involved psychiatrists and physicians working together, presenting an

[37] Controlled acts are defined by the RHPA (1991), as specific activities that may pose a risk to the public if not performed by a qualified practitioner (Kates et al., 2011).
[38] The *Public Hospitals Act* (Ontario) (1990) provides regulations within which public hospitals operate (Government of Ontario, 1990).

"intermediate level or step of care between the primary care provider and the traditional outpatient mental health system" alleviating pressure on existing care providers (Haggarty et al., 2011, p. 32). In Toronto's Parkdale, a neighborhood with a deep connection to Mad history, the West End Shared Care pilot, initiated in 2009, has been actively addressing disparities in access to psychiatric care (Coriandoli, 2014). The program, initiated by the then-new Chief of Psychiatry at St. Joseph's Health Centre, involves a partnership with three Community Health Centres (CHCs)—Four Villages, Stonegate, and Lakeshore Area Multi-Service Project (Coriandoli, 2014). This initiative features psychiatrists dedicating blocks of three hours, two to three times a month, for mental health assessments and consultations at the CHCs (Coriandoli, 2014). This setup not only allows for psychiatric evaluations in a familiar setting, where people accessing the centres already have relationships with care providers, but also significantly reduces wait times to see a psychiatrist (Coriandoli, 2014). The initiative strengthens information exchange and support, by allowing psychiatrists to see how primary care operates in the community and the challenges it faces (Coriandoli, 2014). Both the Thunder Bay and West End Shared Care initiatives tailored their interventions to contextual factors that impact inequities in accessing care. However, consistent funding continues to be a major limitation of shared care models within primary care settings.

***UK***

While the introduction of a purchaser/provider split transformed relationships between regional health authorities and hospitals, the implementation of GP Fundholding (GPFH) reshaped the structure and functioning of GPs (see Figure 3.1. in Appendix B) (Kirby & Keon, 2004b). Before the restructuring in 1991, the UK NHS primarily operated through public entities known as (district) health authorities (Harrison & Choudhry, 1996). These bodies were

responsible for the local distribution of public healthcare funding and the direct management of health services, which included hospitals, clinics, and home care services that were publicly owned and operated (Harrison & Choudhry, 1996). The structure of primary medical care was somewhat separate from the district health authorities, as GPs, who were and remain self-employed, received their remuneration from public funds (Harrison & Choudhry, 1996). In the restructured system, health authorities were assigned a specific geographic population and allocated budgets to procure health services for these populations (Harrison & Choudhry, 1996). However, they no longer directly managed hospitals and other services; this responsibility was transferred to NHS Trusts (Harrison & Choudhry, 1996). Contracts between health authorities, as purchasers, and Trusts, as providers, defined the services to be purchased at the agreed prices (Harrison & Choudhry, 1996). This arrangement limited the referral autonomy of GPs, as referrals had to align with the contractual agreements established by the patient's local health authority (Harrison & Choudhry, 1996). As a result, GP Fundholding (GPFH) was introduced by the government as a voluntary purchasing scheme (Harrison & Choudhry, 1996).

GPFH allowed general practices the ability to manage a deducted budget from the health authority in whose jurisdiction they were situated for the purchasing of a limited range of services directly from Trusts or the private sector (Harrison & Choudhry, 1996; Greengross et al., 1999). Due to the inability of a single general practice to sufficiently spread the financial risk associated with its spending obligations, a "stop loss" mechanism was in place, capping a practice's expenditure at £6,000 for any one patient in a year (Harrison & Choudhry, 1996). Should costs exceed this threshold, the excess was absorbed by the corresponding health authority (Harrison & Choudhry, 1996). Additionally, GPFHs were allocated separate budgets for prescriptions and staff, with the flexibility to reallocate funds between these categories

(Harrison & Choudhry, 1996). Any savings achieved in the general practice, prescription or staffing budgets could be reinvested by the practice, subject to specific conditions, for development purposes, such as enhancing facilities, hiring additional personnel, or introducing new services (Harrison & Choudhry, 1996).

During 1991-97, the Labour Party in the UK, consistently pledged to dismantle the GPFH scheme, should they be elected to office (Kay, 2002). They argued that "the scheme had created a 'two-tier' NHS" (p. 141). Fundholding practices, as opposed to non-fundholders, had the autonomy to manage their own secondary care contracts, choose providers and services, determine the allocation of funds among patients, and retain any financial surpluses they produced. Conversely, for non-fundholding practices, it was the local health authorities that established healthcare priorities for patients. In 1995, fundholding was expanded through the establishment of three distinct forms: standard, community, and total. The standard fundholding option was a broadening of the current system to include specialist nursing services, elective surgeries, and outpatient care. The community mode aimed at smaller practices and included a budget for staffing, pharmaceuticals, diagnostic testing, and most community health services. Total fundholding was the most comprehensive, including all hospital and community health services, staffing, and prescription costs. Total fundholding was initially trialed, signaling a departure from the Conservatives' earlier direct and big-bang approach that characterized the initial rollout of GPFH in 1991. This shift indicated a new Conservative healthcare policy strategy that favoured a more cautious, piloted, and incremental implementation.

In 1997, the Blair Labour Party came to power and suspended new admissions into the fundholding scheme in May of that year (Kay, 2002). Hospitals were also mandated to unify waiting lists, eliminating distinctions between fundholding and non-fundholding patients,

streamlining access to care (Kay, 2002). During its first six months in term, the government released a White Paper, "*The New NHS: Modern, Dependable*" with proposals for a replacement, which led to the passage of the 1999 *National Health Service Act* that dismantled the GPFH scheme and established Primary Care Groups (PCGs) (Health Act, UK Public General Acts, 1999; Kay, 2002, p. 143). This reinstated the big-bang approach to healthcare policy that was characteristic of the fundholding introduction in 1991 (Kay, 2002). PCGs were implemented without a pilot program nor was the fundholding scheme evaluated before its discontinuation (Kay, 2002). Each PCG was provided with a defined budget for hospital and community health services, prescriptions, and GP infrastructure for their patient population (Kay, 2002). PCGs only lasted for a year or two, as a shift in policy mandated the amalgamation of the commissioning functions of PCGs with the provision of community services, giving rise to Primary Care Trusts (PCTs) directed by Chief Executives (Dixon, 2012). This was a departure from the clinician-led structure of PCGs (Dixon, 2012). PCTs, however, encountered challenges in maintaining engagement with their clinical leaders and struggled with the dual responsibilities of service provision and commissioning (Dixon, 2012). In response, the "transforming community services" initiative led to the divestment of community services from PCTs to other providers, primarily acute service providers, Mental Health Trust providers, and Foundation Community Trusts (Dixon, 2012, p. 217). During this period, there was also some attempt to restore clinician involvement via practice-based commissioning (Dixon, 2012). Following the *Health and Social Care Act* in 2012, Clinical Commissioning Groups (CCGs) were established and came to replace PCTs in 2013 (see Figure 3.2. in Appendix B) (Charlton, 2013). Unlike the fundholding initiative, every GP practice in England is mandated to operate within a commissioning group (Charlton, 2013). CCGs receive funding from NHS England and are responsible for the

organization and commissioning of healthcare services, which can be sourced from either NHS hospitals or private providers, for their local areas (Charlton, 2013; Mossialos et al., 2016). Commissioning faces challenges, however, in prioritizing the needs of patients above the constraints of organizational structures (Charlton, 2013).

In 2007, England's Department of Health released its progress report in April titled *Mental Health: New Ways of Working for Everyone*, followed by the release of its corresponding implementation guide in October of that year. The progress report recognized that despite the involvement of various professional groups throughout the full range of mental health services, a shared goal had emerged among all: to determine ways for working flexibly within a team framework (Department of Health, 2007a). The New Ways of Working (NWW) initiative promoted shared responsibilities among team members, moving away from a model in which decision-making concentrated under a single profession (Department of Health, 2007a). The goal was to create a "cultural shift in services" wherein "those with the most experience and skills" work directly "with those with the most complex needs" (Department of Health, 2007a, p. 14). Concurrently, the initiative involved enhancing the capacity of other care providers to perform "less complex or more routine work" (Department of Health, 2007a, p. 14). The NWW initiative broadened the scope of practice among qualified staff and facilitated entry for new staff to join the team at different levels, encompassing roles such as primary care mental health workers[39] and assistant practitioners (Department of Health, 2007a). In October of 2008, the Improving Access to Psychological Therapies (IAPT) program was implemented, working closely with the other NWW project groups (Clark, 2019; Department of Health, 2007a). The Workforce Group

[39] The NHS plan of 2000 established a goal to train 1,000 new graduate primary care mental health workers by December 2004, to support GPs manage and treat people experiencing 'common' mental health issues (Kirby & Keon, 2004b).

of the IAPT program dedicated efforts to define the cognitive behavioural therapy (CBT) skills essential for therapists operating within a stepped care model (Department of Health, 2007a). The structure of the program includes highly skilled therapists qualified to administer "high-intensity interventions within a stepped care model," alongside practitioners who may be less qualified but are still able to provide "low-intensity" support, such as case management, employment coaching, CBT, and guided self-help (Department of Health, 2007a, p. 134). Although there have been numerous initiatives to implement NWW within the NHS, progress in workforce reform has been relatively limited compared to the growth in staffing levels and salary increases (Select Committee on Health, 2007). Furthermore, these reform efforts have been regularly undermined by the "repeated changes to organizational structures" (Select Committee on Health, 2007, chapter 2, section 75.)

***Australia***

Throughout the four National Mental Health Plans released in 1992, 1998, 2003, and 2008, a significant emphasis was placed on transforming the configuration of services by integrating mental health services into the broader healthcare system (Grace et al., 2015). Changes were implemented that included the closure and transfer of acute admission beds from psychiatric institutions to general hospitals. Management of mental health services was also integrated into general health services. The funds saved from deinstitutionalization were allocated for the development of community-based services at both the federal and state/territory levels. Various strategies were also employed to enhance the coordination of care for people across different service providers and jurisdictions. Legislative amendments served as a regulatory mechanism to establish "joint protocols between service providers across service sectors," facilitating coordinated care (p. 7). Case managers and facilitators were also introduced

to facilitate care coordination across various service providers and to expand the capacity of "step-down"[40] facilities (p. 8).

In July 1998 the Practice Incentives Program (PIP) was introduced as part of the Medicare Benefits Scheme (MBS) (Australian National Audit Office (ANAO), 2010). PIP provides financial incentives to GP practices and their GPs and is designed to augment the fee-for-service payments from the MBS which "reward high volume, brief consultations" (ANAO, 2010, p. 15). The incentives are designed to motivate practices to offer after-hours care, establish systems for secure electronic patient information exchange, and formulate care plans for individuals with conditions like diabetes and with mental health needs (ANAO, 2010; Mossialos et al., 2016). Between 2008-2009, 82 percent of GP care was delivered through PIP practices (ANAO, 2010).

In July 2001, the Better Outcomes in Mental Health Care (Better Outcomes) initiative was established to enhance access to primary mental health services (Henderson & Roberts, 2020). The initial phase of reforms granted GPs the ability to bill Medicare for psychological treatments and to refer individuals experiencing mental distress to psychologists and social workers (Henderson & Roberts, 2020). In November 2006, the Better Outcomes initiative was extended through the Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access) under the MBS, with an emphasis on improving referrals between primary and secondary healthcare providers (Henderson & Roberts, 2020; Grace et al., 2015). The Better Access initiative enabled psychologists, social workers, and occupational therapists to bill their services through the MBS following a GP's referral (Henderson & Roberts, 2020). According to

[40] In the context of the stepped care model, step-down services refer to subacute services or prevention and recovery services that bridge the transition from hospital-based inpatient care to clinical, community-based mental healthcare (Ngo et al., 2020).

Medicare data from the 2009-10 financial year, mental health comprised 11.4 percent of GP consultations, with symptoms for depression and anxiety the most addressed concerns (Henderson & Fuller, 2011). There was also a notable rise in claims for allied mental health services, with 3.9 million claims filed, in the 2007-08 period (Henderson & Fuller, 2011). However, beginning in July 2010, the MBS discontinued its support for social work and occupational therapy services (Henderson & Fuller, 2011). Subsequently, the 2011 Budget decreased the number of sessions available through the Better Access initiative and diminished Medicare rebates for GP mental health planning (Henderson & Fuller, 2011). The strategic shift aimed to concentrate resources through Medicare Locals[41] and non-governmental organizations (NGOs), focusing on individuals with limited access to services, particularly those suffering from severe, ongoing mental health issues that require multi-agency care management (Henderson & Fuller, 2011).

Under the Medicare Agreement Acts[42] 1993-1998, mental health, for the first time, received a dedicated allocation separate from other health services (Grace et al., 2015). This resulted in the creation of a specific mental health budget and an increase in ongoing mental health expenditure. From the second National Mental Health Plan (1998) onwards, earmarked funding was directed at enhancing mental healthcare for individuals living in rural or remote areas and among Indigenous Australians. Reforms expanded the delivery of services to rural and remote communities by establishing telephone services and an e-mental health portal, which offers access to online mental health resources. A 24/7 mental health telephone service has also been integrated with the National Health Call Centre Network, with these reforms being

[41] Non-profit companies principally funded by the Commonwealth government.
[42] The Medicare Agreement Acts set the terms for federal funding to states and territories, contingent on their provision of public hospital services (Grace et al., 2015). The first agreement lasted until 1998, with each subsequent agreement spanning a duration of five years.

supported by dedicated funding for NGOs to provide these services. This was supplemented by the development of supportive payment models, including additional MBS items for services like tele-psychiatry. The second Plan also increased government funding to NGOs for the provision of daily supports and employment or vocational services for people experiencing mental distress. The growth in federal support for NGOs within the mental health sector reflected a growing acknowledgment of the critical role these services play in addressing 'consumer' needs. This transition can be linked to the lobbying efforts of the Mental Health Association[43] and other organizations, which advocated for greater NGO participation in mental healthcare.

**Expanding on (Psychological) Initiatives Complimenting Primary Care**

Collaborative care models emphasize a "holistic approach" to individual health, ensuring integration of mental and physical health services while also addressing the interplay between them (MHCC, 2018, p. 26). Although research has highlighted the cost-effectiveness[44] of psychological therapies (Chiles et al., 1999; Hunsley, 2003; Hunsley et al., 2013), they received much less attention than pharmacological interventions for mental distress. Dominant neoliberal values, which prioritize profit and short-term financial gains, at the expense of long-term savings, continue to grant the pharmaceutical industry power to commodify health. Regulatory and financial mechanisms in primary care, although beneficial for enhancing access to psychological therapies, are limited by a physician-centric model. This model fails to extend access to non-physician mental health professionals not covered by public insurance, overlooks the general lack of psychotherapy training among physicians, compounds existing referral

[43] Since its establishment in 1999, the Australian & New Zealand Mental Health (ANZMH) Association has served as a not-for-profit, NGO focused on uniting and supporting mental health workers (ANZMH, 2024).
[44] Psychological therapies cost less than one-third of pharmacotherapy and can offset medical costs associated with use of hospital services and medication (Chiles et al., 1999; Hunsley, 2003). They are also evidenced to be just as effective as pharmacotherapy and more effective in preventing rates of relapse (Hunsley et al., 2013).

challenges to psychiatrists and mental health services due to shortages, and exacerbates the pressures on an already strained healthcare system, particularly in rural and remote areas with limited primary care (Scharf & Oinonen, 2020).

While Better Access in Australia and IAPT in England included engagement with GPs and primary care, neither model prioritized collaborative primary healthcare as the central strategy for enhancing access to psychotherapy (MHCC, 2018). The MBS Better Access initiative, in Australia, is an insurance-based approach that extends public insurance coverage, via Medicare, to include psychotherapy services offered by psychologists, social workers, and occupational therapists (Bartram, 2019a). The Better Access initiative is supplemented by a smaller budget of federal funds designated for other services such as Access to Allied Psychological Services – a grant-based program aimed at supporting low-income individuals and a series of internet-based CBT programs accessible through a central digital mental health platform (Bartram, 2019a). Funded through grants, IAPT operates with a dedicated staff and adheres to specific standards, centrally managed by NHS England (Bartram, 2019a). Services under IAPT are provided at no cost to the user and are delivered by practitioners who received specific IAPT or approved training (Bartram, 2019a). The program employs a stepped-care approach, prioritizing lower-intensity interventions, such as online CBT-based self-help resources and psychoeducation groups, with the option for required face-to-face therapies (Bartram, 2019a). This tiered model of care aims to efficiently allocate resources by matching the level of intervention to the severity of needs (Bartram, 2019a). In contrast to IAPT's centrally controlled approach, Better Access adopts a more "hands-off reliance on professional self-regulation" (MHCC, 2018, p. 2).

In Canada's decentralized healthcare context, both IAPT's grant-based system and Better Access' insurance-based approach could be implemented as "provincial and territorial governments have both sets of policy levers" (MHCC, 2018, p. 2). The initiatives however are not without their challenges. In the UK, disparities in the IAPT service quality are apparent, with indications of lower performance levels in socio-economically deprived areas (Bartram, 2019a). Similarly, in Australia, the distribution of Better Access services tends to be uneven, with a lower uptake in socio-economically disadvantaged areas and a higher concentration in urban areas (Bartram, 2019a). Further assessment of the Better Access initiative indicates a discrepancy between the number of care plans created and the reviews conducted, hinting at a shortfall in the intended collaboration between GPs and mental health service providers (Jorm, 2011). Still, Canada, delayed increasing funding to improve access to mental health services until the 2017/18 federal budget.

**Expanding on the Policy Network Concept and Role for Shared Governance**

Services must adapt to people's needs and not vice versa (Penzenstadler et al., 2020). Fundamental to the person-centered approach is ending healthcare silos and coordinating care around needs through integration. Mental health services alone, however, are not enough to secure personalized, comprehensive, and right-based care (WHO, 2021). It is imperative to integrate with social sector services, including community-based supports that provide for the diversified needs of people, especially people living in poverty, without housing, education, and opportunities to generate an income (WHO, 2021). The concept of policy networks is rooted in inter-organizational theory, which emphasizes the mutual dependence of actors who require each other's resources to fulfill their objectives (khaje Naieni, 2016). These actors come together over policy issues, sharing information, expertise, and political support (khaje Naieni, 2016). The

formation of such networks is influenced by the distribution of political influence and resources among the private and public sectors (khaje Naieni, 2016). Unclear management and governance frameworks between member organizations in a policy network, can create "complexity and confusion in the healthcare system" (Akmal & Gauld, 2021, p. 242). This can result in situations where member organizations are uncertain about their obligations to the alliance and to one another (Akmal & Gauld, 2021). Since organizations are funded to perform services, their primary focus becomes fulfilling their organizational objectives rather than those of the alliance (Akmal & Gauld, 2021). As the scope of integrated mental healthcare networks widens across the states, the implementation of shared governance structures is critical. These mechanisms foster leadership and accountability and enhance the capacity of governments to catalyze collaboration between the different organizational entities.

**Conclusion**

This chapter explored the policy levers of regulation and payment used by the states to shift their service system designs towards more integrated care models. During the 1990s, and the onset of the 2000s, the focus was on improving coordination within primary care. By the end of 2010, the UK and Australia had established initiatives aimed at improving access to psychological therapies via allied mental health providers. A growing emphasis on care integration shifted to strengthening links with community-based care, fostering networks that bridge health and social services under a shared governance structure. This chapter concludes Part One of the dissertation, which explored the historical use of policy levers among the three states focusing on government structures and governance (Chapter One); financing and service system designs (Chapter Two); and regulation and payment models (Chapter Three). Part Two of the dissertation will employ a human right framing for care integration, delving into various

legislative barriers to the right to care. The policy levers, explored in Part One, will be examined through the most recent decade (post-2010) across the states. Paramount to Part Two will be the impact of the various reforms on policy communities, including their perspectives in directing care needs.

## Chapter 5: Human Rights and Policy Trajectories

The transition towards integrated care frameworks in mental health has been guided by a history of well-intentioned policies. However, as the 2010s unfolded, a discrepancy became evident: policy narratives were increasingly recognizing the significance of Social Determinants of Health (SDoH)[45] and the complex interplay of social inequalities,[46] yet the practical implementation within mental health systems often maintained the persistence of inequities in mental health. This chapter is concerned with institutional changes that occur between policy interpretation and enforcement. Feedback from policy communities is instrumental in assessing the impact of mental health reforms. The shift towards integrated care and the shock of a global pandemic further impacted institutional changes, highlighting governmental shortcomings in upholding human rights standards in delivering mental health services that are acceptable to populations. The chapter will begin by exploring legal mechanisms for care and the entrenchment of harmful practices protected under mental health law. It will then analyze the strategic policy levers employed by the states to steer the evolution of mental health reform. This chapter comprises Part Two of the dissertation. Part Three will assess and contrast the policy levers and trajectories pursued by the three states.

### Mental Health as a Matter of Human Rights

Individuals with lived experiences of mental distress, alongside their support networks, have been urgently advocating for "system transformation" (Mental Health Australia

[45] The SDoH framework links the unequal distribution of resources (i.e., income, housing, and access to services) to differences in health (Raphael, 2006). While the framework highlights how health outcomes are unevenly distributed across society, it is criticized for not fully addressing deeper structural determinants, stigma, and discrimination that accompany inequities in mental health (Josewski, 2017).

[46] Drawing on the work of Morrow (2017) and Josewski (2017), power dynamics are interpreted through the lens of Intersectionality, which considers the interplay of social difference, identity, and the broader context of structural oppression. Lived experiences of oppression, domination, or discrimination are shaped by these intersecting forces. The intersectional methodology provides attuned ways of contextualizing lived experiences of mental health injustices.

(MHAustralia) & National Mental Health Consumer & Carer Forum (NMHCCF), 2024, p. 4). The WHO and the UN echo this advocacy, emphasizing human rights violations and coercive practices prevalent in mental health systems and the critical need to adopt "more holistic ways of understanding and responding to psychological distress" (MHAustralia & NMHCCF, 2024, p. 4). In 1996, the WHO outlined ten principles for mental health law based on a comprehensive review of mental health legislation across 45 countries. The principles emphasize the provision of mental healthcare that is "least restrictive" and that any decisions impacting a person's integrity (i.e., treatment) or liberty (i.e., hospitalization) be subject to an automatic periodical review[47] (WHO, 1996). Moreover, the WHO and the Office of the High Commissioner for Human Rights reported evidence indicating that coercive practices in mental health, such as involuntary detention, forced treatment, seclusion, and restraints, "negatively impact physical and mental health, often compounding a person's existing condition while alienating them from their support systems" (2023, para. 9). These practices disproportionately affect marginalized populations who also face numerous forms of social exclusion (i.e., people without homes, living in poverty, or who are unemployed, lack safety, and access to education and health services) (Rose, 2019; Stanford et al., 2017).

### *Human Rights Legislation Across the States*

Mental health legislation, reflecting "societal values," is intended to balance individual rights and dignity with the protection of public welfare and the societal duty to assist those who are unable to support themselves (Kirby & Keon, 2004a, p. 17). Organized advocacy for the rights of people deemed Mad has roots going back to the 19th century in Europe, the United States, and across North America (Brückner, 2021; Sapinsley, 1991). Contemporary advocacy

[47] The automatic periodic review principle is threefold: reviews ought to occur automatically; at reasonable intervals (i.e., every six months); and a qualified authority in an official capacity should conduct the reviews (WHO, 1996).

groups for patients' rights began to form in 1970, with groups appearing in New York and Vancouver (Simmons, 1990). By 1987, 75 contemporary advocacy groups in North American had been established (Simmons, 1990). Advocacy groups for patients' rights emerged in 1970 in New York and Vancouver, and by 1987, 75 advocacy groups in North America had been established (Simmons, 1990). In the late 1970s in Ontario, former psychiatric patients formed the group On Our Own and initiated the publication of the quarterly *Phoenix Rising*[48] (Simmons, 1990). Along with other groups, such as the Patients' Rights Organization and People First, they began advocating for patient rights and challenging prevailing legislation (Simmons, 1990). The introduction of the Canadian *Charter of Rights and Freedoms* (Charter) in 1982 further stimulated legal interest in these issues (Simmons, 1990). Although individuals with psychiatric disabilities were not originally considered, the final phrasing of the Charter (1982) explicitly included "mental illness and disability" as categories protected against discrimination (Griffin, 1989, p. 250). This represented a significant achievement in the lengthy effort to gain societal recognition and acceptance for individuals experiencing mental distress (Griffin, 1989). In 1984, in response to concerns that existing mental health laws might be challenged under the Charter, a "Uniform Mental Health Act" was created by a working group convened by the Uniform Law Conference (Kirby & Keon, 2004a). This group, comprising a lawyer and a senior mental health official from each participating province and territory, sought to create a template for provincial mental health legislation (Kirby & Keon, 2004a). The Uniform Mental Health Act[49] was officially endorsed by the representatives of the Uniform Law Conference in 1987 (Kirby &

[48] The Phoenix Rising magazine operated from 1980-1990 and represented the voice of people who had been psychiatrized.

[49] The proposed Act centered around the following principles: prioritize voluntary over involuntary treatment with informed consent; ensure that involuntary treatment adheres to Charter standards; offer a range of appropriate treatments, favoring less restrictive options; uphold the confidentiality of medical records; grant patients access to their medical information; and require an independent body or court review when a person's rights and freedoms are affected by legislation (Kirby & Keon, 2004a).

Keon, 2004a). While the Act was not adopted uniformly across provinces and territories, many introduced laws to align with its core principles (Kirby & Keon, 2004a). For instance, the Ontario Human Rights Code (1990) safeguards equal rights and responsibilities without discrimination. However, substantial variations persist in the provisions of mental health laws across different jurisdictions (Kirby & Keon, 2004a).

The *Human Rights Act* (HRA) of 1998 established the fundamental rights and freedoms applicable to all individuals within the UK, integrating the provisions of the European Convention on Human Rights[50] (ECHR) into domestic law (Equity and Human Rights Commission, 2018). The Act was put into effect in the UK in October 2000 (Equity and Human Rights Commission, 2018). In its platform for the 1997 general election, the Labour Party promised to integrate the ECHR into British law (Labour Party, 1997). Following a sweeping victory in the election, the Labour government, led by Tony Blair, acted on this commitment by having parliament enact the HRA to "bring rights home" (UK Parliament, 2010, p. 84). The legislation faced criticism, however, characterized by some as a "criminals' charter" citing claims that it has been exploited by claimants (UK Parliament, 2010, p. 84). The Conservative party argued that the existing legislation fosters a culture of "risk aversion" among public authorities (UK Parliament, 2010, p. 84). A review sponsored by the government in 2006 found that the HRA had been "bedevilled by misconceptions" and at times "misapplied" (UK Parliament, 2010, p. 84). The government also recognized a number of "myths" about the HRA, entrenched in public perception (UK Parliament, 2010, p. 84). In 2007, the Labour government initiated consultations to expand upon the HRA with the aim of establishing a Bill of Rights (UK Parliament, 2010). The Bill of Rights was first presented to parliament in June 2022 (The Law

[50] The ECHR, which safeguards human rights and political freedoms across Europe, was enacted in September 1953 (https://www.echr.coe.int/european-convention-on-human-rights).

Society, 2024). It aimed to repeal and replace the HRA (1998) (The Law Society, 2024). The proposed Bill of Rights intended to diminish the degree of protection currently afforded to human rights (The Law Society, 2024). The legislation would have substantially reduced the capacity to utilize judicial processes to hold the government accountable for any breaches of human rights (The Law Society, 2024). By making access to legal recourse more challenging and constraining the extent of protection the courts could offer to individuals whose rights have been infringed, the Bill sought to constrain rights universally and diminish rights for specific groups of individuals (The Law Society, 2024). However, as of 27 June 2023, the government declared that it will not advance the Bill of Rights (The Law Society, 2024).

Initially, the Australian National Mental Health Strategy (1992) included three documents: the strategy alongside the Mental Health Plan, both released in 1992, and the *Mental Health Statement of Rights and Responsibilities*, first released in 1991 (Australian Health Ministers, 1991) and re-released in 2012 (Commonwealth of Australia, 2012). In 2006, Victoria enacted the *Charter of Human Rights and Responsibilities Act*, aligning itself with the Australian Capital Territory and Queensland as one of the few Australian states to adopt dedicated human rights legislation (Australian Human Rights Commission (AHRC), 2022). The Charter outlines the fundamental rights, freedoms, and duties applicable to all individuals within Victoria, and mandates that all current and future statutes be consistent with these principles (Charter of Human Rights and Responsibilities Act, 2006). However, the Charter has shown limited efficiency in curbing human rights breaches concerning mandatory treatment (Victoria Government, 2021). The Australian Human Rights Commission, created under the *Australian Human Rights Commission Act* 1986, is responsible for examining and mediating complaints concerning discrimination and violations of human rights (Parliament of Australia, n.d.). It also

lobbies the government to consider human rights into legislative and policy development, offers counsel, evaluates existing laws, and makes submissions to parliamentary investigations (Parliament of Australia, n.d.). In March 2023, the Commission officially launched its position paper outlining a proposal for a Human Rights Act for Australia (AHRC, 2023). This proposed Act represents a critical legislative component that is currently absent in Australia, aimed at guaranteeing that human rights are incorporated into the government's decision-making processes (AHRC, 2023). Following the release of the position paper, the federal Attorney General initiated an inquiry to assess the need for a new Human Rights Framework in Australia and to consider if such a framework should encompass a Human Rights Act (AHRC, 2023). The Parliamentary Joint Committee on Human Rights sought public feedback regarding the Commission's proposed model to inform potential reforms (AHRC, 2023). The inquiry led by the Parliamentary Joint Committee on Human Rights was scheduled to present its findings in March 2024 (AHRC, 2023). In its June 2023 submission to the inquiry, the Commission outlined a detailed plan for a new Human Rights Framework (AHRC, 2023). This plan includes the proposal for a national Human Rights Act, enhancements to the efficacy of federal discrimination legislation, increased Parliamentary scrutiny of human rights matters, improved educational initiatives on human rights, and a national framework for monitoring human rights indicators (AHRC, 2023).

***Convention on the Rights of Persons with Disabilities (CRPD)***

The adoption of the *Convention on the Rights of Persons with Disabilities* (CRPD) by the United Nations in 2006 marked a historic shift in areas of mental health law and practice (Kaiser, 2014). Ratified by Australia in 2008 (Henderson & Roberts, 2020), the UK in 2009 (UK Parliament, 2024b), and Canada in 2010 (Council of Canadians with Disabilities, 2011), the

purpose of the CRPD is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities [including psychosocial], and to promote respect for their inherent dignity" (UN General Assembly, 2007, p. 4). The Convention emphasizes the promotion of social inclusion by securing social, political, and economic rights, and advocates for the elimination of discrimination on the grounds of disability (Weller, 2010). This marks a departure from former conceptions of rights, which have been focused on minimizing governmental restrictions on the freedoms of people facing distress (Henderson & Robert, 2020).

Article 12 of the CRPD regarding legal capacity mandates that people with disabilities are afforded the same rights and freedoms as everyone else, encompassing both formal and substantive equality (Minkowitz, 2014). Formal equality acknowledges that the rights and freedoms of people with disabilities are the same as others, while substantive equality addresses their unique needs and secures the necessary accommodations to ensure that they can enjoy equal rights; both are a matter of law (Minkowitz, 2014). Explicitly adopting a social model of disability, "affirming disability as a human rights issue for state parties to address" (Hoffman et al., 2014, p. 62), the CRPD challenges involuntary hospitalization and substitute decision-making[51] aspects of mental health law (Chandler, 2016). Accordingly, Article 12 on legal capacity adopts a supported decision-making[52] model (UN General Assembly, 2007). Although, the participating states acknowledged the significance of supported decision-making, they have also expressed views that the Convention should permit substitute decision-making under

[51] Substitute-decision making involves mechanisms like advance directives and legally appointment advocates, where the guardian or representative holds the judicially granted authority to make choices on behalf of the person, without proving that these decisions align with the individual's best interest or wishes (Series & Nilsson, 2019).
[52] Supported decision-making is guided by the principle that the individual with a disability is the primary decision-maker, regardless of the support needed. The role of the support person is to facilitate the individual's ability to fully use their legal capacity in alignment with their own wishes (Series & Nilsson, 2019).

exceptional circumstances (Series & Nilsson, 2019). Canada ratified the CRPD with an interpretive declaration of article 12 to permit substitute-decision making (Series & Nilsson, 2019).

Comparative research has determined that mental health legislation in Australia tends to focus more on treatment, whereas certain Canadian laws lean more towards prioritizing a rights-based perspective (Davidson et al., 2016). Unlike Australian jurisdictions, some Canadian jurisdictions permit individuals to refuse treatment that might be necessary for their discharge (Gray et al., 2010). As well, Canadian Community Treatment Orders (CTOs) are more restrictive than those in Australia, as they require a person to have prior hospitalization, even if they meet the committal criteria (Gray et al., 2010). Yet, Canada still reserves the right to continue use of substitute decision-making in conditions where people are declared "mentally incapable" (Chandler, 2014, p. 21). Similarly, the *Mental Capacity Act* (2005), which outlines the procedures for substitute decision-making, produces added layers of complexities with mental health law in England (Davidson et al., 2016). In Australia, the Victorian Law Reform Commission (2012) has advised that the six distinct forms of substitute decision-making present within three laws in its jurisdiction be consolidated and integrated into a framework that involves supported decision-making (Davidson et al., 2016).

Compliance with the Convention on an international level is challenging due to the ambiguity present within the wording of the CRPD itself and its varied interpretations provided by the CRPD Committee (Dawson, 2015). Such ambiguity is evident in the context of involuntary psychiatric treatment, where there are "competing interests between defending individual autonomy and promoting social inclusion for vulnerable groups" (Dawson, 2015, p. 17). This brings into question whether a person, who is considered to lack capacity, retains the

right to exercise their autonomy (Dawson, 2015). To supplement the implementation of the Convention, the UN proposed an "Optional Protocol," which provides a mechanism for people with disabilities to report violations of the CRPD (Hoffman et al., 2016, p. 3). The UK adopted the Optional Protocol at the time of ratifying the CRPD (2009), while Australia incorporated it into national law the subsequent year (UN Treaty Collection, n.d.). Canada delayed the adoption of the Optional Protocol until December 2018, eight years after its ratification of the CRPD (UN Treaty Collection, n.d.). The ratification of the Optional Protocol is largely attributed to the disability community, which persisted in a lengthy campaign for its advocacy (Council of Canadians with Disabilities, 2016). The previous Conservative government chose not to ratify the Optional Protocol, arguing that the CRPD's commitments to equality and non-discrimination were already embedded within the Canadian *Charter of Rights and Freedoms* (1982), making specific legislation to incorporate the CRPD into domestic law unnecessary (Hoffman et al., 2016). Although it has not been fully taken up by governments, the CRPD instigated a significant departure from the medical model and its legacy of "paternalism and discrimination against persons with psychosocial disabilities towards inclusive equality" (Kaiser, 2009, p. 194). The impact of the CRPD on mental health law continues to "depend on the extent to which [it is] … domestically implemented and followed by state parties (Mitchell, Ring, & Spellman, 2013, p. 189).

### *Mental Health Acts*

Legal mechanisms, such as Mental Health Acts (MHAs), facilitate human rights violations and coercive practices by allowing involuntary confinement and treatment (WHO, 2021). The CRPD conflicts with contemporary mental health law because it expressly forbids detaining and treating individuals without their consent solely on the basis of disability (Kelly,

2014). The gradual privatization of mental health services, often not covered by public health systems, along with the shifting responsibility for care between institutions – emergency departments, criminal justice systems, and mental health hospital units – further complicate issues of equity and the invisibility of individual needs not addressed within the biomedical paradigm (Wiktorowicz, 2005). Mental Health Acts are usually guided by the principle of providing the best therapeutic outcomes for individuals through the least constrictive methods and settings (i.e., voluntary treatment options) (Henderson & Roberts, 2020). The Mental Health Acts also establish protocols for evaluation and protection in cases where involuntary care is necessary, including treatment orders administered in community settings, hospital inpatient care, or emergency crisis intervention (Henderson & Roberts, 2020).

In Canada, each province and territory has its own set of laws and regulations (Kirby & Keon, 2004a). The former Ontario Minister of Health and Long-Term Care, the Honourable Eric Hoskins, first introduced Bill 122 in the Ontario Legislature (CMHA, 2015). Titled, the *Mental Health Statute Law Amendment Act* (2015), the enacted legislation, modified the Mental Health Act (1990) to grant the Consent and Capacity Board[53] with greater authority regarding the criteria and length of treatment time for which an individual can be retained as an involuntary patient in a psychiatric institution (CMHA, 2015). These amendments bolstered the rights of patients, providing them with increased opportunities to challenge the grounds on which they are held involuntarily before the Consent and Capacity Board (CMHA, 2015). In response to the escalating detention rates and disproportionate application of the MHA among individuals from

[53] The board acts as an independent tribunal led by a full-time Chair. Hearing panels include a lawyer, a psychiatrist (or an extended class nurse or physician where allowed), and a community member. The board's primary responsibilities include conducting hearings to review a patient's involuntary status in a psychiatric facility under the Mental Health Act, 1990, and addressing capacity issues under the Health Care Consent Act, 1996, and the Substitute Decisions Act, 1992 (Government of Ontario, n.d.).

Black and minority groups, the British government initiated an examination of the MHA (2007) in October 2017 (UK Parliament, 2023). The white paper, titled *Reforming the Mental Health Act*, was released in January 2021 and was followed by a consultation period (UK Parliament, 2023). The government's formal response was issued in July 2021 and was followed by a draft Mental Health Bill in June 2022 (UK Government, 2022). The Bill underwent pre-legislative scrutiny by a Joint Committee from July to December 2022, with the Committee presenting its findings in January 2023 (UK Parliament, 2023). The department is still evaluating the Committee's suggestions with plans to present the Bill according to parliamentary schedules (UK Parliament, 2023). In Australia, commonwealth laws such as the *National Standards for Mental Health Services* (Australian Government, 2010) apply to each state, however, certain elements of mental health legislation are governed by each of the eight jurisdictions (Cronin et al., 2017). The Royal Commission into Victoria's mental health system, which was established in 2019, advised the Victorian government to repeal the MHA 2014 and institute a new *Mental Health and Wellbeing Act* (State of Victoria, 2022). The new MHA was passed by the Victorian parliament in September 2022 (State of Victoria, 2022). This Act (2022) incorporates specific provisions for supported decision-making and, for the first time, incorporates commitments to the autonomy of Indigenous people within the health statutes of the Victorian government (Department of Health, 2024a).

### Involuntary Treatment

Mental health laws provide "civil compulsory powers" to detain individuals in a sanctioned facility (Cronin et al., 2017, p. 262). Across each site, an individual may be subject to involuntary detention if they are suffering from a mental health or psychosocial condition that compromises their capacity to make decisions (see Table 5 in Appendix A) comparing criteria to

initiate an involuntary detention across the Ontario MHA (1990), England MHA (2007), and Victoria MHA (2014).[54] Individuals may also be detained in accordance with MHAs if they pose a risk to themselves or others. England and Victoria also have separate assessment and treatment orders compared to Ontario, which employs a single order for both admission and detention. The specific detention orders in England and Victoria dictate the terms and length of both detention and subsequent treatment. These orders include immediate emergency detention orders; short-term detention orders typically for assessment purposes; and long-term compulsory treatment orders. For instance, emergency detention orders in England involve only one medical practitioner for filing an application, and the detention duration is capped at 72 hours. Conversely, in Victoria, an assessment order can detain an individual for up to 72 hours, be extended by an additional 48 hours by the consultant psychiatrist, and be followed by a temporary treatment order. Although a need for treatment can justify involuntary admission in Ontario, it is not compulsory; unlike England, and Victoria, where treatment constitutes a criterion for issuing an assessment order, yet treatment requires consent unless it is assessed as immediately necessary. Similarly, Ontario explicitly requires the "lack of capacity" as a basis for detaining an individual; whereas England does not specify, and Victoria requires "impaired judgement." Ontario places greater emphasis on rights than on treatment, observed in the other two jurisdictions, employing capacity legislation instead of mental health legislation concerning treatment without consent. Prioritizing capacity in the context of medical treatment, highlights an individual's ability to make informed decisions, which "removes the dual focus of mental disorder and risk" for detention (p. 267). This capacity-based approach aligns with ethical

[54] Despite the release of updated MHAs in Ontario (2015) and Victoria (2022), the timelines concerning detention, assessment, and access to Mental Health Tribunals (MHTs) have remained unchanged across the respective jurisdictions.

principles across different areas of medical law, ensuring that physical and mental health treatment hold the same regard for patient autonomy and consent. Refusal of treatment, however, could lead to a longer duration of involuntary admission and may increase the likelihood of encountering more restrictive interventions, such as seclusion and restraint. For instance, under the *Health Care Consent Act* (HCCA)[55] (1996), if an individual chooses to appeal a decision regarding their treatment, they cannot be subjected to that treatment during the appeal process. This legal framework has resulted in scenarios where individuals remained detained for extended periods of time, reported in some cases for up to 20 years,[56] due to the legal requirement for consent prior to treatment.

Across the states, detained individuals must be notified and given information about their involuntary status as well as their rights to contest it. The mechanisms for reviewing involuntary admissions under mental health legislation differ between the states. In Ontario, a Mental Health Tribunal (MHT) review is automatic. In contrast, in England and Victoria, it is initiated upon the individual's request. The MHT plays a more significant role in Victoria in issuing treatment orders compared to England and Ontario. The timeline for a tribunal hearing differs as well, with Victoria conducting hearings within seven days, England within 14 days, and Ontario within 28 days. In England, individuals, with prior interactions with the mental health system, who are admitted to an acute psychiatric unit under a treatment order, may be detained for up to six months before a MHT review is automatically scheduled, although they have the option to request an earlier MHT session. In each site, MHT panels are comprised of three members. In England, the trio includes a psychiatrist, legal professional, and a medical professional, whereas

[55] The *Health Care Consent Act* (HCCA) (1996) safeguards individual rights to make medical treatment decisions.
[56] Cronin and colleagues (2017) reference research by Solomon et al. (2009), highlighting significant delays in the administration of treatment.

in Ontario and Victoria, the third member is a layperson instead of a medical professional. A MHT review can be conducted following the issuing of an admission order or a renewal order, with varying durations for subsequent orders. In Ontario and Victoria, the maximum duration of these orders is shorter – three months in Ontario and six months in Victoria. However, in England, an individual under a long-term compulsory treatment order can potentially wait up to three years for an automatic MHT review.

***Other Forms of Coercive Practices***

Several mental health laws authorize the use of restrictive interventions such as seclusion, tranquilization, and restraint (Cronin et al., 2017). The provision of Electroconvulsive Therapy (ECT)[57] to individuals detained under mental health laws requires sanctioned approval (Cronin et al., 2017). This approval must come from an "independent second opinion psychiatrist" in England, or through a MHT in Ontario and Victoria (Cronin et al., 2017, p. 265). While such interventions are to be administered with minimal restrictions, according to best practice guidelines, only Victoria explicitly incorporates the term "least restrictive" within its legislation (Cronin et al., 2017). Additionally, in Victoria, a review of seclusion practices is mandated to occur at minimum intervals of every four hours by a qualified mental health professional (Cronin et al., 2017).

Each site acknowledges community-based compulsory treatment as a less restrictive alternative to involuntary treatment in hospital settings (Kirby & Keon, 2004a). Thus, MHAs allow for Community Treatment Orders (CTOs) that permit the release of involuntarily admitted individuals into the community, where they remain under the hospital's jurisdiction and continue

[57] Electroconvulsive Therapy (ECT) is a treatment that involves sending an electric current through the brain to create a surge of electrical activity (known as a seizure) (Mind England, 2024). Despite scientific evidence to the contrary, ECTs are still regarded as a viable treatment option (Andre, 2009).

their treatment (Kirby & Keon, 2004a). CTOs are intended to enable earlier hospital discharge, ensure continuity of care, and help prevent readmission, despite a lack of evidence supporting their effectiveness in achieving the latter (Harris et al., 2019). Amendments to Section 41 of the MHA Ontario (2015) clarify that the Mental Health Review Board must consider if a physician plans to place an individual under a CTO when deciding if an individual should continue to be held involuntarily (even when the individual is not currently under a CTO) (subsections 2.1 and 2.2); and enables the Board to "rescind a certificate of continuation" if a CTO is issued (3.1). These changes are designed to better integrate the use of CTOs into the decision-making process regarding the continuation of involuntary care, to help a more seamless transition between levels of care. In Victoria, the 2022 changes to its MHA, shortened the maximum duration of a CTO from one year to six months (s. 193), but the criteria for compulsory assessment and treatment remain unchanged (ss. 142 & 143).

Brophy and McDermott (2003) point out that social, economic, and political factors shape the use of CTOs, often leading to unintended outcomes. CTOs might inadvertently replace more specialized, intensive care, possibly reducing the development of advanced clinical skills (Brophy & McDermott, 2003). CTOs overemphasize medication at the expense of psychosocial treatments (Brophy & McDermott, 2003; Fabris, 2011). Additionally, the administrative burden of CTOs can deter medical staff from engaging in their preferred clinical methods (Brophy & McDermott, 2003). Certain groups are more frequently subjected to CTOs,[58] because of assumed risks rather than proven need, suggesting that CTOs may be used for social control (Brophy & McDermott, 2003). A further critique of CTOs is the lack of necessary community services, which can lead to failure in outpatient settings and subsequent rehospitalization (Kirby & Keon,

[58] Brophy and McDermott (2003) highlight evidence indicating that young men and people from minority ethnic or Indigenous backgrounds are disproportionately subjected to CTOs.

2004a). For CTOs to work, the essential supports and services must be accessible to meet the conditions of the order (Kirby & Keon, 2004a). While Ontario mandates that a person can only be placed under a CTO if there are appropriate supports in the community, the mechanism for enforcing this is unclear (Kirby & Keon, 2004a).

### *Towards "Citizenship Rights"*

Adopting a human-rights based approach to mental health, in line with the CRPD, presents challenges. The CRPD asserts that disability is never a reason to deprive someone of their freedom (Article 14(1)(b)) (UN General Assembly, 2007). Consequently, current mental health laws could be seen as discriminatory, as they use "mental illness" – a recognized disability under the CRPD – as grounds for involuntary detention based on perceived risk, without considering the individual's capacity to make decisions (Szmukler et al., 2014; Davidson et al., 2016). While the law enables two sides to engage in a conversation (Costa, 2013), it alone is insufficient to drive the necessary changes in mental health reform that align with the principles of civil or human rights (Rose, 2019). As evident by rights-based strategies that strive to reform social welfare by transforming the conditions of public service provision through individual rights entitlements (Rose, 1985). Judi Chamberlin, who was a prominent psychiatric survivor, challenged the relationship between psychiatry, exclusion, and coercion by providing another perspective for theorizing resistance in her proposal of "citizenship rights" (Bracken & Thomas, 2005, p. 248). Chamberlin argued that rights discourse surrounding people experiencing mental distress focus too narrowly on the right to treatment and not enough on the broader aspects of democracy and autonomy that characterize the relationship between the individual and the state (Bracken & Thomas, 2005). In her view, citizenship in terms of human rights is more than equitable access to the rights that all citizens enjoy; it also encompasses the capacity to define

and understand oneself in a particular way (Bracken & Thomas, 2005, p. 248). Chamberlin's advocacy for citizenship rights embodied a movement against exclusion and coercion, as well as a call for individuals experiencing mental distress to have the autonomy to express their unique perspectives and to shape their own narrativities around the evolution of mental health services (Bracken & Thomas, 2005, p. 99).

To advocate internationally on the potential of the CRPD in rectifying injustices within mental health practices, Minkowitz (2014) founded the Centre for the Human Rights of Users and Survivors of Psychiatry (CHRUSP). This organization consists of activists dedicated to the abolition of coercive mental health laws and involuntary psychiatric interventions (Minkowitz, 2014). CHRUSP members engage in advocacy for implementing and overseeing human rights as they pertain to individuals experiencing mental distress "or [are] labeled with madness, mental health problems or trauma" (CHRUSP, 2009, para. 1). In 2017, Dr. Dainius Pūras, serving as the United Nations Special Rapporteur on the right to health, urged all nations to embrace a Mental Health Declaration of Human Rights (Citizens Commission on Human Rights (CCHR) International, 2019). Dr. Pūras emphasized that human rights extend to "the right to one's own mind, and to protect oneself and one's loves ones against any abusive or harmful treatments given under the guise of mental health" (CCHR International, 2019, para. 2). To ensure that systemic progress occurs, we must move beyond the prevailing biomedical and risk paradigms that govern mental health laws, policies, and practices, which perpetuated inequity and discrimination.

**Covid-19**

The Covid-19 pandemic "both magnified and added" to the mental health service crisis (Centre for Addiction and Mental Health (CAMH), 2020, p. 1). The pandemic negatively

impacted mental health, disproportionately affecting vulnerable groups (including people with disabilities, people without homes, people with prior health conditions, racialized and Indigenous communities, and workers in low-wage and/or precarious employment) (Anderssen, 2020b; Barrera & Deer, 2020; Organisation for Economic Co-operation and Development, 2020; Perri et al., 2020). These patterns underscored "pre-existing inequities in access to health care, housing, income and social support" and "the ongoing impacts of colonialism" (CAMH, 2020, pp. 2, 3). The pandemic exposed "the inadequate and outdated nature of mental health systems and services worldwide" (WHO, 2021, p. VIII), as well as highlighted the importance of addressing "social determinants of health and the associated challenges that people with mental health and psychosocial conditions face daily" (p. XX). The external shock of the Covid-19 pandemic and its repercussions on mental health could serve as a catalyst for public demands for governmental intervention and policy change (Bernardi, 2021). In this (ongoing) context, efforts of mental health and community organizations have been critical in organizing mobilization strategies, with active voices within the public intensifying the often overlooked majority's demand for systemic change (Bernardi, 2021).

## Use of Policy Levers to Advance Mental Health Service Delivery Reform within Countries

### *Canada*

In the current "third phase"[59] of deinstitutionalization, starting from the 1990s, the focus has been on integrating the various mental health services and supports within the community and improving their overall effectiveness (Kirby & Keon, 2004a). This phase is marked by a reliance on empirical research and the adherence to "best practice" models; a recognition of

[59] The *Standing Senate Committee on Social Affairs, Science and Technology* (Kirby & Keon, 2004a), identify the first phase of psychiatric deinstitutionalization to include the shift from care in psychiatric institutions to care in psychiatric units of general hospitals (beginning in the 1960s), and the second phase (spanning the 1970s and 80s) to emphasize the development and expansion of community mental healthcare.

hospitals as integral to comprehensive care systems, necessitating a re-evaluation of their roles to ensure better integration between hospital and community services; and a move towards inclusivity in both planning and implementing services as well as a clearer consensus regarding the reforms required (Kirby & Keon, 2004a, p. 143). Across the provinces, the preferred approach for providing mental health services includes a coordinated network of community services, supplemented by psychiatric units in general hospitals, and connected to regional mental health centres (Kirby & Keon, 2004a). However, there are substantial ongoing challenges: services and supports are fragmented, leading to multiple entry points; the prevailing system still largely mirrors an institutionally centered care model, whereas it should prioritize patient-centered and community-based support; the existing system fails to offer a continuum of required services and supports; historically, the funding for mental health has been inadequate; there is a glaring lack of accountability measures within the system; and there is a shortage of mental health professionals due to the terms of the CHA (1984) (Kirby & Keon, 2004a).

Inadequate integration of mental healthcare within primary care has limited physicians' ability to facilitate access to a community-based network of mental health services (Wiktorowicz et al., 2020). A scoping review on providers' perspectives regarding barriers to mental healthcare in Canada uncovered five themes constituting barriers: health systems availability and complexity, as observed in 72 percent of the studies; work conditions, noted in 55 percent; training and education barriers, identified in 52 percent; patient accessibility challenges, seen in 41 percent; and considerations related to identity-based sensitivity, reported in 17 percent (Wang et al., 2024). Notably, providers frequently reported confusion in choosing the appropriate service for patients, due to the sheer volume of available services, which are not accompanied by clear descriptions (Wang et al., 2024). Without a continuum of care, the current medicare

structure yields income-based inequities where individuals in the highest income bracket have greater access to psychiatric care (Kurdyak et ek., 2014). Some psychiatric practices indicate a tendency to favour patients without complex needs, even though it is the more challenging cases that typically require specialist care (Anderssen, 2020a). People accessing the emergency department for care are also at risk of being given a new prescription without any follow-up care (Anderssen, 2020a). Research has exposed negative consequences due to gaps in the continuity of mental healthcare in Ontario. A 2019 study revealed that 40 percent of youth did not receive outpatient mental health services within a month after their emergency department discharge following an initial psychotic episode, despite evidence linking follow-up care to preventing rehospitalization (Anderssen, 2020a). Furthermore, a 2017 study showed that most individuals treated for suicide attempts in emergency departments were not evaluated by a psychiatrist within six months (Anderssen, 2020a). Notably, two-thirds of hospitalized individuals had not seen a psychiatrist a month post-discharge, even with financial incentives offered to specialists to accelerate patient assessments (Anderssen, 2020a). This incentive was thus found to be ineffective in altering psychiatric practice patterns (Anderssen, 2020a).

Dr. Paul Kurdyak, a psychiatrist, professor, lead of the Mental Health and Addictions Research Program at the Institute for Clinical Evaluative Sciences, and medical director of performance improvement at the Centre of Addiction and Mental Health (CAMH), has expressed concerns regarding decisions being made that may be undermining patient access to care, despite aiming to uphold professional autonomy and flexibility within the mental health sector (Anderssen, 2020a). Dr. Kurdyak envisions a mental healthcare system where specialized care is available to a range of patients with high-needs in a cost-effective manner (Anderssen, 2020a). Psychiatrists would integrate into a collaborative care team, providing both rapid consults and

ongoing follow-up care, supported by psychiatric nurses, psychologists, and social workers (Anderssen, 2020a). He advocates for increased public funding for therapy and the tracking of patient progress to tailor treatments according to individual needs (Anderssen, 2020a). Kirk Corkery (2023), the former Chair of Mackenzie Health in Richmond Hill, Ontario, argues for a reimagined approach to healthcare utilization that focuses on achieving timely patient access without unnecessary expenses. He suggests that the healthcare system of the future may differ from traditional models, but by drastically transforming how healthcare providers offer their services via team-based delivery we can contain long-term costs and enhance the effective use of human resources in healthcare (Corkery, 2023).

Despite consensus among stakeholders for a vision of a comprehensive system of community support, as set out in the Graham Report (1988), there has been criticism about the failure to effectively implement the policy direction (Lurie, 2005). The Graham Report found that while community mental health funding was increasing, mental health expenditures were decreasing when considered as a percentage of total health spending, indicating a discrepancy between policy intent and financial prioritization (Lurie, 2005). Canada's federation is characterized by a significant degree of decentralization, particularly evident within the health sector (MHCC, 2018). Healthcare falls primarily under the purview of provincial and territorial governments, with the federal government contributing 24.5 percent of Ontario's health sector spending in 2022-23 (Financial Accountability Office of Ontario (FAO), 2023). In contrast, the Australian federal government retains authority over Medicare and in 2021-22 funded 72.9 percent of the country's total public health funding (AIHW, 2023a). Although provincial and territorial governments in Canada have control over their respective health systems, they are challenged by budgetary limitations in raising adequate funds to handle rising healthcare

expenses within the confines of their financial arrangements with the federal government (MHCC, 2018). While provincial and territorial governments have "strong health policy levers" at their disposal to reform healthcare, their capacity to enact change is limited by their weaker fiscal positions compared to the federal government (Bartram, 2020, p. 13). This fiscal imbalance has historically shaped Canada's health system, leading to comprehensive (or "deep") public insurance coverage for hospital and physician services, but limited (or "narrow") in terms of the types of services covered, a system of first-dollar coverage that emerged from extensive negotiations between federal and provincial governments in the 1950s and 60s (MHCC, 2018). The absence of mental health from foundational healthcare legislation in Canada has been characterized as "structural stigma" (Wiktorowicz et al., 2020). At the legislative and policy-making level, structural discrimination has influenced the extent to which laws, policies, and plans distributed funding for mental healthcare (Wiktorowicz et al., 2020). In Canada, mental healthcare receives merely 7 cents out of every dollar allocated to healthcare spending, this is considerably low compared to countries like Britain, which allocates 12 cents per dollar, or to certain OECD countries where the allocation may be as high as 19 center per dollar (Gratzer, 2023). Constrained funding for mental healthcare contributed to the delay of its inclusion in the federal Health Accords, which did not occur until 2017 (Wiktorowicz et al., 2020). The prevailing medical model, defined by the HIDSA (1957), MCA (1966), and CHA (1984), perpetuated systemic neglect marginalizing mental healthcare within institutional policies and funding models (Wiktorowicz et al., 2020).

The concept of a coordinated approach to mental healthcare has aligned with the provincial and federal governments' strategic directions. The 10-year 2011 Ontario mental health and addiction strategy, *Open Minds, Healthy Mind*s, outlined a plan to transform services to

ensure Ontarians timely access to an "integrated system of coordinated and effective promotion, prevention, early intervention, and community support and treatment programs" (MOHLTC, 2011, p. 4). Building on the strategy, the 2011 Liberal budget, intended to allocate $257 million over its first three years to improve access to services for children and youth, acknowledging that 70 percent of mental health challenges have their onset during childhood or adolescence (MOHLTC, 2011). Despite this commitment, a 2014 evaluation found that the actual investment was $93 million, falling short from the initial pledge (MOHLTC, 2014). Expanding on this first phase of the strategy, in 2014, the Liberal government committed to additional investments of $65 million in 2014-15, growing to $83 million in 2016-2017 (MOHLTC, 2014). The Mental Health Commission of Canada (MHCC),[60] a non-profit organization, was created by the federal Harper Conservative government in 2007 in response to a Senate Committee established in 2003 that was tasked to provide a three-year study on mental health, mental illness, and addiction in Canada (CAMIMH, 2016). In 2012, the MHCC released Canada's first national mental health strategy, entitled *Changing Directions, Changing Lives*. The strategy, a "blueprint for change," includes 109 recommendations regarding the implementation of mental health policies (Fitzpatrick, 2012, para. 2). To reduce funding inequities, the strategy proposed increasing the proportion of health spending allocated to mental health from seven to nine per cent and increasing the proportion of social spending for mental health by two percentage points (MHCC, 2012). The strategy also recommended assessing if a reallocation of mental health funding could enhance efficiency and outcomes and encouraged contributions from private and philanthropic sectors (MHCC, 2012). Despite recommendations for both federal and provincial governments to prioritize mental health, implementation was seen as a provincial duty, not a federal one, as

[60] The 2015 federal budget renewed the MHCC for another 10-year mandate that started in 2017-18 (CAMIMH, 2016).

expressed by the former Chair of the MHCC, Michael Kirby (Fitzpatrick, 2012). Kirby highlighted that provinces face diverse challenges and have varying service gaps (Fitzpatrick, 2012). The federal structure of Canadian governance and constitutional division of powers restrict the MHCC's capacity to influence provincial resource allocation or prioritization of mental health services (Teghtsoonian, 2009). Achieving the MHCC's target of increasing mental health spending from seven to nine percent of the total health budget would require an estimated additional $3.1 billion annually; lessened by the Liberal government's commitment in the 2017 federal budget to contribute 5 billion dollars over the next 10 years to provincial and territorial governments to support mental health initiatives, which is on average $500 million per year (see Figure 4.1 in Appendix B) (Bartram, 2017).

The expiration of the 10-year Canada Health Accord in March 2014, without renewal by the Conservative government, raised considerable alarm among healthcare providers and patient advocacy groups (CBC News, 2015). They argued that the healthcare needs of several provinces would face significant underfunding issues (CBC News, 2015). The Conservative government declared that the last 10-year Health Accord, which included an annual six percent increase in health transfers to the provinces would end in 2017 (The Council of Canadians, 2016). In response, during their 2015 electoral campaign, the Trudeau Liberal government committed to a $3 billion investment over the subsequent four years, contingent on their election victory (CBC News, 2015). Discussions between a Member of Parliament and a former federal Health Minister about renegotiating the 2004 Health Accord in 2015 included consideration about revisiting the CHA (1984) (J. Philpott, personal communication, August 14, 2019). While the former federal Health Minister mentioned discussions to expand the CHA to include mental healthcare, the federal government, however, hesitates to revise this "crucial" legislation, concerned that

amending it might lead to provinces rescinding their commitments under the CHA (J. Philpott, personal communication, August 14, 2019). This hesitancy is reinforced by the ongoing pressure from private healthcare sectors to modify the CHA, prompting fears that amending the Act might result in loss of current safeguards in pursuit of uncertain benefits. In the context of renegotiating the Health Accord, discussions typically focus on funding with provinces seeking more resources and the federal government being cautious with allocations. However, the former Health Minister argued the emphasis should be on more than just financial aspects, as the primary issues in the healthcare system relate to service delivery improvements. The Minister alluded to a consensus that investment prioritize SDoH, primary care, and mental health, which are deemed more effective in enhancing outcomes compared to traditional healthcare spending. In 2017, the Liberal federal government committed $5 billion over 10 years to enhance mental health and addiction services across provinces and territories, marking the first time in history the federal government made a specific investment in mental health (Finance Canada, 2017). The former Health Minister notes the ongoing challenge is ensuring that the new investments support incremental improvements in mental health and are not absorbed into provincial budgets to maintain the status quo. Ultimately, this led to bilateral negotiations with each province following the 2017 federal investment to determine the specifics of the transfers. By May 2019, all provinces and territories had signed funding agreements and the Canadian Institute for Health Information (CIHI) started to track six national indicators (Bartram, 2020). However, the indicators remain quite broad, (i.e., “frequent emergency room visits for help with mental health and/or addictions”) and the agreements vary in their focus on mental health and substance use priorities (CIHI, 2019, p. 4 as cited in Bartram, 2020, p. 12). Without the agreements made public and limited data on indicator results, it is unclear to what extent these funds have

specifically improved access to mental health services, and more specifically, to psychotherapy, including whether access to these services has become more equitable (Wiktorowicz et al., 2020; CIHI, 2019; Bartram, 2020).

Fulfilling their campaign commitment and guided by the aim to "get rid of the inefficiencies and back office duplication," when the Ford Conservative party took office in Ontario, in 2018, it began transferring the planning and funding functions of LHINs into Ontario Health or Ontario Health Teams[61] (OHTs) (Ministry of Health, 2019, para. 4). Across the province, 58 OHTs have been formed, bringing together a diverse group of healthcare providers, including hospitals, doctors, and home and community care services, to work collectively and seamlessly, regardless of the setting in which they provide care (Government of Ontario, 2024a). A select cohort of 12 OHTs[62] has been identified to expediate their efforts in providing home care within their local communities, with this initiative set to commence in 2025 (Government of Ontario, 2024a). In 2019, aligning with the recommendation made a decade prior by the Select Committee on Mental Health and Addictions, the Centre of Excellence was created within Ontario Health (CMHA, 2020). The Centre forms the cornerstone of the *Roadmap to Wellness* provincial strategy, released in March 2020, and is responsible for centralizing accountability for mental health and substance use care and standardizing and better organizing the system through quality monitoring and performance indicators (Ministry of Health, 2020). The Centre is also responsible for providing resources to Ontario Health Teams to support them in connecting people to the care they need (Ministry of Health, 2020).

[61] The five agencies: Cancer Care Ontario; Health Quality Ontario; eHealth Ontario; Health Shared Services Ontario; and HealthForce Ontario Marketing and Recruitment Agency were also transferred into Ontario Health (Ministry of Health, 2019).
[62] Missing from this cohort is a OHT serving the Toronto central area.

Given a mandate to help transform the mental health system, the MHCC identified e-Mental health as an "important opportunity toward positive change" (2014b, p. 29). The MHCC advised that e-Mental health services be designed as person-centered, tailored in partnership with individuals while prioritizing their unique needs and ensuring cultural relevance, and be scalable, allowing for services to cater to a broader population (2014b). At the 2017 MHCC roundtable, which explored the potential of e-Mental health technologies, promising e-Mental health practices were showcased, such as the Newfoundland and Labrador (N. L.) Stepped Care 2.0 E-Mental Health Demonstration Project. Launched in 2017, N.L.'s Stepped Care 2.0 applies recovery principles to improve access to publicly funded mental health services by integrating e-Mental health services with primary care (MHCC, 2019). The stepped care model has been found to increase provider caseload capacity by matching mental health needs to appropriate level of care (MHCC, 2019), shifting care from specialists to primary care and from primary care to online self-help or peer support (MHCC, 2017). Dr. Michael Krausz (Providence Health Care, British Columbia Leadership Chair in Addiction Research), emphasized at the roundtable that "e-Mental health is not about competition between face-to-face and other modalities … it is one of the most promising tools … to give more people access to get the care and support they need" (MHCC, 2017, p. 25).

Unbeknownst to the MHCC and the rest of the world, in March 2020, the WHO declared Covid-19 a pandemic. The pandemic impacted service delivery, compelling healthcare regulatory bodies to enhance their flexibility, while upholding their accountability to safeguard the public (Leslie et al., 2021). The pandemic highlighted the discrepancy between evolving societies and the comparatively static regulatory and legal structures (Leslie et al., 2021). It also emphasized the importance of fully leveraging the skill set of all healthcare professionals and led

to calls for the removal of unnecessary restrictions on their practice scopes (Leslie et al., 2021). A 2017 study commissioned by the Ontario government identified the current system as inadequate, noting it restricts health professionals from expanding their scope of practice, or performing controlled acts, regardless of their demonstrated competence (McMaster Health Forum, 2017, as cited in Leslie et al., 2021). British Columbia proposed reforms to streamline its healthcare regulatory framework by reducing the number of regulatory bodies from twenty to six, acknowledging the limitation of regulating professions separately in the context of team-based healthcare (Leslie et al., 2021). The Covid-19 pandemic has caused additional emergency reforms to increase healthcare capacity, such as granting emergency licenses to internationally trained health professionals and enabling task shifting related to pandemic demands (Leslie et al., 2021). However, the fragmentation of professional regulation and lack of national uniformity in practice scopes pose challenges to mobility and efficient service delivery reform across Canadian provinces (Leslie et al., 2021).

In 2020, the Ontario government invested $20 million in Mindability, an unprecedented public program providing access to evidence-based cognitive behavioural therapy (Canadian Healthcare Technology, 2020). The initiative was part of Ontario's *Roadmap to Wellness* (2020) strategy, under the fourth pillar focused on improving access (Government of Ontario, 2020). Despite the Conservative government recognizing that over one million Ontarians face mental health or substance use issues (Government of Ontario, 2020), the Mindability program was designed to treat only 80,000 individuals over four years at full operation (Mastracci, 2020). The criteria for joining the program remain vague, including whether a formal diagnosis of anxiety or depression is necessary or if the level of need aligns with the eligibility for individual or group therapy (Mastracci, 2020). Additional uncertainties include the number of therapy sessions

individuals are entitled to and whether these are allocated based on individual needs or the program's available resources (Mastracci, 2020). Also unclear is whether people can access culturally appropriate providers and resources and how people without internet are being supported (Scharf & Oinonen, 2020). While the 2021 Ontario budget included an additional investment of $175 million for the 2021-22 fiscal year to enhance mental health support, it lacked detail on the development of a comprehensive and connected service delivery system as outlined in the *Roadmap to Wellness* strategy (Ministry of Finance, 2021). Furthermore, without recognizing the importance of SDoH on mental health and the need to allocate resources proportional to their influence, as required through institutional change, as Quebec has done through the merging of its ministries of health and social services (O'Hara, 2005; Wankah et al., 2018), SDoHs will continue to place strain on the primary care system. In April of 2023, the Ontario government also stopped providing health coverage for uninsured individuals – a measure introduced during the Covid-19 pandemic for those lacking OHIP coverage (Dellplain, 2023). The decision to deem these services "no longer appropriate or necessary" has met with substantial pushback from medical professionals and organizations (Dellplain, 2023). This reflects a reluctance by governments to adjust funding mechanisms to give priority to the SDoH.

In 2021, the federal government under the Trudeau liberal administration pledged $4.5 billion over five years to provinces and territories if re-elected (Raycraft, 2024). This funding pledge was to be delivered through the establishment of a new and permanent mental health transfer (Raycraft, 2024). However, mental health organizations report seeing little of these funds, despite increasing rates of mental distress since the Covid-19 pandemic began (Raycraft, 2024). Sarah Kennell, director of public policy at the CMHA, argues that the absence of a dedicated mental health transfer has resulted in a healthcare gap, emphasizing that governments

"can't afford" to de-prioritize mental health, insisting on parity in treating mental health and physical health (Raycraft, 2024). The former federal Health Minister pointed out that during the 2015 Health Accord negotiations, provinces showed preference for general funds rather than targeted ones, as they sought flexibility over new federal funding without conditions (J. Philpott, personal communication, August 14, 2019). Although the CHA (1984) predominantly assigns responsibility of healthcare delivery to provinces, healthcare remains a shared jurisdiction constitutionally. This shared responsibility enables the federal government to use its constitutional spending power to stipulate conditions for the allocation of federal dollars. Provincial funding for universal mental healthcare access is scarce and targeted services for disadvantaged groups are generally limited to federally governed populations such as veterans and Indigenous people (Bartram, 2020). Statistics Canada found that individuals in the lowest income bracket are three to four times more likely to rate their mental health as fair to poor compared to those in the highest-income bracket (Mawani & Gilmour, 2010). Individuals without quality employment rely on income supports from social assistance, which fall short of supporting an adequate standard of living (Mawani & Gilmour, 2010). The MHCC (2023a), while acknowledging the "profound and unacceptable" inequities in access to mental healthcare and outcomes within Canada, notes that the diverse array of social justice frameworks aimed at addressing these inequities pose challenges for implementing policies and programs (para. 1). The MHCC (2023b) has developed a proposed integrated and comprehensive equity framework to streamline the implementation of essential equity-focused concepts within mental health policies and programs. The framework emerged from the findings of the *Toward an Integrated and Comprehensive Framework for Mental Health Policy and Programming: Needs Assessment Report*, which included a literature review of key frameworks, drawing comparisons across

them, as well as surveys and interviews with external experts and various stakeholders about the practical application of these frameworks (MHCC, 2023b). The new framework incorporates key aspects of intersectionality, decolonization, health equity, anti-racism, lived and living experience and recovery, sex- and gender-based analysis plus (SGBA+), and the social determinants of health (IDEALSS) (MHCC, 2023b). The MHCC (2023b) is refining the equity framework via public consultations, their own engagement, and discussions with experts who apply equity principles in mental health policy and programming. This process aims to create a toolkit that guides diverse organizations in policy and programming implementation (MHCC, 2023b).

Private health insurance, which about two-third of Canadians have, typically covers services not reimbursed by medicare (Mossialos et al., 2016). In 2015, private health insurance represented about 12 percent of Canada's total health expenditures with most of these insurers operating on a for-profit basis (CIHI, 2015). Bill 60, introduced in Ontario, in 2023, represents a significant shift in healthcare delivery and governance (McGregor, 2023). It facilitates the expansion of private clinics to perform surgeries and diagnostic tests (McGregor, 2023). A new entity, separate from the Ministry of Health, will oversee this privatized segment of care (McGregor, 2023). The goal is for specialized clinics to reduce the backlog of procedures like hip replacements and cataract surgeries, however if this will happen remains uncertain, especially given past volume restrictions by the Ministry of Health (McGregor, 2023). The public has strongly criticized the Ministry for its readiness to finance backlogged medical procedures when they are performed by private clinics outside the public healthcare system (McGregor, 2023). This stance raises questions about the Ministry's funding decisions. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) (2022), founded in 1998, is

an umbrella non-profit organization consisting of 16 national healthcare associations. These associations collectively represent a vast community of individuals, including those with personal experiences of mental distress, their family members, academics, and mental health service providers (CAMIMH, 2022). The second annual National Report Card by CAMIMH indicates that Canadians overwhelmingly rate the federal and provincial governments' mental health and substance use healthcare services with an "F" (CAMIMH, 2024). The survey, run by Mental Health Research Canada and Pollara Strategic Insights between November 1 and 16, 2023, with 3,207 adult participants, saw a drop from the previous year's "D" grade across the key areas of access, confidence, satisfaction, and effectiveness of services (CAMIMH, 2024). CAMIMH (2023) expressed deep dissatisfaction with the omission of the anticipated Canada Mental Health Transfer from the 2023 Liberal federal budget. The absence of the $4.5 billion commitment over five years for mental health, as noted by CAMIMH Co-Chair Ellen Cohen, leaves provinces and territories without crucial support to enhance access to "accessible" and "inclusive" mental health and substance use services (CAMIMH, 2023, para. 2). Although the 2023 federal budget provided $2.5 billion annually over the next ten years to provinces and territories, it lacked detail on mental health investment (CAMIMH, 2023). Margaret Eaton, the National Chief Executive Officer of CMHA, criticized the budget for lacking crucial investments in services provided by community organizations (CMHA, 2023b). The budget is found to not reflect the actual well-being of Canadians or their financial capability to access mental health services, with Canadians having limited public access to mental health and substance use healthcare, indicating a disconnect with the real needs of the population (CMHA, 2023b). Eaton emphasized the government's oversight as a significant shortcoming with potential severe human and economic repercussions (CMHA, 2023b). CAMIMH (2023) further urges for the proposal of

a Mental Health and Substance Use Health Care For All Parity Act[63] to guide federal contributions.

***England***

The NHS Plan (2000) included a strategy to boost funding for mental health, aimed at facilitating the expansion of mental health services. The Sainsbury Centre's[64] analysis of mental health financing found that although there was a 7.1 percent funding increase for adult mental health services by the NHS and local authorities in the 2002/03 fiscal year, the growth rate for mental health services was not commensurate with the overall increase in health and social care funding (Kirby & Keon, 2004b). Once adjustments for inflation and pay increases were considered, funding for mental health services grew at less than half that of the total NHS and social services budget. The Sainsbury Centre's report concluded that mental health, while designated a priority in the NHS Plan (2000), its proportion of the NHS and social services budgets was declining. The Centre highlighted that the funding increase fell significantly short of the necessary 11.5 percent annual growth to fulfill the objectives of the National Service Framework for Mental Health (NSF-MH) (1999) within the set timeline. The Centre indicated to meet this timeline, the funding for mental health services would require nearly double the rate of increase seen in the 2002/03 fiscal period. Acknowledging regional variations in spending, the Sainsbury Centre emphasized that national expenditure trends suggested a growing disparity

[63] In June 2021, CAMIMH called on the federal government to introduce and pass a Mental Health and Substance Use Health Care For All Parity Act – this would guarantee legal access to comprehensive mental health and substance use care, on par with physical health; provide a range of evidence-based, publicly funded mental health services, equitably and timely accessible across various settings; emphasize the need for investment in health promotion, prevention, and to address the social determinants for mental health and substance use; establish clear responsibilities and national performance metrics; and secure sustainable federal funding for provincial and territorial mental health programs and services (CAMIMH, 2021, p. 3).

[64] The Sainsbury Centre for Mental Health (SCMH), associated with the Institute of Psychiatry at King's College London, is a charitable organization that conducts research, development, and training initiatives aimed at shaping policies and practices within health and social care (Kirby & Keon, 2004b).

between the government's commitments and the actual improvements in mental health service delivery. They proposed that policymakers reconsider the scope of the planned reforms or allocate more funding to mental health to meet the set goals. The allocation of funds to meet local needs further introduced new challenges in the early 2000s.

As previously mentioned, locally operated Primary Care Trusts (PCTs) in the early 2000s began receiving their NHS funding directly from the central government instead of the Health Authorities. The PCTs were responsible for distributing these funds across various health services, including those for mental health (Kirby & Keon, 2004b). They also set local priorities for future service development. As the main source of funding for mental healthcare, PCTs, possessed the flexibility to reallocate resources among services and providers to align with local priorities (Kirby & Keon, 2004b). The King's Fund research from 2003 on mental health services in London revealed that many PCTs were not dedicating as much attention to mental health service planning as might be expected, considering the substantial size of their budgets and the urgent need for development in this area (Kirby & Keon, 2004b). Furthermore, mental health budgets were found to be under strain due to various factors (Kirby & Keon, 2004b). Critical among these were staffing shortages, which result in a reliance on expensive temporary staffing solutions, escalating costs of prescriptions, and the need to address accrued debts (Kirby & Keon, 2004b). For instance, the Sainsbury Centre reported a significant budgetary excess where a trust in southern England spent an additional £145,000 on staff recruitment advertisements and £1,672,000 on temporary medical staff (Kirby & Keon, 2004b). Under the Health and Social Care Act (2012) Clinical Commissioning Groups (CCGs) were established and replaced PCTs in 2013 (Charlton, 2013). Moreover, The *Health and Care Act* (2022) led to the establishment of Integrated Care Systems (ICSs), replacing CCGs. ICSs are collaborative

networks of various organizations that strategize and finance health and care services to benefit local needs (NHS England, n.d. -a). An ICS consists of two main components: an Integrated Care Partnership (ICP), which focuses on strategic planning, and an Integrated Care Board (ICB), which oversees implementation and resource allocation (NHS England, n.d. -a). These local partnerships across England bring together public service providers – including the NHS, GPs, local authorities, and community and voluntary sectors (NHS England, n.d. -a). Together, they coordinate to design and offer health and care services that are tailored to local needs, ensuring that these services are of high quality and economically sustainable (NHS England, n.d. -a).

While Integrated Care Boards (ICBs) commission most services locally, NHS England is responsible for commissioning some specialist services (UK Parliament, 2023). In April 2020, continuing the trajectory set by the *Five Year Forward View for Mental Health* (Independent Mental Health Taskforce, 2016) and further developed in the NHS Long Term Plan (Department of Health and Social Care (DHSC), 2019), NHS England initiated a shift in the commissioning of specialized mental health, learning disability, and autism services to NHS-Led Provider Collaboratives (Wickens, 2022). These collaboratives consist of specialist providers led by a principal provider and are tasked with jointly managing the budget and care pathways for the populations they serve, facilitating integrated care and breaking down traditional service silos through innovative care models (Wickens, 2022). Local mental health funding is typically not earmarked, allowing each ICB the discretion to determine its own mental health budget from its overall funding pool (UK Parliament, 2023). Consequently, neither the central government nor NHS England sets specific mental health funding levels for local areas (UK Parliament, 2023).

However, local areas are required to adhere to the mental health investment standard,[65] which mandates that any increase in local mental health funding should match or exceed the relative increase in overall local health funding (UK Parliament, 2023). As part of the NHS Long Term Plan, there is a commitment to increase the portion of the NHS Budget allocated to mental health services, aiming to reach an additional £2.3 billion per year by 2023/24 (UK Parliament, 2023).

The emphasis on community mental health teams and specialist teams in providing mental health services, stemming from the NSF-MH in 1999, led to a fragmented and inconsistent continuum of care (NHS England, 2019c). When care is provided from multiple services, repeated assessments often occur (NHS England, 2019c). This redundancy can cause distress, increase the likelihood of disengagement from the services, delay the onset of treatment, and represents an inefficient allocation of resources (NHS England, 2019c). Consequently, primary care services may face additional burdens when individuals with care needs are turned away from mental health teams due to inflexible service criteria or because they do not meet certain, sometimes arbitrary, thresholds for care (NHS England, 2019c). The Care Programme Approach (CPA),[66] established in 1991, was integral to organizing and delivering secondary care mental health services, aimed at enhancing community care for people with "severe mental illness" through a case management approach (Simpson et al., 2003). Concerns regarding its effectiveness, however, persisted, including criticism that it conflated resource allocation with clinical care planning and that it produced a binary system where people were categorized as

[65] The Mental Health Investment Standard, established by NHS England, supports the objectives of the NHS Long Term Plan (2019) by mandating that all CCGs (now ICSs) in England increase their planned mental health services spending by a larger percentage than their overall budget increase each year (NHS North East London, 2022).
[66] The Care Programme Approach (CPA) served as a framework for mental healthcare provision by secondary services. Individuals within the CPA framework (i.e., individuals were identified as having severe mental illness or associated with risks including self-harm, suicide attempts, or harming other people, including breaking the law), were eligible to receive a coordinated care package, including a case manager and care plan that encompassed a strategy for managing crises (Rethink Mental Illness, n.d.).

either being “on” or “off” CPA (NHS England, 2019c). The role of CPA was further complicated by its association with risk management, where evaluations struggled to conclusively demonstrate its efficacy (NHS England, 2019c). The Care Quality Commission (CQC) observed significant discrepancies in CPA application across trusts, with a service user participation range of three percent to seventy-three percent in their 2016 annual survey (NHS England, 2019c). Additionally, more than half of the referrals to community mental health teams are from non-primary care sources such as other community or inpatient teams, social services, or self-referrals (NHS England, 2019c). Typically, when individuals are transitioned between different teams, over 20 percent fail to connect with the next team, possibly because of complicated referral and transition procedures, or due to the absence of adequate support systems to manage their various needs in a single setting (NHS England, 2019c). The *Community Mental Health Framework for Adults and Older Adults* (2019) proposed “replacing the CPA for community mental health services, while retaining its sound theoretical principles based on good care co-ordination and high-quality care planning” (NHS England, 2019c, p. 7). The NHS Standard Contract 2021/22 reaffirmed the suspension of the CPA (NHS England, 2022a). The mental health system has also been challenged by increased waiting times and lengthy wait lists for psychological therapies from secondary care providers as well as a shortage of resources and the absence of a coordinated strategy to improve both clinical and cost-effectiveness (NHS England, 2019c). Insufficient initial care can lead to health deterioration and result in a need for more acute services (NHS England, 2019c). Consequently, this intensifies the strain on inpatient and urgent community-based services (NHS England, 2019c). Since the 2010s, there has also been a notable rise in the use of the Mental Health Act with patients often placed out of their local areas due to service capacity issues (NHS England, 2019c). There has also been a long-term trend of

reduced services for individuals requiring prolonged care in the community, as the focus has shifted to specialized, typically time-limited services (NHS England, 2019c).

Although the Labor party emphasized the importance of bolstering mental health support in its 2010 election manifesto, it was under the Conservative party's leadership within the Coalition government, and subsequent administrations, that initiatives for mental health investment and Mental Health Act reforms were advanced (Bernardi, 2021). While the Labor party in Britain is traditionally associated with healthcare, mental health has not become a definitive issue for any single party (Bernardi, 2021). Conversely, the Conservative party has faced public scrutiny for its austerity policies and oversight in the public sector, which has led to a perceived shift in the NHS' focus from preventive to acute care, suggesting a systemic breakdown (Sridhar, 2023). This concern is exemplified by the rising cases of preventable blindness and the exiting of higher-income people to the growing private sector (Sridhar, 2023).

Under the 2010 to 2015 Conservative and Liberal Democrat Coalition government the *No Health Without Mental Health* strategy was released (Department of Health, 2011). The strategy committed to "mainstream mental health" and "establish parity of esteem" between mental and physical health services (Department of Health, 2011, p. 2). It outlines the government's approach to improving the mental health and well-being of the nation and mental health outcomes for people experiencing mental distress (Department of Health, 2011). The National Audit Office (NAO) noted that without a concrete definition and measurable criteria, it is not feasible to determine the NHS's progress toward achieving parity of esteem between mental and physical health services (UK Parliament, 2023). The NAO recommends that a clear definition of parity of esteem should encompass the following elements: an estimation of the percentage of individuals with mental health conditions that should be served by mental health services; the

staffing composition needed to provide these services; and the allocation of financial resources between mental health and physical health services (UK Parliament, 2023). Accompanying the strategy, are detailed documents, published separately, which include strategies for delivering better mental health outcomes, an economic case for improving efficiency and quality in mental health, and various impact assessments and analyses related to equality and the effects of talking therapies (Department of Health, 2011). The government also committed £400 million over four years to ensure the availability of psychological therapies for individuals across England, with expanded services for "children and young people, older people, people with long-term physical problems and those with severe mental illness" (Department of Health, 2011, p. 3). The strategy also proposed "a new architect and approach for the NHS," including an outcomes-based approach; establishment of Public Health England within the Department of Health and Social Care to address health inequalities; and Healthwatch England, an autonomous consumer advocate within the CQC (Department of Health, 2011, p. 46).

In 2014, NHS England, alongside its partner organizations CQC, Public Health England, and NHS Improvement (previously Monitor), released the *Five Year Forward View*. The document outlined their vision for the health service's future, pledging to achieve "genuine parity of esteem between physical and mental health" and to introducing and expanding mental health access and waiting time standards (NHS England, 2014a, p. 26). The NHS England's *Forward View into Action: Planning for 2015-16* (2014b) laid out an expectation for CCGs to increase their mental health service spending for the financial year 2015/16, not only in real terms but also at a rate that matched the rise in their budget allocation, reinforcing the commitment to parity between mental and physical health (UK Parliament, 2023). Similarly, in October 2014, the government established the first waiting time standards for mental health

services, aimed at aligning wait periods for mental health with those for physical health (UK Parliament, 2023). From April 1st, 2015, these standards mandated that 75 percent of individuals referred to the Improving Access to Psychological Therapies (IAPT) program receive treatment within six weeks, and 95 percent within 18 weeks; and that more than 50 percent of individuals experiencing a first episode of psychosis receive treatment within two weeks, a target which was later raised to 60 percent (UK Parliament).

In 2013, the government launched the Integrated Care and Support Pioneer programme, set for a duration of five years (2013-2018) (Erens et al., 2020). This initiative was designed to enhance the quality and efficiency, including cost-efficiency, of care for individuals through a unified approach to health and social care services (Erens et al., 2020). In November 2013, the government initiated "14 Wave 1" integration pilot projects, with an additional "11 Wave 2 Pioneers" joining in January 15 (Erens et al., 2020, p. 15). The pilot projects varied substantially in scale, with some as straightforward as a single NHS Clinical Commissioning Group (CCG) paired with one Local Authority (LA), and others involving multiple CCGs and LAs (Erens et al., 2020). The Pioneers received modest starting funds of £20,000 each, later increased by an extra £90,000, alongside support from global experts and a dedicated team at NHS England (Erens et al., 2020). The expectations set for each Pioneer included accelerating transformative changes and fostering comprehensive system integration across health, social care, public health, other public services, and the voluntary sector (Erens et al., 2020). They were to also focus on patient-centric care, achieving better patient experiences, improving better health outcomes, and realizing financial efficiencies (Erens et al., 2020). In 2015, the Cameron Conservative government introduced The Better Care Fund, allocating £3.8 billion from existing NHS and local authority budgets to support integration initiatives, with the goal of diminishing obstacles

typically arising from the segmentation of funding sources (Mossialos et al., 2016; NHS England, n.d. -b). In July, the then Department of Health[67] initiated a comprehensive five-year evaluation of the 25 Pioneer Integration pilot projects in their success in enhancing patient experiences and outcomes in a cost-effective manner (Erens et al., 2020). Surveys from Key Informants (KIs) of the integration Pioneers observed "some" progress towards these objectives, but only a minority perceived "substantial" progress (Erens et al., 2020, p. 20). These findings reinforced initial sentiments among KIs and from similar evaluations of other programs that the advantages of service integration would manifest over a longer period, countering initial expectations for rapid, widespread results as anticipated in 2013 (Erens et al., 2020). The "integration paradox" highlights a challenging dichotomy: as the need for integration grows, with the aim of enhancing outcomes and cutting costs under financially straining conditions, the ability to implement such changes diminishes (Erens et al., 2020, p. 24). The escalating demands and diminishing resources often cause organizations to default back to isolated, "siloed" operations (Erens et al., 2020, p. 24). In February 2021, the NHS put forth its legislative proposal[68] to the government for the establishment of integrated care systems (ICSs), and by April of the same year, all 42 areas of England had transitioned into ICSs (NHS England, n.d. -c). These systems unite primary, secondary, and community health services, including collaborations with local authorities and the voluntary sector (Erens et al., 2020). ICSs build on the foundation set by earlier initiatives like the Integrated Care Pioneers that operated across 25 areas from November 2013 to March 2018 (Erens et al., 2020).

[67] In January 2018, the government changed the name of the Department of Health to the Department of Health and Social Care (Policy Navigator, 2018).
[68] NHS England. (2022b, October 3). *Legislating for integrated care systems: Five recommendations to government and parliament*. https://www.england.nhs.uk/long-read/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/

In February 2016, *The Five Year Forward View for Mental Health* was published, a report by the independent Mental Health Taskforce to NHS England. The independent Mental Health Taskforce, established in March 2015, comprised of health and care leaders, service users, and field experts (UK Parliament, 2023). The taskforce was led by Paul Farmer, the Chief Executive of Mind,[69] and supported by vice chair Jacqui Dyer, who provided expertise through her lived experience and role as a carer (UK Parliament, 2023). The national strategy marked the first time an approach to improving mental health outcomes within the health and care system was developed in collaboration with NHS arm's length bodies (NHS England, n.d. -d). The taskforce received feedback from over 20,000 individuals reflecting widespread public commitment to advancing mental healthcare and support throughout the NHS (NHS England, n.d. -d). In January 2017, the Theresa May Conservative government released its formal response to the recommendations of the taskforce, embracing them in their entirety (UK Parliament, 2023). The response included measures to tackle the Taskforce's suggestions extending beyond NHS boundaries, such as in the realms of education, employment, and the broader community (UK Parliament, 2023). NHS England issued its own implementation plan in July 2016, detailing the procedures for enacting the taskforce's proposals (UK Parliament, 2023). This plan concentrated on the NHS's role in fulfilling its commitments and provided guidance for both commissioners and providers to foster and shape their local plans (UK Parliament, 2023). The government committed an extra £1 billion in funding for mental health with the aim of providing high quality services to an additional one million people by 2020/21 (Her Majesty's Government, 2017). In July 2017, the then Health Secretary, Jeremy Hunt, introduced a Mental Health Workforce Plan to put into action the *Five Year Forward View for Mental Health* (UK

[69] Mind is a mental health charity that was founded in 1946 as the National Association for Mental Health (https://www.mind.org.uk/).

Parliament, 2023). The plan detailed the creation of 21,000 new positions within England's mental health services by April 2021, surpassing the initial pledge to increase the workforce by 10,000 by this date (UK Parliament, 2023). The development of the plan was a collaborative effort, involving Health Education England, NHS Improvement, NHS England, and the Royal College of Psychiatrists (UK Parliament, 2023).

The NHS Long Term Plan, released in January 2019, contains multiple commitments to improve mental health services, among them is a promise to increase the proportion of the NHS budget allocated to mental health (UK Parliament, 2023). The plan also includes the establishment of a new "ringfenced local investment fund" of at least £2.3 billion annually by the 2023/24 fiscal year (NHS England, 2019a). In July 2019, NHS England and NHS Improvement released the *NHS Mental Health Implementation Plan for 2019/20 – 2023/24*, providing direction to local entities on how to achieve the mental health goals outlined in the Long Term Plan (UK Parliament, 2023). The Implementation Plan includes details on funding allocation, transformative initiatives, and projected staff requirements, needed to execute the NHS Long Term Plan through 2023/24 (UK Parliament, 2023). Key initiatives in the NHS Long Term Plan to bolster mental healthcare include the objective of deploying 1,000 social prescribing link workers by the end of 2020/21, with numbers increasing by 2023/24, enabling an estimate of over 900,000 people to benefit from their support by the end of 2023/24 (UK Parliament, 2023). Social prescribing link workers play a crucial role in connecting individuals to community resources that offer social, emotional, and practical assistance (UK Parliament, 2023). As of February 2023, Primary Care Networks (PCNs)[70] employed 3,161 full-time equivalent social

[70] Starting from January 2019, GP practices have been grouping into local networks, allowing them to extend care by sharing staff and portions of their funding. Primary Care Networks (PCNs) in England facilitate the integration of primary care with secondary and community services, serving as a crucial link between GPs and the developing Integrated Care Systems (Fisher et al., 2019).

prescribing link workers (UK Parliament, 2023). Additionally, since the 2022/23 period, PCNs are contractually obliged to provide a comprehensive "proactive social prescribing service"[71] (UK Parliament, 2023, p. 9). The NHS Long Term Plan also outlines initiatives to increase access to talking therapies[72] for up to 1.9 million adults, sustaining both service waiting times and recovery standards laid out in the NHS England's *Five Year Forward View* (2014), and ensuring compliance with the *Five Year Forward View for Mental Health*'s directive (2016) that all regions commission talking therapies for people with chronic conditions (UK Parliament, 2023). In the fiscal year 2021/22, services for talking therapies commenced for 1.24 million individuals, with 688,000 completing their therapy (UK Parliament, 2023). Of those individuals completing therapy, 91.1 percent received their initial appointment within six weeks, surpassing the 75 percent goal and showing an improvement from the previous year (UK Parliament, 2023). The average wait for the first treatment was 21 days, consistent with the prior year, with wait times between first and second therapy treatments reduced to 50 days, a three-day improvement (UK Parliament, 2023). Despite these advancements, significant regional variations in waiting times still persist across England (UK Parliament, 2023). Perhaps most notably, the NHS Long Term Plan ambitiously aimed to restructure community mental health services into integrated, place-based care that unifies primary and secondary care services (UK Parliament, 2023). This new offer for community-based care also includes "access to psychological therapies, improved physical health, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use … [and] maintaining and

[71] As outlined in NHS England. (2023, October). *Social prescribing*. https://www.england.nhs.uk/personalisedcare/social-prescribing/

[72] Individuals aged 18 and above are eligible to use NHS talking therapy services, which were previously known as Improving Access to Psychological Therapies (IAPT), either through a referral from their GP or by self-referral (UK Parliament, 2023).

developing new services for people who have the most complex needs and proactive work to address racial disparities" (NHS England, 2019a, p. 69). To actualize this, local areas are encouraged to restructure core community mental health teams into place-based multidisciplinary services that are coordinated with PCNs (NHS England, 2019a). In 2019, NHS England and NHS Improvement and the National Collaborating Central for Mental Health (NCCMH) released a framework detailing the operationalization of this new offer for adults and older adults (UK Parliament, 2023). The *Community Mental Health Framework for Adults and Older Adults* (NHS England and NHS Improvement and NCCMH, 2019) identified that in the fiscal year 2019/20, as stipulated in the *NHS Operational Planning and Contracting Guidance* (2019), Long Term Plan funding for mental health would begin to be incorporated into CCG baselines. CCGs, in collaboration with Sustainability and Transformative Plans (STPs) and ICSs, are mandated to commission services that deliver on the improvements outlined in the Plan (NHS England and NHS Improvement and NCCMH, 2019). The additional baseline funding allocated to CCGs in 2019/20 is designated to "stabilise and bolster core adult and older community mental health teams and services for people with the most complex needs" (NHS England and NHS Improvement, 2019, p. 35). Supplementary to the yearly increases in all CCGs' baseline funding for adult and older adult community mental health, the NHS Mental Health Implementation Plan (NHS England, 2019b) outlines that from 2021/22 to 2023/24, all STPs/ICSs are assured a proportionate distribution of central/transformation funding, which is projected at an additional £1 billion per year by 2023/24.

The Covid-19 pandemic had a significant impact on mental health and wellbeing, attributable to both the broader societal effects of the crisis, such as economic disadvantages, and the public health measures implemented to contain the virus, like lockdowns (UK Parliament,

2023). These impacts were not equally distributed across society; particularly vulnerable groups at high risk for poor mental health because of the pandemic included young adults, those living alone, individuals with pre-existing mental or physical health conditions, and members of Black, Asian, and minority ethnic communities. To support those facing mental health challenges during this period, in March 2020, the UK government allocated a £5 million grant, managed by Mind,[73] to provide additional mental wellbeing services amid the pandemic. The September 2021 *Build Back Better: Our Plan for Health and Social Care* policy paper by the UK government was developed in response to the pandemic's extensive impact on health and social care systems. Acknowledging the strain on mental health experienced by both healthcare professionals and the public, the government committed additional funding investments to bolster the social care system. These included investments in mental health and wellbeing support and in occupational health services to aid healthcare workers in recovering from the stresses associated with working through the pandemic. Proposed mental health provisions in the Coronavirus Act 2020, which aimed to temporarily relax detention and assessment requirements under the Mental Health Act 1983 due to staffing shortages, were ultimately not implemented. These changes, if enacted, would have significantly lessened the protections against arbitrary detention. Specifically, the provisions included reducing the number of doctors' recommendations needed for detention, extending detention times, and allowing more medical professionals to recommend detention, all to manage the anticipated impact on staffing levels during the pandemic. In September 2020, the Joint Committee on Human Rights (JCHR) published a report examining the human rights implications of the government's Covid-19 response, particularly the suggested revisions to the Mental Health Act. The Committee highlighted the critical importance of upholding safeguards

[73] See footnote 69.

that prevent the unnecessary detention of mental health patients, considering their heightened risk of Covid-19 infection in such settings.

In October 2020, NHS England and NHS Improvement released the *Advancing Mental Health Equalities Strategy*, which outlined the measures the NHS, alongside the Advancing Mental Health Equalities Taskforce, plans to implement to address disparities in mental health services across different communities (UK Parliament, 2023). Acknowledging varied access, satisfaction, and recovery outcomes across different groups, the strategy focuses on three main areas: "supporting local health systems to address mental health inequalities," "improving the quality and flow of data to inform intelligent insights and decision making to advance mental health equalities," and "working closely with partners to promote a diverse and representative workforce at all levels of the system" (UK Parliament, 2023, p. 25). Additionally, the strategy introduced the development and implementation of the Patient and Carer Race Equality Framework for mental health trusts to better collaborate with minority ethnic communities in combating stigma and inequalities across the sector (UK Parliament, 2023). However, a February 2023 review by the NAO indicated the impact of these measures remain uncertain. Under the Health and Care Act 2022, the Secretary of State is mandated to disclose, prior to the commencement of the financial year, whether the budget allocation for NHS mental health services is projected to rise in comparison to the previous year (UK Parliament, 2023). NHS England and ICBs are accountable for reporting on their adherence to this directive (UK Parliament, 2023). The Secretary of State for Health and Social Care, Steve Barclay of the Conservative party, (2022-23), in his first annual statement for the fiscal year 2022/23, found that mental health expenditure accounted for 8.90 percent of the total recurrent NHS budget with an expected marginal increase to 8.92 percent for the 2023/24 financial year (see Figure 4.2. in

Appendix B) (DHSC, 2023a). In July 2023, the Department of Health and Social Care and the Home Office released the *National Partnership Agreement: Right Care, Right Person*, an agreement involving the DHSC, the Home Office,[74] NHS England, the National Policy Chiefs' Council, the Association of Policy and Crime Commissioners, and the College of Policing (UK Parliament, 2023). The agreement reflects a collective pledge to minimize the unnecessary and preventable engagement of police in incidents related to individuals with mental health needs (UK Parliament, 2023). The *Right Care, Right Person* (RCRP) framework guides police on when their intervention is necessary, reserving police involvement for situations with risks of serious harm, potential crime, or life-threatening circumstances (UK Parliament, 2023). Some regions have already adopted the RCRP with noted success in reducing improper police involvement (Home Office & DHSC, 2023). Nevertheless, mental health organizations and other stakeholders voiced concerns about the safe implementation of this change, citing the need for additional funding and adequate workforce support (UK Parliament, 2023). The Royal College of Psychiatrists has highlighted the necessity for "realistic timescales for planning and preparation" for the rollout (2023, para. 6).

In April 2022, the DHSC introduced a *Mental Health and Wellbeing Plan: Discussion Paper* with a call for evidence to guide the development of a new 10-year cross-government mental health strategy (UK Parliament, 2023). The Ministerial foreword highlighted the government's commitment to understanding the priority actions needed to support people at risk of or experiencing mental distress (DHSC, 2023b). The discussion paper emphasizes six key areas for consultation: promoting positive mental well-being; preventing mental health

[74] The Home Office is the government department for immigration and passports, drugs policy, crime, fire, counter-terrorism and police (https://www.gov.uk/government/organisations/home-office/about#:~:text=The%20Home%20Office%20is%20the,%2C%20counter%2Dterrorism%20and%20police).

conditions; enabling early intervention; improving treatment quality and effectiveness; supporting people with mental conditions to live well; and improving support for people during crises (DHSC, 2023b). In January 2023, the government revealed plans to release a *Major Conditions Strategy* that will include mental health, opting for an integrated approach rather than a separate mental health strategy (UK Parliament, 2023). The government argued that an integrated approach will facilitate the concurrent consideration of mental and physical health conditions (UK Parliament, 2023). Input from the 10-year strategy consultation will contribute to shaping the *Major Conditions Strategy* and has already been utilized in formulating the new *Suicide Prevention Strategy* (2023) (UK Parliament, 2023). In August 2023, the DHSC released the interim report[75] of the *Major Conditions Strategy*. The interim report outlines the "case for change" and strategic framework for the strategy (DHSC, 2023c). Mental health is one of the five focal areas of the final report, which aims for greater alignment and integration between physical and mental health services (DHSC, 2023c). The Mental Health Foundation (2023), in collaboration with other charities including Mind, Rethink Mental Illness, and Samaritans, expressed criticism regarding the government's decision to forgo a dedicated mental health strategy, advocating for the urgent need of a specialized mental health plan. In June 2023, NHS England released the *NHS Long Term Workforce Plan*. According to projections based on current trends, the plan anticipates a deficit of more than 15,800 full-time equivalent mental health nurses by 2036/37 (NHS England, 2023, p. 35). To address this, the plan aims for a 93 percent increase in mental health nursing training spots, targeting over 11,000 positions by 2031/32 (NHS England, 2023, p. 43). Additionally, it outlines the creation of over 1,000 yearly training opportunities for clinical psychology and child and adolescent psychotherapy until

[75] The final report is expected to be published this year in 2024.

2028/29 (NHS England, 2023, p. 46). Despite these efforts, the plan forecasts ongoing shortfalls in mental health staffing for the medium term (NHS England, 2023).

Research linking health and political behaviour has uncovered a significant mental health participation gap, potentially impacting political equality (Bernardi, 2021). Analysis of local authority mental health service spending in England from 1994 to 2013[76] shows no clear connection between spending and policy problems and a negative correlation between spending and public preferences, indicating potential misrepresentation of public preferences (Bernardi, 2021). The thermostatic model suggests that public engagement with an issue is a prerequisite for policy response (Bernardi, 2021). Following the thermostatic model, which uses spending as a policy indicator, Bernardi's (2021) work reveals a trend of policy misrepresentation – public desire for increased mental health spending is inversely related to actual spending by local authorities. In September 2023, more than thirty mental health charities and organizations jointly released a document outlining key priorities for a cross-government ten-year mental health strategy (Centre for Mental Health, 2023). The document includes policies on prevention, equality, and support (Centre for Mental Health, 2023). The group calls upon political parties to act upon social determinants, such as poverty and discrimination, to address inequalities and reduce health gaps between different populations, and to ensure local mental health services are adequately funded while reducing reliance on coercive measures (Centre for Mental Health, 2023). A 2022 briefing from the Centre for Mental Health, a UK-based independent mental health charity, reveals the complex interplay between poverty, economic inequality, and systemic racism, and how these factors collectively impair the mental health of marginalized and racially

[76] The data was collected on net current expenditure on adults (18-64) with mental health needs from the social services department of Councils with Adult Social Services Responsibilities (CASSR) in England, which submits data to NHS England for secondary uses (Bernardi, 2012).

diverse communities. The document calls for targeted and specific measures aimed at boosting mental well-being by improving the financial standing and reducing the living costs of economically vulnerable sectors of society (Centre for Mental Health, 2022). Proposals include increasing social security benefits, implementing the Living Wage,[77] aiding with housing and childcare expenses for those most in need, and enhancing the availability of crucial services in the most economically disadvantaged areas (Centre for Mental Health, 2022).

In November 2023, Healthwatch, an autonomous consumer advocate within the CQC, published a report detailing the state of health and social care based on over 65,000 public consultations conducted from October 2022 to September 2023, alongside external data. The report highlighted significant dissatisfaction among the public regarding short-term help and numerous challenges with referral processes, especially in mental health services, where individuals reported notably poorer experiences and faced lengthy waits, sometimes exceeding a year, for community-based mental health or learning disability services. With 1,394,537 people awaiting feedback post-referral in August 2023, and almost three in four adult patients waiting more than four weeks, to start community mental healthcare. Healthwatch advocates for a series of reforms to improve the state of mental healthcare. Acknowledging the need for early and ongoing support, Healthwatch advocates for additional staff roles such as mental health practitioners, peer support workers, and school-based teams to help at every possible opportunity. Calls for the establishment of a parity of esteem definition between mental and physical health services, urging the government to publish this promptly. Moreover, Healthwatch suggests that the Major Conditions Strategy should incorporate a clear plan to reduce waiting times for mental health assessments, treatments, and crisis support, and to ensure that transitions

[77] The Living Wage is calculated according to the cost of living and is voluntary, whereas the National Minimum Wage, which is set by the government, is lower (Living Wage Foundation, n.d.).

from child to adult mental health services are based on individual needs rather than just age. Healthwatch also pushes for the amendment and advancement of the Draft Mental Health Bill, aiming to grant patients greater control over their treatment, improve access to advocates, and mandate a consideration of patients' preferences before compulsory treatments are decided upon, especially to address the disproportionate sectioning of Black individuals. Additionally, Healthwatch supports bespoke training for NHS staff, to improve their understanding of the unique needs of young people with learning disabilities and autism.

***Australia***

The establishment of the National Mental Health Strategy and the initial five-year National Mental Health Plan in 1992 signified a pivotal shift in the evolution of mental healthcare in Australia (Grace et al., 2015). Successive governments acknowledged the need for ongoing reform with the following two decades marked by the release of sequential five-year government mental health Plans (Commonwealth of Australia, 2009; Grace et al., 2015). Each Plan has identified priority areas for investment and reform (Grace et al., 2015). The first Plan (1993-98) was primarily focused on addressing issues related to community mental healthcare as a result of thirty years of deinstitutionalization (Grace et el., 2015). Consumer and carer involvement in service planning and delivery was an essential element of the National Strategy, with federal funding dependent on forming community advisory groups in each jurisdiction (Whiteford & Buckingham, 2005). Initially, inclusion was done as a "token gesture" in some services, merely to fulfill funding requirements (Whiteford & Buckingham, 2005). However, over time, the practice gained wider acceptance, resulting in greater participation from consumers and carers (see Figure 2.3. in Appendix B) (Whiteford & Buckingham, 2005). In November 1997, the Mental Health Council of Australia was introduced as the primary national

body encompassing the majority of key stakeholders in the mental health field (Whiteford & Buckingham, 2005). Its functions include offering counsel to government bodies, advocating on behalf of its member organizations, and overseeing as well as evaluating the nation's mental health policies, the distribution of resources, and the effectiveness of outcomes (Whiteford & Buckingham, 2005). The second Plan (1998-2003) broadened the policy scope to include more prevalent mild to moderately severe forms of mental distress, prioritizing the roles of GPs and primary healthcare providers as the main treatment providers (Grace et al., 2015). Focus was also placed on preventive measures and early intervention strategies (Grace et al., 2015).

By the early 2000s, the primary concern shifted from questioning the accuracy of national policies or their implementation to the adequacy of the pace and scale of change; indications suggested that the progress made was insufficient (Whiteford & Buckingham, 2005). Consumers, carers, and advocates highlighted ongoing challenges in accessing acute care, ensuring continuity of care, and securing availability of rehabilitation services (Whiteford & Buckingham, 2005). Compared to the previous decade, these stakeholders had become significantly more outspoken, held higher expectations, and were justifiably insisting on improved services and support from the health system (Whiteford & Buckingham, 2005). All states and territories had documented a rising demand for mental health services, with data showing a 7 percent surge in overnight admissions to acute psychiatric units from 1998-99 to 2002-03 (Whiteford & Buckingham, 2005). In 2002, expenditure on mental health services was $3.1 billion, marking a 65 percent increase in real terms from 1993 (Whiteford & Buckingham, 2005). This increase comprised a 128 percent increase in federal funding and a 40 percent increase in state and territory spending (Whiteford & Buckingham, 2005). Despite the seemingly impressive increase of 65 percent, it

was proportional to the rise in overall government health expenditure over the same time period (Whiteford & Buckingham, 2005).

The third Plan (2003-08), prioritized enhancing the mental health workforce and improving the integration of care across various systems, including legal, emergency, and substance misuse services (Grace et al., 2015). However, critiques arose that the third Plan dispersed its resources too widely by attempting to tackle all issues identified in the preceding plans without additional federal funding or clear directives for actionable and measurable results (Grace et al., 2015). The fourth Plan (2008-2013) aimed to reinforce workforce agreements, as well as accreditation and reporting standards, deliver targeted resource packages, and define outcome goals specifically for marginalized groups, including Indigenous Australians (Grace et al., 2015). The fourth Plan did not receive any significant resource allocation, as it was overshadowed by a whole of government National Action Plan on Mental Health (Grace et al., 2015). The fourth National Mental Health Plan was endorsed at the federal Health Minister level, while the Council of Australian Governments (COAG), which includes the Prime Minister, state Premiers, and territory Chief Ministers, sanctioned the five-year National Action Plan on Mental Health in 2006 (Grace et al., 2015). The COAG (2006) Plan was bolstered by a federal government commitment to invest $1.9 billion over five years in mental health.

By 2010, objectives to improve service quality and standards in mental healthcare had been predominantly pursued through regulatory measures (Grace et al., 2015). Regulatory emphasis was primarily directed towards strengthening the accountability of federal and state/territory governments to ensure the delivery of better outcomes. The approach to regulation evolved throughout the reform initiatives. Initial approaches were characterized by a more legislative stance that later shifted to elevating service quality and the experiences of service

users. For instance, initial strategies, "such as formal recognition of consumer rights and responsibilities," gave way to "adaptive strategizing and decentralized integration" (p. 9). This federal government came to acknowledge the diversity and autonomy of the states and territories, stepping away from a one-size-fits-all jurisdictional framework. For instance, addressing inconsistencies across state borders was a key element of the earlier Plans, while the COAG Plan and the 2011-12 budget demonstrated a move toward regular assessments against critical national performance metrics, accepting the variability in how states and territories may achieve and measure success. This regulatory transition is argued to be indicative of the "ongoing negotiation and bargaining" between federal and state/territory authorities (p. 9). A National Minimum Data Set[78] was established, and by the end of the second Plan, around two-thirds of mental health organizations were participating in both strategic and routine outcome monitoring.

The effectiveness of using outcome data to foster a culture of quality improvement and to improve service quality in Australian mental health services has been questioned (Oster et al., 2023). Issues include a lack of clear accountability for outcomes and variability in the measurement of outcomes across different programs and services (Oster et al., 2023). Also, an additional need to expand the scope of reporting to include social outcomes such as housing and employment (Oster et al., 2023). Bacchi (2009) suggests that policies construct problems through problematization, shaping problems rather than responding to them. Governments are therefore perceived as producers of problems rather than responders to pre-existing issues within the world (Bacchi, 2009). While research does not conclusively prove the efficacy of outcome measures in improving quality, it also does not "challenge" the use of outcome measures as a "solution to the

[78] In 2005-06, the National Survey of Mental Health Services was replaced by the Mental Health Establishments National Minimum Data Set to sustain and upgrade national data collection for long-term continuity (Department of Health and Ageing, 2010).

problem of quality mental health care" (Oster al., 2023, p. 9). Research also shows that when choosing a service provider, consumers and carers rarely rely on performance data (Oster et al., 2023). Services may also be influenced to "game the system;" discussions with consumers and carers highlighted challenges with linking outcomes to interventions, raising concern that responses could be biased if resources or service delivery were tied to outcomes (Oster et al., 2023, p. 8). The 2020 mental health report by the Productivity Commission further highlighted concern that service providers might manipulate or skew data to present themselves favourably, or prioritize certain performance measures over others, if a benchmarking system were to be implemented. The use of outcome measures to inform resource distribution could also lead to the discontinuation of services for vulnerable groups, further deepening socioeconomic and geographic inequities in access to mental health services (Oster et al., 2023). Managerial discourse surrounding the quality and accountability of mental health services, in addition to deficit-focused frameworks in mental healthcare, continue to shape the selection and use of outcome measures (Oster et al., 2015). A recent systematic review revealed the most common outcome measures in mental healthcare related to psychosocial functioning, impairment, and symptom severity (Gelkopf et al., 2022). Findings indicate that 17 percent of services used clinician-rated measures to assess consumer needs and only 9 percent used consumer-rated measures (Gelkopf et al., 2022). The discrepancy is important as often clinician and consumer evaluations differ and the expectation is that people are involved in their own care (Oster et al., 2023). Furthermore, outcomes measures on service satisfaction and recovery are underrepresented, indicating a disconnect with recovery-focused and trauma-informed care models (Oster et al., 2023). The recent Royal Commission into Victoria's Mental Health System (RCVMHC) (Victoria State Government, 2021) recommended prioritizing personal recovery,

considering the influence of living and working conditions on health, and addressing housing needs specifically. Mental health outcome measures should therefore correspond more closely with services that are rights-based, person-centered, and recovery-oriented, and that also consider the broader social determinants of mental health (Oster et al., 2023).

Following the National Mental Health Strategy, agreed to by the COAG in 2006, the release of the National Mental Health Policy 2008 (Commonwealth of Australia, 2009) reaffirmed the commitment of all Health Ministers and Ministers responsible for mental health to the ongoing improvement of Australia's mental health system. By this time, the vision of the initial National Mental Health Policy (1992) had been operationalized through three National Mental Health Plans, the most recent being the 2003-08 (third Plan). The updated 2008 Mental Health Policy underscored the need for sustained national reform, emphasizing a seamless, consumer-focused, and recovery-oriented care system that supports community participation. The policy highlighted the collective benefits of prioritizing preventative measures and early intervention; called for cooperation across various service sectors, spanning both government and private sectors; and stressed the need for a skilled workforce to provide evidence-based quality services that are "continually monitored and evaluated" (p. 6). The policy also acknowledged Indigenous people's culture and heritage, recognizing their distinctive rights to status and culture, aiming to "close the gap on Indigenous disadvantage" through "mutual resolve, respect and responsibility" (p. 7).

While the Mental Health Policy 2008 did not introduce new funding, the 2011-12 federal budget allocated $2.2 billion to mental health, prioritizing early intervention and prevention, especially for innovative youth support services (Grace et al., 2015). Additionally, the budget established the National Mental Health Commission with a mandate to provide Parliament with a

review of mental health programs and services (Grace et al., 2015). In November 2014, Mental Health Australia,[79] the peak national non-government body advocating for the Australian mental health sector, released its *Blueprint for Action on Mental Health* to support the National Mental Health Commission's review. Mental Health Australia (MHAustralia) (2014), collaborating with its 132 member organizations, identified key directions and priorities for mental health reform. These are listed within the blueprint: the aim to redirect resources towards preventive programs, minimizing the need for costly acute hospital care; bolstering services in the community rather than hospitals to support people who become ill; realigning financial incentives to support desired outcomes, not just service provision; and integrating mental health services and programs with other support systems, recognizing the complexity of human needs, and responding to fundamental needs such as stable housing, employment, social connection, and development of independence (MHAustralia, 2014). Lastly, MHAustralia (2014) called for improved governance across governments and with non-government and private sectors to coordinate activities, oversee performance, ensure accountability, and achieve shared objectives. The National Mental Health Commission submitted its final report to the Commonwealth government in December 2014, which was later published in April 2015. The primary aim of the review was to present recommendations for the government to create a supportive system for mental health and well-being (National Mental Health Commission, 2015). The review outlined 25 recommendations across nine strategies areas, offering a comprehensive ten-year plan for implementation (National Mental Health Commission, 2015). In their initial response to the Commission's review,

[79] Founded in 1997, Mental Health Australia emerged as Australia's first independent peak organization to encompass a wide range of mental health stakeholders and concerns. Its membership comprises national entities that represent consumers, caregivers, groups with special needs, clinical service providers, professional associations, and both public and private mental health service providers, as well as researchers and state/territory community mental health peak organizations (https://mhaustralia.org/about-us).

MHAustralia (2015) highlighted the recommendation to rebrand Primary Health Networks as Primary and Mental Health Networks. This change is intended to enhance the networks' role in managing regional mental health programs, with funding based on population risk (MHAustralia, 2015). Additionally, MHAustralia (2015) pointed out the plan to incrementally redirect $1 billion from hospital budgets to community support initiatives, starting with $50 million in the 2017-18 period and increasing to $300 million annually by 2021-22. While the review focused on health and mental health sectors, it did not extensively tackle necessary reforms in employment, housing, justice, or education sectors nor details on how the mental health system might be integrated with the National Disability Insurance Scheme (NDIS) (MHAustralia, 2015). The review's findings do resonate with MHAustralia's blueprint in areas like setting standardized outcome measures and advocating for a new intergovernmental agreement to define government roles and responsibilities. However, it falls short in proposing specific frameworks for consumer and carer representation and leadership (MHAustralia, 2015).

In August 2011, the COAG endorsed the National Health Reform Agreement, affirming the collaborative commitment of the Commonwealth, states, and territories to improving health outcomes across Australia and the sustainability of the national health system (Federal Financial Relations, 2011). Under this agreement, Medicare Locals, non-profit companies, were established with a budget of $1.8 billion over five years from 2011-2016 (Horvath, 2014). Their mandate was to enhance the coordination and integration of primary healthcare within local communities, respond to service gaps, and streamline the patient experience within the local health system (Horvath, 2014). In 2013, the Liberal Minister for Health commissioned professor John Horvath to review Medicare Locals, examining their structure, operation, and functions to advise on their future direction (2014). The 2014 Horvath review revealed varying performance

levels, with only a few Medicare Locals meeting their objectives. Key findings suggested the importance of aligning with Local Hospital Networks (LHNs) for effective engagement and the necessity to accommodate to local needs, indicating that a uniform approach is ineffective (Horvath, 2014). The report also recommended renaming Medicare Locals to Primary Health Organisations (PHOs) to better convey their role in primary healthcare and a more comprehensive wellness approach (Horvath, 2014). PHOs would collaborate with GPs, specialists, LHNs, private hospitals, and other health providers to develop patient-centered clinical pathways that span across different health sectors (Horvath, 2014). In 2015, the federal government introduced reforms in primary healthcare, which included the launch of the aforementioned Primary Health Networks (PHNs) and a review of the MBS[80] (Mossialos et al., 2016). PHNs, replaced Medicare Locals, and were created to foster better coordinated care for individuals at risk of adverse health outcomes (Mossialos et al., 2016). Funded by federal government grants, PHNs collaborate with primary care providers, healthcare specialists, and LHNs to achieve these goals (Mossialos et al., 2016). The government also formed the Primary Health Care Advisory Group to explore new approaches to funding and service delivery, including a focus on mental health (Mossialos et al., 2016). These reforms aimed to optimize the efficiency and efficacy of primary care delivery and secure Medicare's financial sustainability (Mossialos et al., 2016).

Since the second National Mental Health Plan (1998-2003), "strengthening the complementary roles" of public and private mental health services has been a key focus (Kirby & Keon, 2004b, p. 14). The private sector offers various mental health services, including psychiatrists in private practice financed via the Commonwealth MBS, and inpatient as well as

[80] The MBS Review, conducted between 2015-2020, evaluated the alignment of MBS items with current clinical evidence and practices to improve health outcomes (Department of Health and Aged Care, 2023a).

community-based care in private hospitals covered by private health insurance (Kirby & Keon, 2004b). Services in general hospital settings, along with those provided by GPs and allied health professionals, form part of the private sector's contribution (Kirby & Keon, 2004b). The private healthcare sector, though complex, caters to a significant portion of the population (Kirby & Keon, 2004b). In 2023, half (55 percent) of Australians had private health coverage (Private Healthcare Australia, 2023). The National Mental Health Strategy is therefore more than just a public sector strategy as it encompasses psychiatrists, GPs, and private hospital providers (Kirby & Keon, 2004b). Fostering service integration and interprofessional partnerships has been a policy goal since the first National Mental Health Plan, but implementation has yielded different outcomes (Henderson & Roberts, 2020). By 2010, service fragmentation was prevalent, attributed to population dispersion, federalism causing ambiguous federal-state accountability, and divergent political views on private healthcare provision (Henderson & Roberts, 2020). Rural and remote areas suffered from reduced service access; a Department of Health and Ageing (2011) assessment showed growing gaps between service availability and demand. In 2015, psychiatrist availability ranged starkly from 13 per 100,000 in major cities to only 2 per 100,000 in very remote areas (National Rural Health Alliance, 2017). Federal-state dynamics, with states managing specialist services and the federal government overseeing the NDIS and primary care, complicated service coordination (Henderson & Roberts, 2020). Moreover, collaboration between public and private entities proved challenging due to differing operational styles; private providers like GPs focused on individual outcomes, while public services targeted population health. Negotiating in bureaucratic systems posed additional hurdles for private providers (Henderson & Roberts, 2020). This is problematic as in 2021-22, GPs were responsible for the highest proportion of Medicare-funded mental health services (Liotta, 2023).

In Victoria, the Andrews Labor government made a pledge to develop a 10-year mental health strategy within its first year in office (State of Victoria, Department of Health and Human Services (DHHS), 2015). *Victoria's 10-year Mental Health Plan*, launched in November 2015, fulfilled that commitment, and provided a vision to improve mental health and services and outcomes for Victorians (State of Victoria, DHHS). Over 1,000 Victorians contributed to the development of the plan, including people experiencing mental distress, their families, caregivers, healthcare providers, and various community stakeholders (State of Victoria, DHHS, 2015). With a vision for "all Victorians [to] experience their best possible health, including mental health," the Victorian government pledged to foster a healthier, more equitable, and inclusive community (State of Victoria, DHHS, 2015, p. 1). The plan outlined specific outcomes to direct efforts toward fostering the best possible conditions for the mental health of Victorians (State of Victoria, DHHS, 2015). The Victorian Branch of the Australian Nursing and Midwifery Federation (ANMF) reviewed the 10-year strategy discussion paper in August 2015 and noted that it blurred the lines between state and federal responsibilities, implying a state-centric approach to mental health. They emphasized the importance of clearly delineating the roles of various organizations involved in each proposed outcome and associating specific workforce measures with these outcomes (ANMF, Victorian Branch, 2015). Furthermore, they argued the strategy should detail the government's investment plans for each outcome and improvements for each outcome, as well establish measurable and evidence-based outcomes (ANMF, Victorian Branch, 2015). It was also recommended that the strategy be articulated in plain language to be accessible and comprehensible to the broader community (ANMF, Victorian Branch, 2015). The plan also claimed that the Mental Health Act of 2014, passed five years after *Because Mental Health Matters* (2009), "fundamentally changed" and "minimiz[ed] the use" of compulsory

mental health treatment (State of Victoria, DHHS, 2015, p. 13), when data shows that the rate of compulsory treatment in both inpatient and community contexts actually increased from 2009-2014, and has continued to rise since then (Light, 2019; Victoria State Government, 2021). The plan, however, did demonstrate a commitment to grow the peer workforce (Victorian Mental Illness Awareness Council (VMIAC), 2024). In 2016, the Post Discharge Support Initiative was implemented across all adult mental health services and at Orygen youth mental health service, marking the first program of its kind to integrate peer support workers into clinical settings statewide (VMIAC, 2024). The Department of Health and Human Services (DHHS) sponsored a five-day Intentional Peer Support (IPS) training for peer support workers within the initiative, as well as a two-day introductory IPS session for their colleagues and managers (VMIAC, 2024). Additionally, the Consumer Coproduction Workforce Group, later known as the Consumer Workforce Development Group, was formed to prioritize and address consumer workforce development (VMIAC, 2024). This initiative also saw the appointment of the first statewide Consumer and Carer Workforce Development Officers, Vrinda Edan and Lorna Downes (VMIAC, 2024). Despite such advancements, the 2017 National Report on Mental Health and Suicide Prevention raised concerns that consumer engagement in services might be "tokenistic" (Mental Health Commission, 2017). The report pointed out that adherence to standards is lax, compensation for involvement is inconsistent, and policies do not adequately incorporate human rights and a recovery-oriented methodology (Mental Health Commission, 2017). Following the launch of the 10-year mental health plan, the Victorian government allocated an additional $117.8 million in the 2015-16 budget towards mental health initiatives (State of Victoria, DHHS, 2015). This included $5 million to community organizations aimed at improving mental health support and access in the community, particularly for individuals facing complex challenges

such as homelessness (State of Victoria, DHHS, 2015). Additionally, the Victorian government signed the Bilateral Agreement for the National Disability Insurance Scheme, a crucial move to ensure the scheme's operation for Victorians, with a statewide rollout commencing July 2016 (State of Victoria, DHHS, 2015).

The Fifth National Mental Health and Suicide Prevention Plan (2017-2022) was rooted in the extensive consultations conducted by the National Mental Health Commission in 2014 (National Mental Health Commission (NMHC), 2017). It incorporated insights from mental health consumers, the mental health sector, including service providers and suicide prevention organizations, Aboriginal and Torres Strait Island organizations, state and territory governments, and other stakeholders (NMHC, 2017). The Plan acknowledged and integrated the extensive national discussions about mental health priorities, facilitated by MHAustralia (2014), ensuring representation of the wider mental health community's perspectives (NMHC, 2017). Building on the groundwork laid by its four predecessors, the fifth Plan, was endorsed by the COAG Health Council in August 2017, and outlines a five-year national strategy for collaborative government action aimed at improving the delivery of integrated mental health and related services (NMHC, 2017). The fifth plan coincided with significant changes in Australia's social policy. The *National Disability Insurance Scheme Act* was legislated in 2013, marking the first national system for people with disability. The NDIS achieved complete nationwide rollout in 2020 (National Disability Insurance Agency, 2023). Originating from a grassroots movement, NDIS was driven by the collective efforts of individuals with disabilities, community organizations, advocates, and government bodies, who all strived to transform disability services (National Disability Insurance Agency, 2023). The NDIS employs a market-based approach where individuals are assessed and allocated a budget to purchase the services they need (Henderson &

Roberts, 2020). However, consumer advocates report concerns regarding the NDIS's capacity to serve individuals with less severe mental health issues (Henderson & Roberts, 2020). The critiques highlight that the NDIS primarily caters to those with severe, ongoing psychosocial disabilities, resulting in individuals with milder forms of mental distress often not being adequately supported, revealing significant gaps in the system (NMHC, 2017; Henderson & Roberts, 2020). The Plan prioritized regional organization of primary mental healthcare (NMHC, 2017). The Coalition government consolidated Medicare Locals into Primary Health Networks in 2015 (Henderson & Roberts, 2020). This reorganization assigned PHNs the duty of managing federally funded programs like headspace[81] and psychological service access (Henderson & Roberts, 2020). PHNs' key function in primary mental health involves planning and commissioning stepped care services, a system that allocates interventions on a scale from least to most intensive, based on individual needs (Henderson & Roberts, 2020). The fifth Plan also directed attention to suicide prevention, Indigenous mental health, and services for severe and complex mental health issues (Henderson & Roberts, 2020).

In 2020, the National Mental Health Commission released *Vision 2030: Blueprint for Mental Health and Suicide Prevention*. Vision 2030 began with the Connections Project, which engaged with over 3000 Australians to gather insights on their experiences with the current mental health system, as well as their hopes for an improved one (NMHC, 2020). These discussions revealed the varying experiences across and within communities (NMHC, 2020). The Commission recognized that while the "principles of person centred care delivered in community have been the focus of advocacy by many over a number of years," Vision 2030 sets

[81] headspace, is the national youth mental health foundation, offering early intervention services to individuals aged 12-25, and is supported by the Australian Government Department of Health. Its services include online and phone counseling; headspace centers providing access to counselors and psychologists; and headspace school support, which aids secondary schools in preparing for, responding to, and recovering from suicide (Healthdirect, 2024b).

forth the systemic changes required to actualize these principles (NMHC, 2020, p. 4). It emphasizes the need to rethink the delivery of mental healthcare and suicide prevention by considering housing, economic stability, employment, environmental factors and social trends as equally important to clinical treatment in mental health and suicide prevention (NMHC, 2020). Similarly, in 2020a, amidst the Covid-19 pandemic, the Australian government released the *National Mental Health and Wellbeing Pandemic Response Plan*, backed by $48.1 million in funds. The plan emphasizes mental health alongside physical health and establishes key principles to guide jurisdictions during the pandemic (Australian Government, 2020a). These include involving consumers and carers in all response efforts; collaborative partnerships across sectors to enable efficient use of resources; an integrated approach to wellbeing that recognizes the influence of social determinants, trauma, and one's environment; community-based approaches to care delivery; care that is accessible, appropriate, person-centered, trauma-informed, and evidence-based; outcomes focused on local needs; and a commitment to equity and equality in health as a human right (Australian Government, 2020a).

In November 2020b, the federal government released the *Productivity Commission's Inquiry into Mental Health*. Established in 1998, the Productivity Commission, an agency of the federal Treasury, is the federal government's independent research and advisory body on economic, social, and environmental matters (Whiteford, 2022). The fundamental purpose of the Productivity Commission is to assist governments in developing policies that serve the long-term interests of the Australian public (Whiteford, 2022). The Commission was tasked with proposing strategies to improve population mental health, with the aim to actualize long-term economic and social participation and productivity benefits (Whiteford, 2022). The Commission's inquiry from November 2018 to June 2020, which was its largest inquiry to date, revealed that mental distress

costs Australia up to $220 billion annually, or $600 million daily, due to costs from health and social services, loss productivity, informal caregiving, and most significantly, the impact of diminished health and reduced life expectancy (Whiteford, 2022). The sum represented roughly one-tenth of the nation's Gross Domestic Product in 2019 (Whiteford, 2022). The Commission's inquiry also highlighted the "missing middle" – individuals with needs too complex for GPs yet not severe enough for specialized services – with limited access to alternative care due to cost or wait times (Australian Government, 2020b). The Commission found the gap, largely due to a shortfall in community mental health services, to vary by demographic and location (Australian Government, 2020b).

In December 2020, MHAustralia assessed the Productivity Commission's inquiry report, juxtaposing its recommendations with the nine principles[82] of Charter 2020 – a document endorsed by over 110 organizations that set out the mental health sector's reform priorities (MHAustralia, 2019). MHAustralia (2020) noted the inquiry is broad and did not fully address gaps in multidisciplinary care in the community, known as the missing middle. While the inquiry suggests improvements like Better Access sessions and improving referral pathways, concerns remain about the predominantly private primary care system, which imposes extra costs and operates in service silos (MHAustralia, 2020). The inquiry's grasp of the potential for psychosocial care was also deemed insufficient, with MHAustralia (2020) calling for a service model that integrates NDIS components with state and territory provisions. MHAustralia (2020) supports the inquiry's focus on regional planning for mental health but emphasized that this

[82] These nine principles include: "strike a new national agreement for mental health; build a mental health system that is truly person-led; address the root causes of mental health issues; invest in early intervention and prevention; fund Indigenous mental health, wellbeing and suicide prevention according to need; provide integrated, comprehensive support services and programs; expand community based mental healthcare; support workforce development; build an evidence based, accountable and responsive system" (MHAustralia, 2024a).

requires firm federal commitment and a partnership agreement for pooled PHNs and LHNs funding and co-commissioning that is highly accountable and transparent to the community. However, MHAustralia (2020) challenged the inquiry's stance that should local mental health partnerships fail to advance adequately, control should transfer entirely to state and territory governments. MHAustralia (2020) points out that these jurisdictions have historically been challenged with demonstrating the capacity and commitment to fund non-hospital mental healthcare. Additionally, MHAustralia (2020) found that the Commission assigned "unprecedented responsibility on a revamped NMHC" to lead change and as such will require "real teeth to execute this role, as well as legislative and persuasive powers" (p. 7).

In 2024, MHAustralia and the National Mental Health Consumer & Carer Forum (NMHCCF) released a joint statement urging the funding of psychosocial services outside the NDIS. While the federal government launched the Psychosocial Support Program in 2021 to assist the missing middle – individuals ineligible for NDIS support – the $237 million funding was limited to the period between 1 July 2021 and 30 June 2023 (Department of Health, 2021). MHAustralia & NMHCCF (2024) argue that Australia has not yet succeeded in creating a comprehensive network of community-based mental health support. They maintain that solely medical responses to mental health issues are insufficient and advocate for psychosocial services to aid personal recovery and community integration. Such services, often offered by community organizations, encompass a variety of supports including coordination of care, housing assistance, and social connectivity (MHAustralia & NMHCCF, 2024). They cite the Productivity Commission's (2020) estimate that 154,000 people lack access to necessary psychosocial services and the personal and societal impacts of this gap (MHAustralia & NMHCCF, 2024). They also refence the Commission's recommendation for an increase in psychosocial support

funding by state and territory governments, supported by the federal government (MHAustralia & NMHCCF, 2024). MHAustralia and NMHCCF (2024) support the Commission's critiques of short funding cycles for psychosocial supports that create instability and inefficiency in service provision and support the recommendation to extend funding terms for psychosocial supports from a one-year term to a minimum of five years with a six-month notice before cycle completion. Additionally, they support the Commission's suggestion that PHNs commit to long-term service contracts with commissioning psychosocial services to align with these extended funding cycles (MHAustralia & NMHCCF, 2024). Amidst these discussions and release of the MHAustralia and NMHCCF (2024) joint statement, the federal government allocated an additional $254.9 million in 2023 to prolong the Psychosocial Support Program for two more years, extending its operation until June 2025 (Department of Health and Aged Care, 2023b).

In March 2021, the Victorian Government published the Royal Commission's Final Report, outlining a blueprint for the reform of Victoria's mental health system. Commenced by the Labor Andrews government in February 2019, the Commission's report came after two years of inquiry and resulted in 65 recommendations detailed across six volumes and spanning over 3,000 pages (Victoria State Government, 2021). The comprehensive report informed an extensive redesign of the mental health and wellbeing system in Victoria (Victoria State Government, 2021). The Victorian government pledged to adopt all the recommendations, dedicating $3.8 billion in the 2021-22 budget for mental health reforms (Department of Health, 2024b; Federal Financial Relations, 2022). Concurrently, the federal government allocated $2.3 billion over four years through its 2021-22 budget to the *National Mental Health and Suicide Prevention Plan* (fifth Plan), informed by the Productivity Commission's (2020) findings (AIHW, 2023c). The following year, in March 2022, the National Mental Health and Suicide

Prevention Agreement was signed by the Australian Government and all state and territory governments, with the aim of delivering a coordinated, consumer-focused mental health and suicide prevention system with shared accountability (AIHW, 2023c). This Agreement outlines key priorities including regional planning and commissioning, suicide prevention and response, and psychosocial supports outside the NDIS (AIHW, 2023c). It is underpinned by bilateral agreements committing joint investments in mental health and suicide prevention services by the Commonwealth and state and territory governments (AIHW, 2023c). The bilateral agreements prioritize investments in community-based services to address gaps in the mental health and suicide prevention system and includes varying commitments across demographics and service types (AIHW, 2023c).

The Commonwealth government earmarked an additional $547 million in the 2022-23 budget for mental health reform initiatives (AIHW, 2023c). The following fiscal year's (2023-24) budget saw the allocation of $586.9 million for the development and expansion of various projects, such as delivering psychosocial support to individuals outside the NDIS scope and establishing 20 new headspace centers targeting rural and underserved communities, and increasing language interpreting services at these centers (AIHW, 2023c). The budgets also saw the provision of Medicare bulk billing for allied health professionals, including psychologists, for rural and remote regions via the MBS, and the integration of expanded telehealth services into MBS arrangements as of January 2022 (AIHW, 2023c). An independent *Evaluation of the Better Access Initiative* was released in December 2022, finding inequities in service benefits with individuals in lower socioeconomic, regional, rural, and remote areas, and individuals in long-term care deriving less benefit (Department of Health and Aged Care, 2022a). The federal response *Improving Better Access for all Australians* committed to improving the equity of the

Better Access program, by integrating perspectives from mental health experts and individuals with lived mental health experiences (Department of Health and Aged Care, 2022b). The October 2022-23 federal budget revived MBS-subsidized bulk billing psychiatry services in rural and regional areas, previously discontinued, with a $47.7 million fund (AIHW, 2023c). Concurrently, the *National Mental Health Workforce Strategy* for 2022-2032 was introduced to cultivate and sustain a skilled and motivated mental health workforce to meet the future demands of the mental health system (Department of Health and Aged Care, 2023c). MHAustralia (2023a) applauded the federal government's 2023 budget allocation of $7.5 million to establish two national lived experience mental health peak bodies, a consumer and a carer body. This move fulfilled a recommendation from the Productivity Commission's Inquiry into Mental Health (2020) and is a testament to MHAustralia's long-standing advocacy efforts for a national voice (MHAustralia, 2023a). MHAustralia also (2023b) commended federal support for enhancing digital and crisis mental health services, as well as the federal partnership with Aboriginal and Torres Strait Islander communities to improve social and emotional wellbeing services. However, MHAustralia's (2024a) pre-budget submission for 2024-25 pointed out that despite increased mental health funding, its share of total health expenditure decreased from 8 percent in 2019-20 to 7 percent in 2020-21 (see Figures 4.3. and 4.4. in Appendix B), and remains significantly lower than the Productivity Commission's estimations of the yearly economic impact of mental distress and suicide. The Commission estimated that addressing its primary recommendations would require $2.4 billion annually, while full implementation of all recommendations would cost between $3.5 and $4.2 billion each year (MHAustralia, 2020). In view of the significant economic costs of mental distress, the current investment is seen as considerably inadequate (MHAustralia, 2022).

## Conclusion

This chapter serves a dual purpose: it examines the prioritization of mental healthcare as a human right across the states and analyzes the use of mental health legislation to compulsorily treat or detain those in need. Moreover, it seeks to reveal the use of policy levers within government documents, contrasting these with community-wide perspectives, to outline directions for mental health policy reform.

Assessing how the states value human rights in mental healthcare and the degree to which they utilize civil compulsory powers for treatment is important. The balance they maintain between providing care and enforcing control is indicative of their stance on how they choose to respond to mental distress. Tracking policy developments among states for mental health reform and comparing these with insights from community organizations, reveals the levers most relied upon to actualize objectives. Part Three, will build on the sociopolitical contexts and use of levers across the states from Part One, and the focus on human rights in the context of involuntary care and policies for care integration identified here in Part Two, to facilitate a comparative exploration of how the different states progress towards more equitable mental health systems.

## Chapter 6: Comparison of Policy Levers and Policy Trajectories

This chapter, forming Part Three of the dissertation, provides a comparative analysis of the policy levers used across the states and the consequent policy trajectories aimed at mental health reform. The chapter builds on the examination begun in Part One, which explored the policy levers – namely the organization of healthcare delivery as shaped by governance models and managerial strategies; changes in financing and service system designs; and the interplay of regulatory frameworks with payment methods, providing a historical context on "windows of opportunity" that critically shaped the trajectory of reforms in each site leading up to the 2010s. Employing policy levers or "control knobs," governments aim to enact mental health reforms with the choice of lever contingent upon the prevailing political environment and existing institutional constraints. Part Two advances this exploration by analyzing the use of these policy levers and their resulting impact on mental health reforms and intersections with human rights, focusing on developments from the early 2000s to the current day. Through a comparative analysis of policy levers and their subsequent impact on mental health policy trajectories across the states, this chapter serves as a bridge between the first two sections, investigating the "scale" and "pace" of reforms aimed at promoting mental healthcare integration and equity.

### Context of Mental Health Policy Reforms

The primary concern in mental health policy is not just the correctness of national policies or the implementation of policy directions but whether the scope and speed of changes implemented have been enough (Whiteford & Buckingham, 2005). Evidence suggests that the progress made falls short of what is required (CAMIMH, 2024; Centre for Mental Health, 2022; 2023; MHAustralia, 2022). This shortfall is underscored by a historical legacy of neglect where

mental health investments lag behind those for overall health across the three jurisdictions, perpetuating the struggle to achieve parity of esteem between mental and physical health.

The discourse on mental health reform calls for a shift from an institutional-based model to a community-focused approach as substantiated by historical governmental reports. This transition reflects the voices of the policy community, highlighting an urgent need for community investment to address significant social determinants of mental health. Reconceptualizing mental healthcare demands a commitment to the three P's – "people," "place," and "purpose" – as delineated by Dr. Thomas Insel, former Director of the National Institute of Mental Health (CAMH, 2022). This approach emphasizes the importance of social support, secure housing, and meaningful engagement for individuals and their recovery paths (CAMH, 2022).

Despite a general acknowledgment of the three P's for recovery and the social determinants of health, the prevailing neoliberal governance structures continue to favour biomedical models leading to persistent tensions between risk, needs, and rights. The biomedical model serves to justify a political reluctance to incur the costs associated with addressing equity and the broader social determinants of health. It requires a paradigm shift from a focus on "mental illness" to a broader conception of mental health. Moreover, this biomedical preference empowers the pharmaceutical industry to commodify health thereby influencing the representation of communities in policy and reinforcing a risk paradigm. This not only perpetuates discrimination and social exclusion but can also lead to the misuse of Mental Health Acts (MHAs), coercion, and human rights abuses. The challenge remains to include policy communities in shared decision-making processes and reconfiguring the prevailing power dynamics that inform mental health discourse and practice.

### *The Intersection of Neoliberalism and Biomedicalism in Mental Health Policy: Critique of Risk Rationalities and Governance*

Neoliberalism and biomedicalism reinforce each other ideologically as both focus on the individual level (Morrow, 2013; 2017). The neoliberal risk paradigm "create[s] the climate of risk in order to justify its overall politic" (Stanford et al., 2017, p. 46). It provides its own logic for how public services or welfare should be conceptualized and distributed (McDonald, 2006). To understand the logic of neoliberal welfare, Stanford and Taylor (2013) outlined a typology of three risk rationalities: theoretical, substantive, and formal, which influence how experiences of mental distress are understood, come to exist, and in turn how responses are informed. Theoretical rationality concerns how risk is defined and conceptualized as a "way of thinking" (Parton, 1996, p. 96) and how things associated with it (i.e., people experiencing distress) are acknowledged (Stanford et al., 2017). Substantive rationalities of risk are described as the core values guiding the logic of welfare (McDonald, 2006). In a neoliberal risk society, the "logic of security" equates to economic security, which translates to economical prudent and responsible citizens (Stanford et al., 2017, p. 48). Accordingly, neoliberal welfare aims to secure and control people associated with risk, such as people experiencing mental distress (Stanford et al., 2017). Lastly, formal rationality comprises "the rules, laws, and regulations that govern [institutions'] actions" (McDonald, 2006, p. 40), with the enactment of risk in neoliberal welfare playing out through these formalities (Stanford et al., 2017).

The tension between risk, needs, and rights in mental healthcare provision is intrinsically linked to power structures where neoliberalism supports biomedical understandings of mental distress at the expense of equity and social supports in mental health (Morrow, 2013). Despite Canada, the UK, and Australia's ratification of the *Convention on the Rights of Persons with*

*Disabilities* (CRPD) (UN General Assembly, 2007) and their adoption of its Optional Protocol, along with reforms to their MHAs – Ontario's Bill 122 or the *Mental Health Statute Law Amendment Act* (2015), the UK's Draft Mental Health Bill (June 2022), and Victoria's *Mental Health and Wellbeing Act* (2022) – challenges persist. In each site, individuals may face involuntary detention under the premise of "need for treatment" – a non-compulsory measure in Ontario but enforced in England and Victoria – which affects the capacity of individuals with mental health or psychosocial conditions to make informed decisions about their care. Individuals may also be detained in accordance with MHAs if they pose a risk to themselves or others. MHAs facilitate Community Treatment Orders (CTOs), which authorize the conditional release of involuntarily admitted individuals into the community. These individuals are still considered under the hospital's authority and are mandated to adhere to their treatment program (Kirby & Keon, 2004a). The success of CTOs depends on the availability of essential supports and services that satisfy the conditions of the order (Kirby & Keon, 2004a). However, implementation of CTOs within a predominantly biomedical framework, without the integration of necessary community services, can result in a higher likelihood of outpatient care failures and subsequent hospital readmissions (Kirby & Keon, 2004a). Additionally, evidence suggests that CTOs are disproportionately applied to certain groups based on presumed risks rather than established needs, indicating CTOs function as instruments of social control (Brophy & McDermott, 2003). England's recent enactment of the *National Partnership Agreement: Right Care, Right Person* (2023) is designed to minimize the unwarranted involvement of law enforcement in mental health crises. However, the absence of corresponding increases in funding and workforce support has led to skepticism about the agreement's practical impact. CTOs, when enacted within a biomedical context without strengthening community services, can undermine

individual rights by favouring medical management over individual capacity and community-based interventions (Fabris, 2011).

### *Integrative Responses to Mental Health Service Crises*

As emphasized in Chapter Two, Part One, integration has been the strategic response to ongoing crises in mental health service delivery. This response has been echoed throughout the early 2000s, with policy communities increasingly highlighting deficiencies in acute, continuous, and recovery-focused care. The consensus within global mental health discourse has been to enhance service accessibility, particularly through community-based models.

Despite the prevalent discourse, government responses have predominantly favoured biomedical systems as the Covid-19 pandemic starkly highlighted. The pandemic accentuated inequities in responding to mental distress solely through medicalization and unmasked the human rights requirement of governments to provide mental health services that are acceptable to its population. This entails providing a comprehensive continuum of services and supports that acknowledge the context of needs and are seamlessly delivered between sectors not complicated by fragmented power relations. Central to this person-centered approach is ending healthcare silos and coordinating care around needs.

To this end, integration efforts call for a systemic reconfiguration of service "distribution, delivery, management, and organization of services to develop a comprehensive continuum of services to improve access, quality, efficiency and user satisfaction" (Kates et al., 2018, p. 3). The goal is to produce "accessible" and "flexible" mental healthcare systems capable of addressing the wide-ranging bio-psychosocial needs of individuals and thus preventing crises that could lead to hospitalization (Fleury & Mercier, 2002, p. 57) and other adverse outcomes such as loss of housing and employment. To adopt a framework grounded in human rights and

recovery, changes to the "rules" that organize healthcare through legislation, financing, and the ways in which community members are engaged in all processes of policy development and implementation must be made. Ultimately, the challenges which impact care integration surround the way healthcare systems will structure around needs.

**Role of Institutionalism in Comparative Analysis of Policy Levers and Policy Trajectories**

Institutionalism as a theoretical framework facilitates the examination of state political systems and the variety of policy levers employed, acknowledging the entrenchment of healthcare policies within the broader context of "institutional settings and political settlements" (Tuohy, 2018, p. 513). Institutional theory aids in understanding how established frameworks guide policy flow; although policy-making generally adheres to established paths shaped by existing institutions, significant shifts in contextual conditions can spur policymaking to instigate major reforms (Tuohy, 2018).

Institutionalism highlights that policies tend to evolve incrementally within the established frameworks, yet, occasionally, windows of opportunity catalyze profound changes (Tuohy, 2018). It provides a lens to examine the rationale behind the selection and application of specific policy levers – such as organization, finance, service system design, and professional regulation – and how they function within the healthcare system. For example, the policy lever of organization reflects macro-level changes in resource allocation and service delivery, focusing on the degree of vertical integration and ownership types within mental health facilities (Grace et al., 2015). This becomes particularly relevant when considering the transformation from decentralized to networked models of governance aimed at enhancing system integration and accountability.

Employing an institutional lens offers understandings of the strategic assumptions underlying decisions in mental health reform and the scale and pace of policy change. Recognizing decisions as "revealed preferences," the methodology dissects the strategic assumptions that inform policy changes (Tuohy, 2018, p. 75). Institutionalism thus provides a critical analytical tool to examine policy levers and their outcomes in comparative terms, highlighting the complex interplay of political will and capability that informs mental health reform paths. Despite shared challenges in healthcare across the states, the analysis highlights the importance of situating these within each country's distinct historical, political, and cultural context (Tuohy, 1999). Central to the comparative analysis is the recognition that Canada has lagged behind the UK and Australia in healthcare equity, outcomes, and accessibility, partly due to a narrower range of covered services (Schneider et al., 2017).

The analysis, similar to the analysis in Part One, will focus on isolating a dominant lever for comparative analysis among the three states, albeit acknowledging the complexity of disentangling interconnected levers. Instances where financial mechanisms were exclusively employed, such as the establishment of dedicated mental health budgets, underscore the increasing trend towards fiscal drivers as key elements of reform. The increasing reliance on financial incentives and the devolution of responsibilities to non-governmental sectors reflect the pervasive influence of neoliberal governance strategies. This tendency requires a deeper critical evaluation due to the significant implications it carries for the control and direction of healthcare funds and services.

## Comparison of Policy Levers and Trajectories in State Mental Healthcare Reforms

### *Policy Communities*

The participation of policy communities[83] serves a dual role, acting as both a lever and outcome of policy processes – serving as a lever through their engagement in the formulation of mental health policymaking and their representation across the different systems, and as an outcome by using reports from community service agencies to evaluate the effectiveness of policy trajectories and outcomes in addressing the mental health needs of the community.

**Involvement and Work**

As described in Chapter Two, Part One, the need to bolster community-based mental healthcare has been a consistent theme among policy communities, notably illustrated by the Canada Tyhurst Report published in 1963. Similarly, participation from individuals with mental health and psychosocial conditions across Canada, the UK, and Australia, has advocated for increased community support to address the social determinants of mental health including employment security, housing access, and comprehensive health services. Involvement of policy communities in policymaking is represented in the 1988 Graham Report published in Ontario, the NHS England *Local Voices* released in 1992, and the Burdekin Report released in 1993 by the Australian government.

Policy community feedback across Canada, the UK, and Australia is captured by key service agencies. The Canadian Mental Health Association (CMHA) serves as a cornerstone in Canada, recording community input and providing advocacy, alongside programs and resources to bolster mental health support (2024b). CMHA operates a network that spans across Canada, with a national office, 11 divisions, and 75 branches, including one in Ontario (2024b). The Canadian Mental Alliance on Mental Illness and Mental Health (CAMIMH) further amplifies

[83] The term policy community refers to the individuals and groups involved in the process of policymaking. The terminology used to describe these participants varies by site and includes phrases such as "people with lived experience of mental distress;" "people with mental health and psychosocial conditions;" "service users" and "user involvement" and "consumers" and "caregivers" (discussed further in Terminology in Introduction).

policy community voices. In England, two notable charities, The Centre for Mental Health (2024) and Mind England (2024) – originally the National Association for Mental Health – offer insights on mental health services and support, while also critiquing and influencing policies through action research, collaborative partnerships, and the development of peer researchers. In Australia, Mental Health Australia (MHAustralia) (2024) represents the national non-governmental sector and includes entities like the National Mental Health Consumer and Carer Forum (NMHCCF), reflecting the collective voice in shaping the mental health landscape. The Victorian Mental Illness Awareness Council (VMIAC) (2024) stands as the state's premier consumer-run body, advocating for individuals with lived experiences of mental distress.

**Initiatives to Improve Participation**

The states demonstrate an increasing trend towards involving the experiences and voices of policy communities into policy development and service delivery. While all three states share the challenge of adapting their mental health systems to better meet community needs, each does so within its unique political and governance context.

Australia secured community involvement in its National Mental Health Plan (1992), making federal funding contingent on the establishment of community advisory groups within each jurisdiction (Whiteford & Buckingham, 2005). In Victoria, adherence to the Plan was demonstrated through the required engagement of consumer consultants in paid roles (Meadows & Singh, 2003; Gerrand, 2005). Following *Victoria's 10-year Mental Health Plan* (2015) the Consumer Coproduction Workforce Group was established and tasked with advancing consumer workforce development (VMIAC, 2024). At the national level, it was not until 2023 that Australia began funding national consumer and carer mental health organizations, allocating $7.5

million for the creation of these two peak bodies for lived experience advocacy (MHAustralia, 2023a).

Since the creation of Community Health Councils in 1973, the participation of users has been fundamental to the evolution of NHS policy (Tait & Lester, 2005). Likewise, the *NHS and Community Care Act* of 1990 legally mandated the inclusion of service user feedback in the planning of services (Tait & Lester, 2005). The implementation of the *No Health Without Mental Health* strategy in 2011 built on this commitment by establishing Healthwatch England, which operates as an independent consumer advocate within the Care Quality Commission. This entity assists the public with service complaints and stands as a model for consumer advocacy (Mossialos et al., 2016). Additionally, the *Health and Social Care Act* of 2008 marked a significant shift towards public involvement in health professional regulation, mandating non-professional public membership on regulatory councils to at least fifty percent, fostering public influence in healthcare governance (Leslie et al., 2021).

Canada demonstrates ongoing developments toward enhancing community participation in healthcare regulation. There is a trend towards parity between professional and public members on the boards of regulatory authorities, although this varies by province and profession (Leslie et al., 2021). The lingering presence of elected professional majorities on some boards points to a gradual transition from traditional self-regulation to more inclusive governance structures. In contrast, Australia's Health Practitioner Regulation Agency (AHPRA),[84] since 2013, has bridged community voices and regulatory boards through its community reference group, signifying a proactive approach to public engagement in professional regulation. Collectively, these efforts signify a shift towards a model of healthcare governance that values

[84] Described further in Chapter Four, Part One.

community input, with each site taking steps to empower consumers and the public in influencing mental health services and policies.

### From Tokenism to Shared Decision-Making

The involvement of policy communities in shaping mental health polices has evolved from superficial involvement to significant participation. Initially, in Australia, this involvement was often just for show to secure funding, without much impact on real change (Whiteford & Buckingham, 2005). Over time, this tokenism was replaced by a deeper engagement, leading to increased input from consumers and caregivers.

A systematic review of 148 collaborative mental health programs, located across Canada, Europe, and Australia, highlighted inconsistencies in community involvement (Menear et al., 2016). The review found that the most common form of community involvement was through "patient education programs" and "self-management supports," while fewer than one third of the programs offered strategies related to "personalized care planning," "shared decision making," and "family or peer supports" (Menear et al., 2016, p. 528). This suggests that, despite progress towards more inclusive practices, a significant disparity persists between offering educational resources and actualizing frameworks for shared decision-making.

Effective mental health governance demands a shift beyond tokenistic engagement of policy communities to a model based on shared decision-making and co-production. Shared decision-making involves the equal participation of policy communities in planning and decision-making, ensuring that policies and practices are tailored to the diverse needs of the policy communities they serve (Menear et al., 2016). This is aligned with a person-centered approach that advocates services be designed to adapt to individual needs instead of individuals conforming to fit into pre-existing, often in-flexible, service structures. Moving towards this

model requires deliberate effort to dismantle tokenistic practices and replace them with structures that promote equity, empowerment, and partnership in policy formulation.

### *Government Structures and Healthcare Governance*

This section delves into the multifaceted context of healthcare policy across the states, shedding light on the diverse governance frameworks, policy reasoning, and managerial implications that underline the universal healthcare systems. It traces the evolution from transformative "big-bang" reforms that changed access to healthcare to the varied trajectories of mental health policy reforms, each reflecting the distinct political and socio-economic context of their respective states. Furthermore, it scrutinizes the role of managerialism in mental health services, assessing its implications on service quality and accountability, and considers the shift towards service delivery that is regionalized, emphasizing healthcare systems that are responsive and integrated to the needs of local communities.

#### Creation of Universal Healthcare Coverage and Policy Logics

Across the states, universal healthcare coverage emerged from political consensus or significant shifts within their respective systems of governance. A commonality in the strategic deployment of big-bang policy changes[85] across the three states enabled rapid and large-scale healthcare transformation (Tuohy, 2018). In Canada, the enactment of the *Medical Care Act* in 1966 represented a transformative big bang event in the creation of universal healthcare. Despite seemingly unfavorable conditions under a federal minority Pearson Liberal government, a unique all-party federal consensus catalyzed this critical healthcare reform (Tuohy, 2018). The legislation instituted a cost-sharing agreement between federal and provincial governments for physician services, which significantly altered the professional landscape by establishing a

[85] Four strategic types of policy change – big-bag, blueprints, mosaics, and incremental identified in Chapter Two, Part One, and displayed in Figure 1 in Appendix B.

bilateral monopoly between the medical profession and the state (Tuohy, 2018). The creation of universal healthcare in the UK can be traced back to the election of the Atlee Labour government in 1945, a moment described as a "political earthquake" (Brown, 2001, para. 1). The creation of the NHS in 1948 under this new government was a direct outcome of this major shift in political power. However, this big bang change was more than just a reaction to the current political climate; it was also a piece of wider reforms in social services (Tuohy, 2018). Australia's healthcare landscape was also dramatically reshaped through big bang policy changes, though this happened through a more gradual process. The Commonwealth initially played a limited role in health until a federal health department was established in 1921 (Philippon & Braithwaite, 2008). A big bang change occurred in 1946 when a Liberal and National party coalition expanded the Commonwealth's healthcare authority through an amendment to the *Commonwealth of Australia Constitution Act* (1901) (Philippon & Braithwaite, 2008). This legislative change propelled the Commonwealth to a predominant role in health policy, particularly regarding doctors and pharmaceuticals.

In the millennial reform era (1981-1996), a distinct pattern of policy logic emerged in the transformation of healthcare systems across the UK, Canada, and Australia. The UK, under Thatcher's Conservative government, instigated a radical shift from hierarchical governance within the NHS to market-type mechanisms (Tuohy, 1999b). This was accomplished by introducing a contractual relationship between independent purchasers and providers, marking a significant move from traditional managerial authority to a competitive internal market (Tuohy, 1999b). This reform fostered a new era of accountability and performance-focused healthcare delivery (Tuohy, 2003). Canada, conversely, observed a period marked by structural and institutional stability throughout the 1990s (Tuohy, 1999b). *The Canada Health Act* (CHA)

(1984) setting the terms for provincial healthcare plans, constrained the role of private finance and limited market-based competition (Tuohy, 1999b). The prevailing logic in Canadian healthcare policy favoured a collegial approach that emphasized cooperative agency relationships between patients and healthcare professionals, thereby maintaining a system steeped in medical influence and interprofessional accommodation (Tuohy, 1999b). Australia's healthcare reforms during this period were focused on balancing health outcomes with equitable access to care within a resource-constrained environment (Baum & Dwyer, 2014). Significant changes were initiated by the Liberal-Country party in 1976 to introduce competition between private and public insurance with the aim to reduce health expenditures (Philippon & Braithwaite, 2008; Boxall 2010). However, this led to an increase in service inflation and a migration from public to private healthcare prompting subsequent governments to review and overhaul the system (Boxall, 2010). The Howard Liberal-National coalition government's introduction of the Medicare levy surcharge in 1997 exemplified a big bang policy shift towards a market system underpinned by government subsidies (Boxall, 2010), encapsulating the ongoing ideological debate between market-driven models and government-controlled universal coverage (Philippon & Braithwaite, 2008).

Incremental change marked the early 2000s across the states. In the UK, the Blair Labour government methodically worked to dismantle previous Conservative reforms, maintaining the purchaser/provider split while reinforcing the centralized nature of the NHS (Tuohy, 2018). Canada's Liberal government, under Martin, capitalized on opportunities for federal funding, resulting in the Health Reform Fund, which prioritized primary care, home care, and catastrophic drug coverage (Hutchison et al., 2011). Meanwhile, Australia under the Rudd Labor government set up the National Health and Hospitals Reform Commission, culminating in a major funding

guarantee for hospital services and a proposal to become the principal funder of public hospitals (Wells, 2013).

The UK and Australia leaned towards market models, in contrast to Canada's collegial system, which, under the stability of the CHA, evolved more slowly in its mental health reforms. Canada's deliberate pace reflected its preference for public financing and cooperative healthcare relationships over market competition. These different approaches during the millennial era highlight the varied values and strategic priorities each state brought to healthcare and mental health reforms.

### Managerialism in Healthcare Governance and Policy Implications

The examination of the adoption and implications of managerialism supported by neoliberal governance across the different mental healthcare systems indicates a trend towards market-oriented values and performance-based accountability. Managerialism, rooted in neoliberalism, emphasizes market values such as efficiency, cost-effectiveness, and competition within public services (Gavin, 2020). In mental health, managerialism has manifested in the form of outcome measures, benchmarking, and key performance indicators (Oster et al., 2023). The approach is driven by the belief that quantifiable measures can improve service quality and accountability, reflecting broader neoliberal ideas of market-driven efficiency in public services.

The states embraced managerialism to varying degrees within their mental health policies. The *No Health Without Mental Health* (2011) strategy in England demands the integration of specific quantifiable outcomes within NHS frameworks to hold healthcare professionals accountable for the results they produce. Similarly, the Australian *Mental Health Strategy* (1992) and subsequent Plans emphasize outcome-based measures. The creation of a national minimum data set further reflects a commitment to quantifiable metrics. This approach,

however, can also be interpreted as an answer to the growing call for more accountability and transparency within mental health service provision. Canadian federal and provincial strategies exhibit a managerial approach by focusing on outcomes and benchmarks. The Centre of Excellence established within Ontario Health in 2019, is recognized as the cornerstone of the *Roadmap to Wellness* provincial strategy (2020), in establishing clear connections between mental health services and outcomes, and solidifying outcome-related expectations. The Centre integrates performance indicators into mental health governance aligning with managerial values.

While managerialism and outcome measures are intended to address quality care issues, research suggests no conclusive evidence of their efficacy (Oster et al., 2023). Moreover, managerial discourse shapes policy creation, often defining problems based on the measures available to track them rather than on inherent needs or rights. As Bacchi (2009) argues, this may result in governments constructing problems through policy rather than simply responding to pre-existing conditions. Data also suggests a significant discrepancy between clinician-rated and consumer-rated measures, which signals a divergence between service provision and consumer involvement in their care (Gelkopf et al., 2022). Furthermore, underrepresentation of service satisfaction and recovery in outcome measures indicates a potential misalignment with recovery-focused and trauma-informed care models (Oster et al., 2023).

The Royal Commission into Victoria's Mental Health System (Victoria State Government, 2021) emphasizes the need to shift towards personal recovery, advocating that outcome measures should align more closely with rights-based, person-centered, and recovery-oriented services. The Commission also recommends considering broader social determinants of health, which traditionally fall outside the scope of market-oriented measures. This aligns with a

growing recognition of the importance of addressing the underlying social factors that significantly impact mental health outcomes, thereby extending beyond the confines of neoliberal governance and embracing a more integrated and person-centered approach to mental healthcare.

### Federal Accountability and Organizational Collaboration for Care Integration

The UK and Australia's healthcare policies shifted toward greater federal oversight earlier than Canada's prompting quicker mental health service reforms – as demonstrated by their mental health strategies, published well over a decade ahead of Canada's.

In healthcare governance, England adopts a centralized model, with the Secretary of State for Health legally committed under the *Health Act* (2006) to endorse a comprehensive health service (Mossialos et al., 2006). The Department of Health oversees the strategic direction of the health system, while NHS England, an independent public body, manages its daily operations (Mossialos et al., 2006). Strategic initiatives such as the NSF-MH (1999), the NHS Plan (2000), the *Five Year Forward View* (2016), and the NHS Long Term Plan (2019) are directed at enhancing mental health outcomes.

Australia's federated system allows the Commonwealth government a substantial role in healthcare through Medicare where in 2021-22 it funded 72.9 percent of the country's public health funding (AIHW, 2023a). Since the introduction of the National Mental Health Strategy in 1992, and subsequent Mental Health Plans, the Commonwealth has played a key role in financing mental health initiatives. Additionally, the Council of Australian Governments (COAG), which includes the Prime Minister, state Premiers, and territory Chief Ministers, collaborated to devise and fund mental health improvement plans tailored for each state. This collaborative effort is reflected in initiatives like the COAG National Action Plan on Mental

Health 2006-2011 and the National Health Reform Agreement (2011), which established Medicare Locals, later replaced by the current Primary Health Networks (PHNs).

Canada also presents with a federated structure, but stands in contrast, with a more limited role for the federal government in healthcare delivery guided by its Constitution (*The British North American Act* 1867). Canada's provinces and territories, under the CHA (1984), must adhere to its five principles to receive federal financing for provincial/territory medicare plans. Provincial and territorial governments hold the primary responsibility for healthcare, evidenced by the federal government funding only 24.5 percent of Ontario's health sector spending as of 2022-23 (FAO, 2023). Similarly, medicare in Canada offers less comprehensive coverage, compared to NHS England or Australian Medicare (Bartram, 2020). The decentralized healthcare delivery model has historically limited federal influence on provincial/territorial health policies. Mental healthcare, notably absent from initial medicare coverage, faced delays in federal funding inclusion, not addressed until the federal Health Accord in 2017 (Wiktorowicz et al., 2020). The 2012 National Mental Health Strategy, while a federal initiative, did not have the mandate to direct provincial/territorial resource allocation for mental health services.

### Commissions Guiding Mental Health Reforms

The commissioning approach has been instrumental in guiding mental health policy with numerous commissions across the states contributing to continuous mental health evaluation and reform. In Canada, under the Chrétien Liberal federal government, the Commission on the Future of Health Care was established in 2001 to examine medicare, followed by the Standing Senate Committee on Social Affairs, Science and Technology in 2003 to provide a comprehensive study of mental health and substance use. The Mental Health Commission of Canada (MHCC), launched in 2008 and renewed in 2015, under the Harper Conservative federal

government, was tasked with creating a national strategy, combating stigma, and creating a knowledge exchange centre (CMHA, 2013; CAMIMH, 2016). In Ontario, the Health Services Restructuring Commission, created in 1996, under the Harris Progressive Conservative party, advised on reinvestment in health services and proposed system restructuring (Nelson et al., 2001). This was succeeded by the 2009 Select Committee on Mental Health and Addictions, appointed by the legislative Assembly of Ontario, which recommended a provincial strategy (Select Committee on Mental Health and Addictions, 2010a), and later, the 2019 establishment of the Centre of Excellence within Ontario Health, under the Ford Progressive Conservative party, aimed at centralizing accountability for mental health and substance use care (CMHA, 2020). The UK saw the formation of the independent Mental Health Taskforce by NHS England in 2015, under the Cameron Conservative party, leading to the *Five Year Forward View for Mental Health* (2016), an initiative supported by contributions from a broad public consultation (NHS England, n.d. -d). In Australia, the National Health and Hospitals Reform Commission initiated in 2008, under the Rudd Labor party, advised on systems reforms (Boxall, 2010), followed by the establishment of the National Mental Health Commission in 2012, under the Gillard Labor party (Grace et al., 2015). The Productivity Commission, since 1998, has provided economic, social, and environmental policy advice, including a significant inquiry into mental health in 2020, under the Morrison Liberal (Coalition) party (Whiteford, 2022). Moreover, the 2019 Royal Commission into Victoria's Mental Health System, under the Andrews Labor party, was tasked with providing a comprehensive blueprint for system reform (State of Victoria, 2022). These efforts across different political administrations and healthcare systems highlight the universal recognition of the need for collaborative, informed, and strategic policy-making in mental health.

**Divergent Implementation Mechanisms in Shared Mental Health Reform Vision**

Strategies for mental health reform (see Table 1 in Appendix A), as detailed in Chapter Two, Part One, endorse a shared vision of systemic change but reveal diverse implementation mechanisms reflective of each state's governance context. These strategies are united in their advocacy for a whole-of-government approach aimed at achieving population mental health. Yet, their practical application diverges, adopting either policy integration, innovative funding mechanisms, or structural transformations as their main instrument for actualizing this vision.

Ontario's *Open Minds Healthy Minds* (2011) and the national *Changing Directions, Changing Lives* (2012) strategies represent pivotal milestones in mental health reform, aiming for system-wide improvements through policy integration. However, both fell short in actualizing their vision due to the absence of new funding streams. A paradigm shift occurred with Ontario's 2020 *Roadmap to Wellness*, supported by an unprecedented $3.8 billion funding over ten years, aligning with the 2017 federal Health Accord's $5 billion over the same period. These investments marked a significant shift towards fusing policy integration with funding mechanisms to reinforce a vision of a comprehensive and connected mental health and substance misuse system for Ontarians.

In the UK, the *New Horizons* 10-year mental health strategy and the *Future Vision for Mental Health*, both released in 2009 and building upon the NSF-MH (1999), emphasized financial drivers as critical for fostering cross-sectoral collaboration. The innovative 'payment by results' scheme introduced by the *Health and Social Care Act* (2012) solidified this connection between financial incentives and improved health outcomes. Subsequent policies, including the *No Health, Without Mental Health* (2011), the *Five Year Forward View for Mental Health* (2016), the NHS Long-Term Plan (2019), and the Major Conditions Strategy – Interim Report

(2023), continued to highlight the importance of funding incentives to support collaboration, evident in the grant-based funding for psychological services and the investment in transformational initiatives in lines with the NHS Long Term Plan. However, the release of the Major Conditions Strategy, which encompasses mental health within a broader health context rather than a standalone ten-year strategy as seen with *New Horizons*, signifies a pivot towards policy integration, positioning mental health alongside physical health for comprehensive policy consideration. This strategic shift has sparked debate, with the policy community expressing concerns that such an approach may redirect the focus from prevention to treatment, potentially neglecting the deeper societal issues that contribute to mental distress and undermining the delivery of necessary care (Mental Health Foundation, 2023).

Australia has highlighted the significance of structural transformations to advance mental health reforms. Federal strategies, including the National Mental Health Policies of 1992 and 2009, along with a series of five Mental Health Plans, and the *Vision 2030 Blueprint for Mental Health and Suicide Prevention* (2020), have been unified in their focus on reshaping the governance of health and social services to better meet the needs of populations. Notable initiatives include the National Disability Insurance Scheme (NDIS) and the Psychosocial Support Program, specifically designed to address gaps left by the NDIS, as addressed by the Productivity Commission's *Inquiry into Mental Health* in 2020. Complementing these federal efforts, the Council of Australian Governments' (COAG) *National Action Plan on Mental Health* released in 2006 has guided state-specific reform plans, notably in Victoria. Subsequent to the COAG Plan, Victoria has released two mental health strategies – *Because Mental Health Matters* in 2009 and *Victoria's 10-year Mental Health Plan* in 2015 – both of which received state funding aimed at reducing disparities, enhancing prevention efforts, fostering cross-sector

collaboration, and integrating peer support roles into healthcare settings. This commitment to reform was further propelled by the Royal Commission's Final Report into Victoria's Mental Health system in 2021, which informed a comprehensive overhaul of the system, backed once again by dedicated state financial support.

Similarly, while the strategies across the states, all emphasize a recovery or person-centered approach, they differ in how they integrate the concept into their broader healthcare frameworks and the specific operational measures they employ to achieve recovery-oriented outcomes. In Canada, the 2011 Ontario provincial and 2012 national strategies, conceptualize recovery through the lens of empowerment and self-determination, positioning the individual at the centre of their care journey. In contrast, the 2020 Ontario *Roadmap to Wellness* provincial strategy, linked recovery with community independence and care outcomes. The UK's NHS Long Term Plan (2019) highlights recovery-focused care and supports this with the establishment of a Financial Recovery Fund, which reinforces the sustainability of NHS Services. In Australia, the Fourth National Plan (2009), identifies recovery as one of its five priority areas, directing attention to services designed to support recovery and foster social inclusion by improving access to housing, education, and employment opportunities. Similarly, Victoria's 10-year mental health initiatives – *Because Mental Health Matters* (2009) and Victoria's 10-year Mental Health Plan (2015) – prioritize recovery and social inclusion, as well as practices oriented towards recovery and the tailoring of recovery processes to the individual. As detailed in Chapter Two, Part One, both Australia and England implemented performance indicators and outcome measures that are specifically aligned with recovery to ensure objectives related to recovery are being met.

**Regionalization and Local Service Delivery**

A consistent shift towards regionalization and local autonomy in mental health service delivery is observed, with an increased adoption of network governance models. This trend recognizes the importance of tailoring services to local needs and facilitating coordinated care through shared governance structures. In Ontario, the evolution from District Health Councils (DHCs) to Local Health Integration Networks (LHINs), and subsequently to Ontario Health Teams (OHTs), reflects a trajectory towards more localized health planning and service integration, despite varied degrees of fiscal and administrative authority. The NHS in the UK has experienced its own transformations, beginning with Regional Health Authorities (RHAs) and progressing through Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs), and now to Integrated Care Systems (ICSs). This journey mirrors a progression from regional planning and resource allocation to more integrated collaborative models of care delivery, aiming to provide comprehensive health services that align with community needs. In Australia, the progression from Medicare Locals to Primary Health Networks (PHNs) and the establishment of Local Hospital Networks (LHNs) exhibits a similar drive towards strengthening local health service coordination and integration. The regionalized approach is further reinforced by recommendations from the Royal Commission into Victoria's Mental Health System (2021), advocating for localized decision-making to ensure that mental health services are responsive and adapted to the distinctive requirements of each community. The transition towards more regionally oriented health governance and service delivery models across these states exemplifies an ongoing commitment to improving mental health outcomes through more responsive, integrated, and locally governed healthcare systems.

***Financing and Payment***

This section provides a comparative analysis of healthcare financing and delivery, focusing on the role of physicians within public healthcare systems in Canada, the UK, and Australia. It examines the differences in healthcare financing across the states, emphasizing the varied roles of government and the mechanisms of funding delivery. The section highlights the broader scope for private healthcare options in England and Australia, and the predominantly fee-for-service (FFS) payment models in Canada and Australia. Additionally, it addresses the challenges of aligning mental health services with physical health services, reflecting on the strategic allocation of healthcare expenditures to improve mental health outcomes.

**Healthcare Financing and Delivery**

Within public healthcare systems, physicians are often the primary point of contact for mental health services, guiding patient navigation and care coordination (Kirby & Keon, 2004b). In comparing the financing of healthcare and physicians across Canada, the UK, and Australia, several notable distinctions emerge based on the varying roles of government and the mechanisms by which funding is delivered. England and Australia provide a wider scope for private healthcare options, and both Canada and Australia typically compensate their public sector physicians on a FFS basis.

In Canada, healthcare financing is predominantly the responsibility of the provinces and territories, which utilize general tax revenues (Kirby & Keon, 2004b). The federal government contributes through the Canada Health Transfer, calculated on a per capita basis. Canadian medicare provides public insurance for essential hospital and physician services, with variations in covered services across provinces and territories. A private healthcare insurance sector exists, predominantly for services not covered by medicare such as psychological counselling. Family physicians, who are central to mental health service delivery, operate under a FFS payment

model, which has been criticized for poor remuneration for mental health services, potentially incentivizing volume over quality of care.

The NHS in England, funded largely by general taxation, offers a broader spectrum of coverage compared to Canadian medicare, and includes an adjunctive private sector where individuals may obtain private insurance for faster or alternative care options (Kirby & Keon, 2004b). The NHS framework allows for patient co-payments for certain services. GPs in England, contrasting with Canada's fee-for-service model, predominantly receive capitation payments, which constitute the bulk of their remuneration. These GPs, as independent contractors, fulfill a critical role in mental healthcare delivery and act as essential intermediaries within the NHS structure. Since 2019, GP practices formed local networks, known as Primary Care Networks, to scale up care delivery through shared staffing and funding resources (Fisher et al., 2019). NHS England holds formal responsibility for commissioning primary healthcare services, a role that has evolved through various organizational bodies, culminating in the *Health and Care Act* of 2022, which established Integrated Care Systems (ICSs) that guide the commissioning and integration of primary care services (NHS England, n.d. -a).

In Australia, responsibility for healthcare is shared between the Commonwealth and state and territory governments (Kirby & Keon, 2004b). The Commonwealth plays a stronger role in healthcare compared to Canada, as the Australian states and territories rely more on it for their healthcare funding. The Commonwealth government manages Medicare, which is comprised of the Medical Benefits Scheme (MBS), the Australian Health Care Arrangements (AHCAs), and the Pharmaceutical Benefits Scheme (PBS), and oversees the private healthcare insurance sector. Commonwealth healthcare funding stems from general taxation and is supplemented by a dedicated healthcare levy of 1.5 percent on taxable income. State and territory healthcare

financing also comes from Commonwealth allocations, their own tax revenues, and user charges. Similar to Canada, GPs in Australia are largely remunerated through an FFS payment scheme. Unlike Canada, GPs can practice in both public and private settings, and there are fiscal incentives and penalties designed to encourage private health insurance uptake among higher-income individuals who might otherwise opt out.

### Reassessing Healthcare Expenditure: Case for Strategic Allocation

While Canada allocates a greater proportion of its Gross Domestic Product (GDP) to healthcare than both the UK and Australia, the 2021 report by the Commonwealth Fund indicates that the latter countries outperform Canada in terms of healthcare efficiency relative to spending. This data supports the notion that the key to improving healthcare performance may not lie solely in increasing expenditure, but rather in optimizing the way in which funds are utilized (Tollinsky, 2021).

The WHO (2021) has linked community resourcing with improved health outcomes particularly addressing poverty, inequality, discrimination, and violence. Echoing this perspective, a 2009 report by the Canadian Senate highlighted that the healthcare system impacts only a quarter of health outcomes, placing more significant emphasis on the socioeconomic environment as the predominant determinant of health. This is aligned with research from Greener (2003), which posits that socioeconomic factors account for over 40 percent of health outcomes within a health authority in the UK. To elevate community services, to achieve a quality on par with that of hospital care, requires funding that is commensurate with that of hospital care (Flood & Thomas, 2016). Research demonstrated that without change to total government spending, reallocating funds from healthcare to social services, within nine Canadian provinces between 1981 to 2011, improved various population health outcomes,

including reduced mental health related work absences (Dutton et al., 2018). As little as a one-cent increase in social spending per dollar spent on health was linked to reduced avoidable mortality and longer life expectancy (Dutton et al., 2018, p. E66). These findings support the potential for community service networks, which rely on comprehensive support and services (Wiktorowicz, 2005), to benefit significantly from a larger share of health budgets dedicated to social care.

### Data Comparability and Reporting in Mental Health Expenditure

When evaluating mental healthcare costs, a note of caution must be exercised due to the complex nature of data comparability across the different states. Each state has distinct methods for measuring and reporting on mental health spending, creating challenges for direct comparisons (Kirby & Keon, 2004b). Despite this, it is feasible to track spending trends over time within the states to identify the factors that drive increased attention and sustained funding for mental health.

Australia and England, notably, have been more active in generating mental health reports, providing more comprehensive insights into the trajectory of mental health spending. Australia, with its series of National Mental Health Plans, offers detailed longitudinal data that surpasses what is available from the UK and Canada. These reports exemplify the benefits of continuous and systematic data collection, contributing to a deeper understanding of how mental health budgets are managed and allocated.

Furthermore, both Australia and England established highly detailed targets and standards within their mental health strategies. Australia has been measuring outcomes since the 1992 Mental Health Policy and subsequent Plans, while England started tracking performance

targets with the implementation of the National Service Framework for Mental Health (NSF-MH) in 1999.

In contrast, Canada lagged behind, only beginning to track indicator outcomes in May 2019, with the establishment of six broad national indicators (Bartram, 2020). This delay in the implementation of systematic outcome measurement reveals gaps in transparency and accountability within Canada's mental health system. Such gaps underscore the need for improved and consistent data reporting practices to facilitate better comparisons and informed decision-making regarding healthcare spending priorities (see Tables 2.1.-2.3. in Appendix A).

### Mental Health Funding and Outcomes

The states show different degrees of integration and prioritization of mental health within their healthcare systems. Canada's approach has been reactive, characterized by structural stigma and funding delays that are slowly being rectified. In contrast, historically, England and Australia have been proactive, with England focusing on integrating mental health into broader healthcare reforms and Australia implementing a long-term, well-funded national strategy. The distinct funding approaches and outcomes are shaped by the differing governmental frameworks and policy priorities.

#### *Canada*

In Canada, the challenge of accountability for federal transfers to provincial and territorial governments is significant, exacerbated by a decentralized government structure that complicates reforms and the tracking of new public investments in mental health (Bartram, 2020). Such systemic issues have been described as structural stigma, where mental health consistently remains marginalized within foundational healthcare legislation and funding models (Wiktorowicz et al., 2020). This exclusion has historically influenced how laws, policies, and

plans allocate resources for mental healthcare, perpetuating a cycle of neglect within institutional policies and funding models.

The Standing Senate Committee on Social Affairs, Science and Technology, under the leadership of the Honourable Michael Kirby and Deputy Chair, the Honourable Wilbert Joseph Keon, highlighted the necessity of ring-fencing mental health spending (2004b; 2006). This approach aims to prevent the misallocation of funds designated for mental health to general healthcare or other governmental levels without corresponding increases in mental health funding. Despite these recommendations, it was not until the 2017 Health Accord that significant funding was allocated – $5 billion over ten years. Further investment followed at the provincial level with the 2020 *Ontario Roadmap to Wellness* strategy, which earmarked $3.8 billion over ten years to develop a comprehensive mental health and substance use system in Ontario (FAO, 2023).

While there have been discussions about expanding the CHA (1984) to include mental healthcare, the federal government remains cautious. There is concern that amending the CHA could lead to provinces retracting their commitments under the Act, driven by fears that such changes could compromise existing protections for the sake of uncertain benefits. This apprehension is further compounded by pressures from the private healthcare sector advocating for modifications to the CHA. Public criticism has also emerged, particularly concerning the government's willingness to fund medical procedures at private clinics, which is perceived as a significant shift in healthcare delivery and governance, as seen with Ontario's Bill 60 in 2023 (McGregor, 2023).

### *England*

England's mental health strategy has been marked by consistent and specific targeting of funds and outcomes. Initiatives began with the establishment of the National Service Framework for Mental Health (NSF-MH) in 1999, setting a precedent with a £700 million allocation over three years (Marshall, 1999), followed by an additional £300 million from the 2000 NHS Plan earmarked specifically for mental health improvements (Kirby & Keon, 2004b). The launch of the *No Health Without Mental Health* strategy in 2011 further solidified this commitment by dedicating £400 million over four years to broaden access to psychological therapies nationwide (Department of Health, 2011). The momentum continued with the 2016 publication of the *Five Year Forward View for Mental Health* by the independent Mental Health Taskforce to NHS England, which secured an additional £1 billion to expand high-quality services to an extra one million people by 2020/21 (Her Majesty's Government, 2017). In 2019, the NHS Long Term Plan introduced a ring-fenced local investment fund that promised at least £2.3 billion annually by the 2023/24 fiscal year, aiming to further fortify mental health services (UK Parliament, 2023).

England's approach to mental healthcare, characterized by strategic funding and integration within broader health policies, shows a strong commitment to improving mental health services. However, incorporating mental healthcare into the general health strategy, through the Major Conditions Strategy, raises concerns about the potential shift in focus from prevention to treatment. There is a risk that such integration might dilute the attention to specific mental health needs and overlook societal factors contributing to mental distress, which could compromise the effectiveness of targeted mental health interventions.

Community feedback, highlighted by the Centre for Mental Health (2022), reflects a significant public demand for targeted initiatives to improve mental well-being. Proposed

interventions include increasing social security benefits, implementing the Living Wage, and providing support for housing and childcare expenses. These suggestions also emphasize improving service availability in economically disadvantaged areas aiming to tackle both immediate and broader social determinants of mental health. Such community-driven proposals advocate for maintaining distinct and dedicated mental health strategies within the healthcare system to ensure that mental health receives the targeted attention and funding necessary to effectively address the social determinants of health.

### *Australia*

Australia's national involvement in mental health significantly picked up with the initiation of the National Mental Health Policy in 1992, followed by a series of structured five-year plans. These plans have been essential in shaping a sustained and strategic approach to mental health reform and investment. By the beginning of the second National Mental Health Plan, federal spending had increased from 27 percent from the start of the first Plan to 35 percent (Kirby & Keon, 2004b), underscoring the Commonwealth and state governments' joint effort under the National Mental Health Strategy. This collaborative funding effort led to notable funding milestones, including $1.9 billion allocated between 2006 and 2011 under the COAG National Mental Health Plan (2006), and $2.2 billion in 2011-12, ahead of the fifth Plan (Grace et al., 2015). The momentum continued, with $2.3 billion committed in the 2021-22 federal budget over four years (AIHW, 2023c). This was complemented by the establishment of the National Mental Health and Suicide Prevention Agreement in March 2022, signed by the Commonwealth government and all state and territory governments, cementing a framework supported by bilateral agreements for continued joint investments in mental health and suicide prevention initiatives. Following this, the federal budgets for 2022-23 and 2023-24 contributed

$547 million and $586.9 million, respectively (AIHW, 2023c). These funds have been instrumental in supporting the objectives set forth in the 1992 Mental Health Policy and the subsequent five Mental Health Plans, which include initiatives such as early intervention and prevention programs, Medicare bulk billing for psychologists, the support of national mental health peak bodies, and the development and expansion of headspace centers.

In Victoria, commitment to mental health has been demonstrated through substantial funding allocations. Notably, $128 million was dedicated over four years in 2009 as part of the *Because Mental Health Matters* Reform Strategy, and an additional $117.8 million was allocated in the 2015-16 state budgets (State of Victoria, DHHS, 2015). These investments supported a wide array of initiatives, with a particular focus on improving community-based support and access for individuals facing complex challenges such as homelessness. Continuing this trajectory, the 2021-22 State budget committed $3.8 billion (Federal Financial Relations, 2022) to enact the reforms recommended by the Royal Commission's (2021) final report, further emphasizing Victoria's dedication to strengthening mental healthcare.

### Challenges with Proportional Allocation of Mental Health Funding

The use of finance as a lever for influencing mental health policy and service delivery has increased over time. However, the proportional investment in mental health services relative to overall health expenditures continues to raise significant concerns about the adequacy and focus of these investments across the states. While England and Australia implemented stronger safeguards to secure dedicated funding for mental health, there remains a significant challenge in transforming these financial commitments into targeted actions that meet the distinct needs of mental healthcare systems across all states. Achieving this goal requires a more transparent and

accountable approach to strategically aligning financial resources with the recognized importance of mental healthcare.

### *Canada*

While provinces and territories traditionally handle healthcare funding and delivery, in 2017, the Liberal federal government took a significant step by committing $5 billion over ten years to bolster mental health and substance use services across Canada (Bartram, 2017). This marked the first time in history where the federal government allocated a specific investment for mental health (Department of Finance Canada, 2017). However, Figure 4.1. in Appendix B illustrates the financial requirements necessary to bridge the mental health funding gap, specifically detailing the funds needed to raise the healthcare spending allocation for mental health from seven to nine percent (Bartram & Lurie, 2017). This adjustment aligns with the recommendations set forth by the Mental Health Commission of Canada (MHCC) in their 2012 national strategy and considers the 2017 federal commitment of $500 million annually.

In 2021, an additional pledge by the Liberal government proposed a $4.5 billion mental health transfer over five years, although this specific transfer was never realized (Raycraft, 2024). Instead, in 2023, the government allocated $2.5 billion over the next ten years through bilateral agreements focused on several priorities, including mental health (CAMIMH, 2023). Yet, this allocation falls significantly short of the $5.3 billion annually, valued at 12 percent of provincial and territorial spending, recommended by the Canadian Mental Health Association (CMHA) (2023) to achieve parity between mental and physical healthcare funding, with 50 percent of funds suggested for community-based care. The ongoing challenge is ensuring that these dedicated funds are effectively utilized for mental health initiatives and not absorbed into broader provincial budgets. Despite all provinces and territories signing bilateral funding

agreements with the Liberal federal government, the lack of public access to these agreements limits transparency and accountability regarding the actual utilization of these funds.

While there has been a noticeable increase in community mental health spending, the portion of total health spending dedicated to mental health in Ontario was only 1.2 percent of an additional $2.9 billion in federal health transfers from 2005 to 2011 (Wiktorowicz et al., 2020), which was considerably lower than the national average of 7.2 percent in 2014 (Lurie, 2014). Further research reveals that in 2013, public expenditure on community mental health services in Quebec was approximately ten times greater than that in Ontario (Wang et al., 2018). The preference for general rather than targeted funds during the 2015 Health Accord negotiations also reflects a trend where provinces seek greater flexibility in the use of federal funds, which can lead to dilution of targeted mental health funding (J. Philpott, personal communication, August 14, 2019).

The Financial Accountability Office (FAO) of Ontario's review in March 2023 found that mental health and substance use programs accounted for only about 3 percent of the total health sector spending in 2021-22, with projections for this spending to grow at an average annual rate of 5.4 percent from $2.0 billion in 2021-22 to $2.7 billion in 2027-28 under the Province's *Roadmap to Wellness* Strategy. This roadmap includes commitments to invest $3.8 billion over ten years in mental health, with half of this funding coming from the federal government under the Canada-Ontario Home and Community Care and Mental Health and Addictions Services Funding Agreement (bilateral agreement with the Liberal federal government established from the 2017 Health Accord). Ontario's budgets for 2021 and 2022 further allocated $175 million (Ministry of Finance, 2021) and $204 million (FAO, 2023), respectively, to expand mental health capacity. The establishment of the Financial Accountability Office in 2013 and the

bilateral agreements following the 2017 federal investment mark a new phase of accountability and transparency in Canada's healthcare expenditure, aiming to ensure that healthcare dollars are effectively used and lead to the intended health outcomes.

### *England*

In England, while there have been absolute increases in funding for mental health, these have not always kept pace with increases in the broader healthcare sector. Analysis by the Sainsbury Centre revealed that while there was a 7.1 percent increase in adult mental health service funding by the NHS and local authorities in 2002/03, this rate was not comparable to the overall increase in health and social care funding (Kirby & Keon, 2004b). Adjusting for inflation and salary increments, mental health funding growth was less than half that of the total NHS and social services budget. Despite the NHS Plan (2000) labeling it a priority, the Centre highlighted that the funding increase fell below the necessary 11.5 percent annual growth to meet the NSF-MH (1999) objectives within the 10-year timeline.

Mental health funding by local Integrated Care Boards (ICBs) is typically discretionary, allowing them to decide their mental health budget allocations from the general funding pool (UK Parliament, 2023). Neither central government nor NHS England sets specific mental health funding levels for local areas. However, local areas must comply with the mental health investment standard,[86] ensuring local mental health funding rises at least in proportion to the overall local health funding increases (NHS North East London, 2022).

Under the *Health and Care Act* (2022), the Secretary of State must disclose before the financial year begins whether the budget allocation for NHS mental health services is expected to increase over the previous year (UK Parliament, 2023). Steve Barclay, Secretary of State for

[86] See footnote 65.

Health and Social Care, noted in his 2022/23 annual statement that mental health expenditure was 8.90 percent of the total recurrent NHS budget, with a projected slight increase to 8.92 percent for 2023/24 (see Figure 4.2. in Appendix B) (DHSC, 2023a). Additionally, the NHS Long Term Plan (2019) commits to increasing the NHS budget portion for mental health services by an additional £2.3 billion annually by 2023/24, including the creation of a new ringfenced local investment fund of at least £2.3 billion starting in the 2023/24 fiscal year (NHS England, 2019).

***Australia***

In Australia, the use of payment as a policy lever to control and standardize mental health service reform has grown. This reflects a broader federal intention to improve accountability and outcomes-based funding within the sector. In 2002, spending on mental health services reached $3.1 billion, a 65 percent real-term increase since 1993, the year after the National Mental Health Policy was introduced (Whiteford & Buckingham, 2005). This funding growth consisted of a 128 percent increase in federal contributions and a 40 percent rise from state and territory governments (Whiteford & Buckingham, 2005). Despite this notable increase, the rise in mental health spending was in proportion to the overall increase in government health expenditure during the same period. For the first time, the Medicare Agreement Acts of 1993-1998 earmarked a dedicated allocation for mental health separate from other health services, leading to the establishment of a specific mental health budget and a rise in ongoing mental health expenditure (Grace et al., 2015). Despite significant investments, MHAustralia noted in its 2024 pre-budget submission that mental health funding's proportion of total health expenditure dropped from 8 percent in 2019-20 to 7 percent in 2020-21. This decrease is perceived as inadequate when compared to the Productivity Commission's (2020) recommendations, which

estimate that addressing the primary recommendations would require $2.4 billion annually, with full implementation costing between $3.5 and $4.2 billion each year (MHAustralia, 2020).

### Advocacy for Mental Health Parity and Community Investment

Across the states, discourse highlights the need for legislative and financial commitment towards creating parity between mental and physical healthcare. This stems from widespread dissatisfaction with the current levels of investment in community mental health services. Such investments are crucial to comprehensively address needs for mental health.

In Canada, the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) has actively advocated for legislative changes to ensure mental healthcare is on par with physical healthcare. In 2021, CAMIMH urged the federal government to pass the Mental Health and Substance Use Health Care for All Parity Act, first proposed in their *Mental Health Now* 2016 document. This Act aims to secure legal access to a comprehensive range of publicly funded, evidence-based mental health and substance use care services. These services would be equitably and timely accessible across various settings and would focus on health promotion, prevention, and addressing social determinants impacting mental health and substance use. The Act also demands the establishment of clear national responsibilities and performance metrics, along with sustained federal funding for provincial and territorial mental health programs.

Despite this advocacy, the 2023 Liberal federal budget excluded the anticipated Canada Mental Health Transfer, leading to significant backlash from mental health policymakers and community leaders. Sarah Kennell, Director of Public Policy at the Canadian Mental Health Association (CMHA), highlighted the widening healthcare gap due to the lack of a dedicated mental health transfer, emphasizing the need to prioritize mental health on par with physical health (Raycraft, 2024). CMHA National CEO, Margaret Eaton, critiqued the budget for

neglecting the investment needs of community service providers, disconnecting from the realities of Canadians' well-being and affordability of mental health services (2023b).

In England, policies such as the 2011 *No Health Without Mental Health* and the 2014 *Five Year Forward View* laid foundational commitments for mainstreaming mental health and establishing parity of esteem with physical health services. These policies required Clinical Commissioning Groups (CCGs) to increase mental health funding in alignment with their budget increases. However, the National Audit Office (NAO) has highlighted difficulties in measuring the NHS's progress towards achieving this parity without defined standards and measurable criteria (UK Parliament, 2023).

In September 2023, over thirty English mental health charities formulated a report outlining key priorities for a cross-government ten-year mental health strategy aimed at improving prevention, equality, and support (Centre for Mental Health, 2023). This strategy calls for political action on social determinants such as poverty and discrimination to alleviate health inequalities and stresses the need for sufficient funding for local mental health services while reducing dependence on coercive practices.

Meanwhile, in Australia, the challenge remains to establish a comprehensive network of community-based mental health support. Reports from MHAustralia & NMHCCF in 2024 acknowledge some progress but indicate that the network is not yet adequately comprehensive, leaving notable gaps in service availability and accessibility.

***Service System Designs and Regulation***

Canada, the UK, and Australia share a commitment to transitioning mental healthcare from institutional to community-based settings to improve care quality and protect individual rights. This shift reveals gaps in community resources and persistent access inequities (Kirby &

Keon, 2004b). Decentralizing funding decisions to better align with community needs is a central strategy, as illustrated by regionalized service delivery models that focus on local integration. The benefits of engaging in long-term, integrated planning are evident, with efforts towards comprehensive reforms that adapt to individual needs by integrating services like housing, employment, and peer support. These strategies, which move away from rigid service structures, aim to improve accessibility and effectiveness through significant investments in community-based services.

### Aligning Services with Needs through Expanded Community-Based Support

A primary goal of mental health strategies across the various states is the reorganization of services to align more closely with individual needs, indicating a shift towards a more person-centered approach. Despite extensive data on the prevalence, types, and impacts of mental health and psychosocial conditions, a significant research gap persists concerning mental health resources (WHO, 2021). This gap highlights a disconnect between the understanding of mental health and psychosocial conditions and the systems designed to address them, emphasizing the limitations of traditional biomedical psychiatry in meeting the population's comprehensive needs. Recovery in mental health extends beyond the typical scope of biomedical care, which often prioritizes risk reduction through medication, therapy, and case management (Penzenstadler et al., 2020). Contemporary recovery-oriented models of community-based mental healthcare promote a service system that adjusts to individual needs rather than conforming individuals to a set service structure (Penzenstadler et al., 2020). This model includes crucial elements such as access to housing, employment, transportation, and peer support (Kirby & Keon, 2004b). Therefore, substantially investing in and strengthening connections to community-based mental health services and supports is imperative. These

services and supports offer a wide range of interventions – from crisis support to ongoing care and community living and inclusion – ensuring a comprehensive approach that supports the diverse needs of individuals and their recovery journey (WHO, 2021).

### Improving Mental Healthcare Accessibility in Primary Care Settings

Each state's reforms aim to improve the accessibility and quality of mental healthcare in primary care settings, although each encounter presents distinct challenges in implementation and in achieving systemic integration. Canada struggles with fully realizing collaborative care models due to legislative and regulatory barriers, England continuously adapts its commissioning structures to better meet patient needs, and Australia seeks to enhance care coordination through Primary Health Networks (PHNs) and financial incentives. Overall, these efforts demonstrate a common focus on improving mental healthcare integration within primary care to provide more comprehensive, accessible, and patient-centered services.

#### *Canada*

In 1997, the College of Family Physicians of Canada and the Canadian Psychiatric Association unveiled a shared vision for mental healthcare that set the stage for collaborative efforts across the nation (Kates et al., 1997). This vision led to the creation of the Canadian Collaborative Mental Health Initiative, supported financially by Health Canada's Primary Health Care Transition Fund. In Ontario, the *Regulated Health Professions Act* (RHPA) of 1991 was amended through the *Health System Improvements Act* of 2007 and the *Regulated Health Professions Statute Law Amendment Act* of 2009 (Government of Ontario, 1991; 2007; 2009) to increase interprofessional collaboration. These amendments facilitate overlapping scopes of practice and support shared controlled acts, fostering a more integrated approach to care (Kates et al., 2011). Despite these legislative advancements, the existing *Public Hospitals Act* of 1990

has impeded the realization of collaborative care models in Ontario (Kates et al., 2011). Challenges persist due to regulatory gaps and the absence of clear, measurable objectives for the execution of shared controlled acts (Kates et al., 2011). Nonetheless, within the confines of Ontario's Health Insurance Plan (OHIP), initiatives likes Family Health Teams demonstrate the application of collaborative care by integrating various healthcare professionals, including physicians, nurses, and social workers, to enhance service delivery (Government of Ontario, 2024b).

### *England*

In England, significant NHS reforms in the 1990s introduced market principles, creating an internal market and a purchaser-provider split that distinctly separated the planning and delivery of healthcare. This model, established through the *National Health and Community Care Act* of 1990, led to the formation of NHS Trusts, including Mental Health Trusts (Turner et al., 2015). As a result, NHS and Mental Health Trusts were formed to manage hospitals and other healthcare services, transitioning the direct control from health authorities which were assigned to manage specific geographic populations with designated budgets (Harrison & Choudhry, 1996). This shift meant that health authorities, as purchasers, and Trusts, as providers, entered into contracts that specified the services to be delivered, thereby influencing the referral autonomy of GPs (Harrison & Choudhry, 1996). The introduction of GP Fundholding (GPFH) allowed GPs to manage a deduced budget from their health authority for purchasing a limited range of services directly from Trusts or the private sector. The scheme provided fundholding practices significant autonomy over their secondary care contracts and financial management, unlike non-fundholding practices that were subject to the priorities set by local health authorities (Harrison & Choudhry, 1996; Greengross et al., 1999). However, the arrival of the Blair Labour

Government in 1997 led to the cessation of new admissions to the fundholding scheme, and by 1999, the scheme was replaced with Primary Care Groups (PCGs), which subsequently evolved into Primary Care Trusts (PCTs) and later Clinical Commissioning Groups (CCGs) in 2013 (Kay, 2002; Dixon; 2012; Charlton, 2013). Each GP practice was required to operate within a CCG, responsible for organizing and commissioning local healthcare services from both NHS and private providers (Charlton, 2013). Further reforms in 2022 with the *Health and Care Act* introduced Integrated Care Systems (ICSs), replacing CCGs. ICSs are collaborative networks comprising various local organizations that strategize and manage healthcare financing and services to address local needs. These systems consist of Integrated Care Partnerships (ICP) for strategic planning and Integrated Care Boards (ICB) for overseeing implementation and resource allocation (NHS England, n.d. -a).

***Australia***

In Australia, several legislative and programmatic initiatives have been implemented to improve access to mental healthcare within primary care settings. Legislative reforms established joint protocols between diverse service sectors to foster coordinated care (Grace et al., 2015). Additionally, the introduction of case managers and facilitators aids in navigating the complex landscape of healthcare providers and improves the capability of step-down facilities, ensuring continuity of care for patients transitioning between levels of care (Grace et al., 2015). The Practice Incentives Program (PIP), launched in July 1998 as part of the Medicare Benefits Scheme (MBS), provides financial incentives to general practices (ANAO, 2010). These incentives support practices in offering after-hours care, establishing secure electronic patient information exchange systems, and developing care plans for chronic conditions, including mental health needs (ANAO, 2010). This program is designed to complement the traditional fee-

for-service model, which tends to reward high-volume, brief consultations (ANAO, 2010). In July 2001, the Better Outcomes in Mental Health Care initiative was introduced to increase the capability of GPs to provide mental health services directly (Henderson & Roberts, 2020). This initiative allows GPs to bill Medicare for psychological treatments and to refer patients to psychologists and social workers, thus expanding access to specialized mental healthcare (Henderson & Roberts, 2020). The establishment of Primary Health Networks (PHNs) in 2015, succeeding Medicare Locals, under the Turnbull government marked a significant shift towards a more integrated approach to primary care, including mental health services. PHNs are tasked with commissioning primary care and mental health services that are tailored to meet the specific health needs of the population, addressing service gaps and improving access and equity in healthcare provision (Healthdirect, 2024a). They work closely with Local Hospital Networks (LHNs), which manage hospitals, to ensure that mental health services are comprehensive and integrated across the care continuum. These reforms have been further supported by a federal government review of the MBS (2015-2020) and the creation of the Primary Health Care Advisory Group to explore innovative approaches to funding and delivering primary healthcare, with a particular focus on improving mental health services (Mossialos et al., 2016).

### Improving Community-Based Care and its Integration with Primary Care

The states adopted varying strategies to integrate community-based care with primary care, with the goal of improving the scope and coordination of community-based services to better meet needs.

#### *Canada*

In Canada, the strategy for coordinating health and social care services varies by province. In Ontario, the Ministry of Health oversees several initiatives aimed at improving

community care coordination. For instance, the Community Care Access Centres (CCACs), funded since 2007, played a crucial role in organizing in-home and community-based services, including supportive housing and various health professional services such as psychiatric nurses and occupational therapists (SeniorAdvisor, 2022). Historically, the progression from District Health Councils (DHCs) in the 1990s to Local Health Integration Networks (LHINs) in 2004, and ultimately to Ontario Health Teams (OHTs) in 2019, reflects ongoing efforts to refine the delivery and accessibility of health services. However, the MOHLTC frequently resisted decentralizing control, preferring to implement a systemic approach through the Community Investment Fund (CIF) (Wiktorowicz, 2005). This fund aimed to integrate services between community agencies and hospitals by tying funding to the successful coordination of client assessment, intake, and referral processes (Wiktorowicz, 2005).

Research initiatives like the Provincial Psychiatric Hospital and Community Comprehensive Assessment Projects (CAPs) and the Community Mental Health Evaluative Initiative (CMHEI) during the McGuinty Liberal administration underscored significant capacity gaps in community mental health services. These studies indicated that although community services cost significantly less than hospitalization, they require greater support to meet growing demands. Reacting to these findings, the MOHLTC in 2004 increased funding by 53 percent for specific community mental health supports and services, aiming to lessen reliance on institutional care (CMHA, 2011).

Despite these financial investments, the integration of primary care with community mental health services remains fragmented, characterized by multiple entry points and an overarching system that still mirrors an institutionally centered care model. The LHINs' role was supposed to bridge this gap, but audits revealed that they were not consistently effective in

fostering a more integrated health system (AGO, 2016), leading to subsequent restructuring into Ontario Health Teams (OHTs) under the Ford administration.

Policy community feedback, as demonstrated in the second annual National Report Card by the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) (2024), reflects significant public dissatisfaction with the current state of mental health services. Canadians overwhelmingly rate the available mental health and substance use healthcare services poorly, citing issues with access, confidence, satisfaction, and overall effectiveness. This feedback highlights a clear need for a continued focus on improving the integration of community-based mental health services with primary care to improve individual outcomes and experiences across the continuum of care.

### *England*

In the 2000 NHS Plan, mental health was prioritized alongside cancer and heart disease, leading to increased funding and the introduction of services such as assertive outreach, crisis resolution, and early intervention for psychosis (Kirby & Keon, 2004b). These efforts were designed to elevate the standard of care and integrate mental health services more closely with other health services, as reflected in overall health budget allocation for mental health services from 12 percent in 2000 to 13 percent by 2001-2002 (Kirby & Keon, 2004b).

The National Service Framework for Mental Health (NSF-MH), introduced in 1999, initiated a focus on community mental health teams and specialist teams. Although this model aimed to create a seamless continuum of care, the teams often resulted in isolated services, repeated assessments, and fragmented care pathways, revealing significant integration challenges (NHS England, 2019c). The Care Programme Approach (CPA), established in 1991 to improve community care through a case management model, further faced criticism for conflating

resource allocation with clinical care planning and creating a binary system, ultimately leading to its discontinuation in the NHS Standard Contract 2021/22 (NHS England, 2022a).

Primary Care Groups (PCGs) were initially set up to facilitate community service provision but were quickly replaced by Primary Care Trusts (PCTs), which shifted away from the clinician-led model (Dixon, 2012). These trusts faced difficulties in maintaining clinician engagement and managing the dual responsibilities of service provision and commissioning, prompting the "transforming community services" initiative that redistributed community services to various providers, including Mental Health Trusts and Foundation Community Trusts (Dixon, 2012, p. 217).

The 2012 *Health and Social Care Act* tasked NHS England, Monitor, and Clinical Commissioning Groups (CCGs) with advancing integrated care by improving connections between hospital and community-based services, including primary and social services (Mossialos et al., 2016). Health and well-being boards were also established to encourage cooperation between NHS services and local government.

Substantial reforms continued with the launch of the Integrated Care and Support Pioneer programme in 2013 and the Better Care Fund in 2015, which allocated significant funds to integration initiatives and to reduce the barriers caused by the segmentation of funding sources. By 2021, all areas in England had formed Integrated Care Systems (ICSs), aiming to unify primary, secondary, and community health services under a single framework (NHS England, n.d.-c).

The NHS Long Term Plan (2019) set forth ambitious goals to revamp community mental health services, introducing integrated, place-based care systems that blend primary and secondary care (UK Parliament, 2023). This Plan emphasizes comprehensive support including

psychological therapies, physical healthcare, and employment support, ensuring services are personalized and responsive to patient needs (NHS England, 2019a). The plan also secured additional funding for CCGs to strengthen community mental health teams, particularly for complex cases (NHS England and NHS Improvement, 2019).

Policy community feedback, however, has highlighted ongoing challenges. A 2023 report from Healthwatch indicates significant public dissatisfaction with the state of mental health service access, efficiency, and the overall effectiveness of current integration strategies. The feedback highlights long wait times, inadequate referral systems, and the need for better support during transitions from child to adult services, urging for better reforms to address these systemic issues (Healthwatch, 2023; Mental Health Foundation, 2023).

***Australia***

In 1993, prompted by Brian Burdekin's report as Australia's first Human Rights Commissioner, the Australian government, under Prime Minister Paul Keating, recognized significant lags in the implementation of community mental health services as outlined by the earlier Richmond Report (Mental Health Commission of New South Wales, 2014). This acknowledgment led to the initiation of the National Mental Health Strategy in 1992, designed to shift mental health services from institutional to community-based settings. This strategy not only introduced mobile crisis intervention units and assertive community treatment teams but also emphasized enhancing community involvement in mental health policy-making (see Figure 2.3. in Appendix B) (Rosen, 2006). From 1999 to 2000, funding for community-based mental health services nearly doubled (see Figure 2.4. in Appendix B) (Kirby & Keon, 2004b), indicating a substantial shift in resource allocation to improve access and treatment outside hospital settings. This period marked a critical shift towards integrating mental healthcare within

a broader healthcare framework, sustained across five National Mental Health Plans spanning from 1992 to 2017. The reform efforts were further supported by significant structural changes, including the establishment of the National Disability Insurance Scheme (NDIS) in 2013, and the reorganization of Medicare Locals into Primary Health Networks in 2015. These networks were tasked with managing key federal mental health initiatives such as headspace and psychological service access (Henderson & Roberts, 2020)

The National Mental Health Strategy (1992) mandated that each Australian state independently implement the strategy's service reform framework (Meadows & Singh, 2003). By 1994, a new service delivery framework was established in Victoria that centralized services within defined local catchment areas to better address community needs (see Figure 2.5. in Appendix B) (Gerrand, 2005). Further developments included the release of *Because Mental Health Matters*, the Victorian Mental Health Reform Strategy in 2009, which emphasized a holistic approach covering prevention, early intervention, recovery, and social inclusion. This strategy marked a significant evolution in mental healthcare, focusing on comprehensive care strategies. In March 2021, the momentum continued with the Victorian Government publishing the Royal Commission's Final Report, which provided a detailed blueprint for overhauling Victoria's mental health system. Building on this foundation, in March 2022, the National Mental Health and Suicide Prevention Agreement was implemented. This agreement, endorsed by the Australian Government along with all state and territory governments, aims to establish a coordinated, consumer-focused mental health and suicide prevention system underscored by shared accountability (AIHW, 2023c). Supporting this framework are bilateral agreements that ensure joint funding from the Commonwealth and state and territory governments. These agreements are specifically designed to enhance community-based services, addressing existing

gaps in mental health and suicide prevention, and are structured to accommodate diverse demographic and service needs (AIHW, 2023c).

In 2020, Australia's National Mental Health Commission introduced *Vision 2030*, emphasizing the integration of broader social determinants like housing and employment into mental healthcare strategies. Alongside this, the Productivity Commission's 2020 Inquiry into Mental Health highlighted the considerable social and economic costs associated with mental distress, particularly spotlighting service gaps for the missing middle – individuals needing more than primary care but less than acute psychiatric care (Whiteford, 2022). Critiques by MHAustralia (2020) expressed that the inquiry overlooked significant aspects of community-based multidisciplinary care and criticized the existing primary care system for its high costs and operational silos. Advocating for a better-integrated service model that incorporates components of the NDIS and employs a regional planning strategy, MHAustralia (2020) highlights the necessity for strong federal support and a collaborative framework for the pooling and co-commissioning of funds by PHNs and LHNs. This approach must also ensure high levels of accountability and transparency to the community. MHAustralia (2020) also cautions against the risks associated with decentralizing mental health management to state and territory levels without adequate support, pointing out potential impacts on the quality and accessibility of care.

**Regulatory Reforms and Professional Flexibility**

As the focus of mental healthcare shifts to community settings, the need for strong organizational relationships and a shared vision becomes important (Wiktorowicz et al., 2010). However, establishing mutual trust and cooperation among a diverse array of stakeholders, each with different cultural and philosophical backgrounds, has proven challenging. This was particularly apparent in Canada, where the relationships between community organizations and

hospitals have historically been inconsistent, thereby complicating the integration of care systems.

The Covid-19 pandemic has prompted significant changes in health professional regulation to increase system flexibility and expand the workforce while ensuring public safety (Leslie et al., 2021; Clamp, 2020). In the UK and Australia, healthcare regulation has undergone extensive reform (Adams, 2020). Regulatory oversight has intensified, and the number of regulatory bodies has been reduced. Core principles such as "health systems sustainability, accountability, transparency, standardization, centralization, and … efficiency" drive these reforms (Adams, 2020, p. 5). In contrast, Canada has modified traditional professional self-regulation by implementing multiple layers of regulation and oversight from various authorities, including government bodies and professional organizations, although complete elimination of self-regulation has not yet occurred (Adams, 2020). The regional nature of professional regulation, previously seen as a benefit, is now often viewed as a detriment – fragmenting the system and creating barriers to the free movement of healthcare professionals (Adams, 2020). These barriers are particularly pronounced for internationally trained professionals, suggesting a growing need for international cooperation in regulatory practices (Adams, 2020).

Traditional strategies of social closure, which regulate the entry of new practitioners to maintain economic dominance of the profession, are being increasingly challenged (Bourgeault & Grignon, 2013). A noticeable trend is emerging towards dismantling regulatory barriers that hinder inter-professional cooperation. This includes expanding the scope of practice for nurses to include tasks traditionally reserved for physicians, thereby increasing the fluidity and permeability of professional boundaries. Yet, within universally accessible and publicly funded healthcare systems, where there is a perceived shortage of providers and limited patient choice,

the prevailing strategy has been to reinforce the medical profession's dominance by mandating collaboration or shared care practices under physician oversight.

In response to the impact of the pandemic, each state has implemented measures to strengthen mental healthcare, including significant investments to improve mental wellbeing services. The pandemic has served as a catalyst to accelerate these transformations, underscoring the requirement for systems that are adaptable and can effectively respond to global health crises while addressing local needs. These developments are indicative of a wider movement toward community-based care that is flexible, inclusive, and attuned to the diverse needs of populations.

**Initiatives and Challenges in Mental Health Workforce and Service Accessibility**

The states all face significant challenges in mental health workforce shortages. In Canada, there is a discrepancy between the ideal psychiatrist-to-population ratio and the actual availability, especially outside urban centers (Bartram, 2019b). Similarly, in Australia, psychiatrist availability dramatically decreases from major cities to very remote areas (National Rural Health Alliance, 2017). In the UK, staffing shortages forced reliance on expensive temporary staffing solutions, exacerbating budgetary strains within the mental health sector (Kirby & Keon, 2004b).

A significant trend across all states involves moving psychiatrists from solo practice to integrated settings, where they collaborate with other mental health professionals and leverage technology to expand their reach. This approach directs psychiatrists to focus on the most severe cases and integrates them into a comprehensive care team that includes psychiatric nurses, psychologists, and social workers. This shift is evident through various initiatives: public advocacy in Ontario (Anderssen, 2020a; Corkery, 2023), the UK's New Ways of Working initiative and subsequent Mental Health Workforce Plans (Department of Health, 2007a; UK

Parliament, 2023; NHS England, 2023), and Australia's National Mental Health Workforce Strategy for 2022-2032 (Department of Health and Aged Care, 2023c). This transition is recognized as a way to address the complexities of mental health needs more effectively by fostering collaborative care environments.

The integration of technology in mental health services in Canada and Australia has increased care accessibility and efficiency, particularly through projects like Newfoundland and Labrador's Stepped Care 2.0 in Canada (MHCC, 2019), and the extension of services to rural areas via telephone services and e-mental health portals in Australia (Grace et al., 2015). However, challenges such as reinforcing health inequalities – evidenced by lower internet access among lower-income households in Canada – and difficulties integrating e-mental health into existing care pathways require careful management (MHCC, 2014b). Moreover, the World Health Organization (2021) warns against over-reliance on technology for mental health solutions, emphasizing the importance of maintaining comprehensive, rights-based community services. Effective implementation thus requires strong buy-in from healthcare providers and a strategy that addresses potential inequalities and integrates technology seamlessly with existing healthcare models to ensure equitable access for all (MHCC, 2017).

The states implemented initiatives to improve access to psychological services. In 2020, Ontario launched the Mindability program, investing $20 million to offer public access to evidence-based cognitive behavioral therapy, in line with its *Roadmap to Wellness* (2020) strategy (Canadian Healthcare Technology, 2020). Similarly, the UK's Improving Access to Psychological Therapies (IAPT) program, started in 2008, adopts a tiered approach ranging from low-intensity online resources to high-intensity therapies, all within a stepped-care framework (Clark, 2019). Additionally, since February 2023, the UK has integrated social prescribing link

workers into primary care networks, helping bridge connections between individuals and community resources that provide social, emotional, and practical support (UK Parliament, 2023). Australia has broadened access through its Better Access program, initiated in 2006, which improves referrals between primary and secondary healthcare providers and includes services like a grant-based program for low-income individuals and internet-based cognitive behavioral therapy (Henderson & Roberts, 2020; Grace et al., 2015). Recent federal budgets have significantly increased funding for mental health initiatives, including the development of new headspace centers targeting rural and underserved communities, enhancing telehealth services, and reintroducing bulk billing psychiatry services in rural areas with a dedicated fund (AIHW, 2023c). Moreover, in March 2022, the Australian Government and all state and territory governments signed the National Mental Health and Suicide Prevention Agreement, establishing a coordinated, consumer-focused mental health and suicide prevention system with shared accountability. This agreement emphasizes regional planning, suicide prevention, and the provision of psychosocial supports outside the National Disability Insurance Scheme (NDIS) framework (AIHW, 2023c).

Feedback from policy communities across Canada, the UK, and Australia has consistently emphasized the importance of ensuring mental health services that are accessible, timely, and culturally appropriate. To foster equitable access to psychological services, equity must be a clear priority in all healthcare strategies (Bartram, 2020). In Canada, public discussions highlight the need for more consistent access to psychiatry and psychotherapy, spanning various income levels and geographic locations. The UK has introduced the New Ways of Working initiative, which prioritizes flexible, team-based environments in mental health services to enhance person-centered care. Meanwhile, Australia focuses on expanding

community-based supports and better integrating mental health services with general healthcare, highlighted by the National Mental Health and Suicide Prevention Agreement of 2022. Collectively, these efforts indicate a global move towards care models that are more integrated and community-focused, aiming to be adaptive, inclusive, and responsive to complex needs while addressing systemic challenges like workforce shortages and access inequities.

## Conclusion

This chapter offers a comparative analysis of the use of policy levers across the different states to direct mental health reforms. It highlights the involvement of policy communities, governance structures, and the strategies for financing and service system design that support these reforms. The effectiveness of these levers is evaluated within diverse political and institutional contexts, observing their influence from past opportunities through to current initiatives. The analysis highlights a common goal among these states – to improve mental healthcare integration – yet emphasizes that the approaches are shaped by distinct institutional and cultural factors.

Through a comparative lens, this chapter explores the various strategic approaches and fosters an understanding of the strengths and limitations of policy levers across different settings. It critically assesses the balance between risk management and rights-based approaches and emphasizes the importance of community-focused, recovery-oriented services in meeting the diverse needs of populations. By linking previous discussions, it sets the stage for ongoing debate about the need for flexible, context-aware policy frameworks that can address both global and state specific aspects of mental health reform. The analysis contributes to both academic discourse and practical policy development, highlighting the importance of a nuanced understanding of the intersections that shape mental health policy outcomes.

## Conclusion

Promoting mental health through public policy is crucial due to global social injustices and inequities in mental healthcare. The trajectory of mental health policy has historically been shaped by strategic decisions made within distinct political and institutional contexts. These decisions reflect prevailing ideologies that shape the perception of problems and solutions within mental health, emphasizing the need for critical analysis to uncover underlying assumptions and biases.

Mental health reform is necessary as traditional biomedical approaches fail to address the complex social realities of mental distress. These traditional methods, focusing primarily on symptom management through pharmaceutical interventions, are bolstered by neoliberal risk rationalities that perpetuate human rights violations and coercive practices under laws such as Mental Health Acts. The dominance of biomedicalism in public policy not only limits the scope of possible interventions but also reinforces a problematic narrative that isolates those experiencing mental distress as "others," disregarding the universality of these experiences.

Advancing equity and social justice in mental health demands a paradigm shift that recognizes the impact of social and structural determinants. Policies need to move beyond the confines of traditional institutional approaches to prioritize community-based care that integrates mental and physical health services and focuses on person-centered care. This shift requires a whole of government approach to support recovery-oriented systems that empower policy communities and policymakers to deliver care that respects and responds to the diverse experiences and needs of individuals.

This dissertation investigates the impact of state-based institutional configurations on the causes (policy-levers) and outcomes of mental health reform (policy-trajectories). This is studied

by comparing the relationship between the institutional processes: healthcare governance and government structure; financing & service system designs; regulation and payment. The research evaluates the degree of participation and impact of individuals with lived experience in the policymaking process, as well as their feedback as represented by community service agencies. These agencies play a critical role in assessing the progress of reforms in each state.

The research is unique in providing a comparative analysis of mental health policy trajectory through the theoretical lens of historical institutionalism. It addresses a gap in existing literature by comparing mental health policies across different countries and sub-national regions over time, which has rarely been done before. Additionally, this dissertation integrates insights from postpsychiatry and Mad activism with institutional processes, providing a novel perspective on mental health reform. It also uniquely assesses the responses of policy communities to the current state of mental health reforms, offering an examination that has not been extensively covered in previous studies.

The states selected for this study – Canada, the United Kingdom, and Australia – share the commonality of being parliamentary democracies with broadly universal healthcare systems, yet they exhibit distinct approaches to healthcare governance and degrees of government control and privatization. This comparative analysis highlights how the United Kingdom's centralized control via NHS England contrasts with the more federated systems of healthcare governance in Australia and Canada, where federal involvement varies. Specific focus regions, Victoria in Australia and Ontario in Canada, are chosen to deepen the comparative exploration and illustrate the nuanced differences and similarities in their mental health reform trajectories.

Historical institutionalism considers institutions like healthcare to be enduring legacies of historical political conflicts. This perspective implies that policy decisions are influenced not

only by the rational actions of individuals but also by the governing institutional contexts. Through this lens, the methodology assesses the strategic assumptions guiding mental health reform and the "scale" and "pace" of policy changes. By treating policy decisions as reflections of deeper strategic preferences, this approach systematically examines the reasons behind policy shifts across the various states, highlighting the dynamic interplay between enduring institutional practices and significant policy changes.

A comparative-historical approach (CHA) is utilized to explain significant political and political-economic outcomes influencing reform trajectories. CHA is particularly beneficial for its emphasis on macro-level configurations and the temporal dimensions of political actions, providing a deeper understanding of how historical events and decisions continue to shape current policies.

The research draws on insights from Esping-Andersen's *Three Worlds of Welfare Capitalism* (1990) to explore how political constructs shape market dynamics and power distribution within societies, thereby influencing mental health policies. The study also incorporates the principles of Postpsychiatry, as described by Bracken and Thomas (2005) and further explored by Rose (2019), which challenges the limited biomedical approach of traditional psychiatry by recontextualizing mental distress within its social context and advocating for a more inclusive understanding of mental distress. Additionally, the research embraces Mad Studies, promoting a holistic perspective that views individuals as shaped by their social and economic contexts, rather than merely as carriers of symptoms (LeFrançois et al., 2013).

The methodology includes both primary and secondary research, with a significant focus on archival policy research and documentary analysis of mental health policies. This approach allows for a detailed mapping of policy trajectories and the identification of unique policy logics

within different mental healthcare systems. Archival sources include records from key mental health advocacy groups and community service agencies, which provide historical perspectives and valuable insights into the processes and outcomes of mental health policy development.

The analysis is divided into three parts. Part One, comprised of three chapters, focuses on a dominant policy lever for comparative analysis across the three states. It provides a historical overview of "windows of opportunities" that have been critical in shaping the direction of reforms in each site up to the 2010s.

Chapter One, *Government Structures and Healthcare Governance*, examines the use of organizational policy levers by governments to facilitate changes in healthcare governance. It delves into the historical narratives from policy communities concerning care integration, which emphasize transitioning the locus of care from institutional to community-based settings. The chapter discusses the concept of the "healthcare state" and its historical tension with democratic institutions, highlighting that certain aspects of the health system predate modern democratic structures and were sometimes established in opposition to democratic principles. In Canada, healthcare significantly influenced federal-provincial relations during the late 1990s. Meanwhile, the NHS reforms in the UK during the 1990s introduced market-driven accountability by splitting purchasing and providing functions. In Australia, the 1992 National Mental Health Strategy promoted a shift towards privatization, redefining patients as consumers who make choices about their healthcare services, thus changing their role within the system. The chapter also explores the rise of managerialism associated with neoliberalism, highlighting how market values have driven the need for mental health outcome measures, benchmarking, and key performance indicators as representations of problems in public mental health services. It further reviews the historical policy logics that guided mental health reforms across the different states,

underlining significant “big bang” changes such as the creation of universal healthcare and more “incremental” changes seen in the political climates of the early 2000s. Despite a common vision for mental health reform articulated through various strategies across the states, the implementation approaches varied significantly. The chapter concludes by examining the regionalization and decentralization of healthcare governance, emphasizing the need for accountability within a networked governance model that supports integrated care networks.

Chapter Two, *Financing and Service System Designs*, explores the application of the policy lever of finance to changes to service system designs across the states. The chapter begins with an exploration of the policy logics that govern decisions on resource allocation in healthcare, suggesting that government priorities are best understood through their spending patterns. It discusses the shaping of policy frameworks by prevailing coalitions of interest, which, once established, perpetuate existing power structures by influencing decision-making. The chapter moves on to explore market-oriented reforms initiated in the mid-1980s, highlighting the emergence of new stakeholders who merge public mandates with private resources to effect policy changes. The chapter then compares health financing and service system designs across the states and provides a detailed historical overview of mental health financing and organizational strategies within each state. It also examines the sociopolitical contexts of mental health service delivery reforms up to the 2010s. By this decade, common trends across the states included changes towards decentralizing funding decisions and regionalizing care to provide services more responsive to local needs. The chapter acknowledges that while England and Australia had already established national mental health strategies, Canada delayed such initiatives until 2012 due to historical structural stigma. Key features of these strategies include increased funding and the ring-fencing of mental health budgets,

particularly in Australia, to ensure that funds are specifically used for mental health improvements. Additionally, Australia ensured consumer participation in mental health service planning and decision-making, as mandated by its national Mental Health Plan.

Chapter Three, *Regulation and Payment*, examines how regulatory and payment levers have been used across the states to improve their mental health service systems. Regulatory frameworks for primary health professionals vary widely: Canada delegates regulation to provincial and territorial authorities, leading to a variety of regulatory practices; the UK centralizes its regulation under the General Medical Council; and Australia has implemented a unified national registration and accreditation scheme to streamline health professional regulation. The chapter also delves into licensing healthcare professionals, discussing traditional strategies for maintaining professional exclusivity and the increasing push for inter-professional cooperation, identified during the Covid-19 pandemic. It critiques the regulation of process through patient service quality assessments, pointing out a "service drift" where the focus on clinician and service performance to improve care outcomes neglects the broader socio-economic factors affecting health. In discussing payment levers, the chapter analyzes how financial incentives like fee-for-service in Canada and Australia and capitation in England regulate the quantity and quality of healthcare services. It provides case studies on integrated care, showcasing early 2000s efforts by state governments to improve care integration, and reviews the impact of regulation and payment on improving primary mental healthcare integration up to the 2010s. Initiatives discussed include: Ontario's Community Investment Fund and shared care sites involving psychiatrists and physicians, England's GP Fundholding scheme and the New Ways of Working initiative which supports the stepped-care Improving Access to Psychological Therapies  program. In Australia, the Practice Incentive Program and the Better

Outcomes in Mental Health initiative, which led to the Better Access to Psychiatrists, Psychologists and General Practitioners scheme under the Medicare Benefits Schedule, are further highlighted. The chapter concludes with a discussion on the importance of implementing shared governance structures to support the expanding scope of integrated mental healthcare networks across these states.

Part Two of the dissertation advances the explorations made in Part One by analyzing the outcomes of mental health policy reforms across the states from the early 2000s to the present. This analysis focuses on the use of policy levers that reflect the trajectory of mental health policies and their intersection with human rights. The resulting policies are compared with feedback from community service agencies to assess the efficacy of mental health reforms in improving mental healthcare.

Chapter Four, *Human Rights and Policy Trajectories*, begins with an analysis of rights-based mental health legislation across the states, emphasizing mental health as a fundamental human right. The historical advocacy for the rights of people experiencing mental distress dates back to the 19th century. Although the *Convention on the Rights of Persons with Disabilities* (CRPD) forms the foundation for right-based legislation in each state, current Mental Health Acts and practices such as involuntary treatment and Community Treatment Orders often conflict with these international obligations. A human rights-based approach to mental health, aligned with the CRPD, advocates for "citizenship rights" – rejecting exclusion and coercion and supporting the autonomy of individuals in distress to contribute their unique perspectives and influence the trajectory of mental health services. The Covid-19 pandemic has acted as a catalyst for mental health reforms, highlighting pre-existing inequities in access to care and emphasizing the need for systemic changes that consider social determinants of health. The chapter then

provides a detailed analysis of how policy levers have been employed by the states to advance mental health reforms towards human rights and person-centered care. Appendix A's Table 1 outlines the history and impact of mental health policy trajectories, while Tables 2.1.-2.3. in Appendix A tracks targeted mental health investments across the states. Assessing how states prioritize human rights in mental healthcare, particularly in their application of civil compulsory powers, reveals the balance they strike between providing care and exerting control, as well as their overarching strategy for addressing mental distress. Tracking policy developments among states for mental health reform and comparing these with insights from community service agencies, reveals the levers most relied upon to actualize policy objectives and implement change. While all states embraced a vision of integrated care, they varied in their choice of policy levers which is indicative of their scale and pace of reforms. A common thread of dissatisfaction among community service agencies across the states regarding mental health reforms was evident, coupled with a unanimous demand for increased community investment to improve recovery-focused and rights-based mental healthcare.

Part Three of the dissertation compares policy levers and policy trajectories across the states, linking the earlier sections: Part One, which explored the historical use of policy levers by states to shape initial reform trajectories, and Part Two, which analyzed current policy levers and mental health trajectories. Part Three investigates the scale and pace of reforms aimed at advancing the integration and equity of mental healthcare.

Chapter Five, *Comparison of Policy Levers and Policy Trajectories*, examines the context of mental health policy reforms across the states. The chapter discusses how care integration is influenced by neoliberal risk rationalities within institutional settings. This framework promotes specific types of integration while limiting significant policy reforms. The

analysis employs themes identified in Parts One and Two of the dissertation – initially in the identification of policy levers and subsequently in the examination of their outcomes – to examine the scale and pace of changes within each state's institutional settings.

The analysis reveals significant differences in the scale and pace of mental health reforms across the states, with Australia and the UK implementing larger scale and quicker paced reforms compared to Canada, which has historically been more reactive and conservative in implementing reforms. This stems from Canada's historical marginalization of mental healthcare within its legislative and financial frameworks, which has limited federal involvement in provincial healthcare systems. Both Australia and the UK established strong legal and financial frameworks to integrate policy communities into mental health policy development. They have also been quicker to adopt outcomes-based measurements, leading to greater service accountability, while also potentially reinforcing managerialism in mental healthcare. These states demonstrated greater use of financing to support system change, exemplified by England's mental health investment standard and Australia's Medicare Agreement Acts. These agreements in turn facilitated quicker and larger-scale reforms in Australia, such as the Better Access program, headspace centers, and the expansion of the National Disability Insurance Scheme (NDIS), significantly improving the scale of mental health services available, including for those outside the NDIS. Additionally, the UK and Australia implemented greater structural reforms to improve care integration between community and institutional settings. These reforms are driven by larger scale changes in the levers of service systems design, regulatory frameworks, and finance. Both Australia and the UK have also embraced team-based care models, unlike Canada, which relies more on technology to extend mental health services. While Australia and the UK implemented reforms on a larger scale and at a faster pace, policy communities across all states

continue to advocate for increased community investment and equitable financial representation of mental health within universal healthcare systems to improve the integration and accessibility of mental health services. Apparent is an inability to overcome the barriers to reach and access by simply increasing the availability of traditional forms of care.

The dissertation, while aiming to comprehensively examine the application of policy levers and the trajectories of mental health policies across three states and sub-states, presents several limitations. The institutional lens allows for only limited insights into preferences for policy lever usage across states. Incorporating qualitative interviews with policymakers could provide a deeper understanding of the institutional and socio-economic contexts that shape reform decisions. Additionally, the majority of feedback from the policy community was sourced from reports by community service agencies. Including direct input from grassroots communities could offer a more nuanced understanding of their involvement or exclusion in the policy-making process. The dissertation also relies heavily on secondary sources. Referencing the primary sources over the secondary would strengthen the statements and comparisons made. Moving forward, this dissertation can inform the development of context-aware policy frameworks that consider both global and specific aspects of mental health reform. Such frameworks should aim to include a broader spectrum of stakeholder perspectives, ensuring that future policies are more inclusive and responsive to diverse needs. Changing the frameworks through which we understand mental distress will reshape how policy communities participate in policy development and improve the alignment of mental health services with actual needs.

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# Appendices

## Appendix A: Tables

**Table 1**. History of Mental Health Reform – Revealed in Government Reports

| Report Title | Year | Level of Government | Governing Party | Emphasis | Impact |
|---|---|---|---|---|---|
| **<u>Canada</u>** | | | | | |
| *Building Community Support for People*: A Plan for Mental Health in Ontario (Graham Report) | 1988 | Provincial | Liberal Party | • Proposed guidelines for the development and implementation of a comprehensive community mental health system.<br>• Outcome of an extensive community consultation process. | • Marked a paradigm shift from an institutional-medical approach to a community-based approach to mental health.<br>• Created a partnership among psychiatric consumers/survivors, family members, service providers, and the government.<br>• First time psychiatric consumers/survivors and their families were given a voice in mental health policy. |
| *Putting People First*: The Reform of Mental Health Services in Ontario | 1993 | Provincial | New Democratic Party | • Proposed a 10-yr plan for mental health reform in Ontario – shifting the proportion of funds from 80 percent for institutions and 20 percent for community programs in 1993, to 40 percent and 60 percent respectively, by 2003.<br>• Called for new linkages among the four solitudes of mental health – provincial psychiatric hospitals, general hospitals, community mental health programs, and services provided by family physicians and psychiatrists on a fee-for-service basis.<br>• Confirmed the government's commitment to its new partners by | • Criticized for being an administrative document – too far removed from the direct service interface between patients and professionals.<br>• Pitted psychiatric consumers/survivors against medical professionals and labour unions.<br>• Failed to address how funds would be reallocated to support the development of community based mental health and addiction services.<br>• The Ministry of Health did not consult the policy community prior |

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| | | | | emphasizing supports and programs run by consumers/survivors and their family members. | to the report's release; many argued about the lack of employment supports. |
| *Making It Happen*: Implementation Plan for Mental Health Reform | 1999 | Provincial | Conservative Party | • The report outlined the MOHLTC's strategy to increase the capacity of the mental healthcare system.<br>• The report was to guide investments in mental health over the next three years to support a comprehensive continuum of services.<br>• The government committed to investing in community mental healthcare prior to the divestment of psychiatric hospitals. | • Government did not provide transitional funding nor adequate investment in community mental health and addiction supports and services over the following three years. |
| *Open Minds, Healthy Minds*: Ontario's Comprehensive Mental Health and Addictions Strategy | 2011 | Provincial | Liberal Party | • In 2011, the government released the 10-yr comprehensive mental health and addictions strategy for Ontario.<br>• The Strategy outlined a plan to provide integrated mental health and addiction supports and services to all Ontarians.<br>• The first three years (2011-2013) of the strategy, were aimed at improving access to youth.<br>• The Moving on Mental Health Plan (part of the Strategy) was launched in 2012 to assist children, youth, and families in navigating the mental health and addictions system.<br>• In 2014, the MOHLTC expanded on the first phase of the Strategy to improve service transitions (youth-adult) and quality of services for all Ontarians. | • Over the first three years of the Strategy, the government invested $93 million in children and youth. In 2014, more than 50,000 additional children and youth were receiving mental health services, while more than 770 new mental health workers were hired in communities, schools, and courts.<br>• In 2014, the government committed to additional investments of $65 million in 2014-2015, growing to about $83 annually by 2016-2017.<br>• Although the Strategy referred to its partners, (psychiatric consumers/survivors and their families), it was unclear how partners would be involved in the reform process. |

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| *Changing Directions, Changing Lives:* The Mental Health Strategy for Canada by the Mental Health Commission of Canada (MHCC) | 2012 | Federal | Conservative Party | • In 2012, the Mental Health Commission released Canada's first national mental health strategy.<br>• The strategy includes 109 recommendations regarding the implementation of mental health policies.<br>• The Strategy is divided into six strategy areas: promotion and prevention; recovery and rights; access to services; disparities and diversity; First Nations, Inuit, and Métis; leadership and collaboration.<br>• The Strategy proposed increasing the proportion of health spending allocated to mental health from seven to nine per cent and increasing the proportion of social spending for mental health by two percentage points; identifying whether mental health spending should be reallocated to improve efficiency and outcomes; and encouraging contribution from private and philanthropic sectors in order to reduce funding inequities. | • The MHCC, operating at the federal level, is unable to direct provinces in the resourcing of/ priority for mental health services as rooted in Canadian federalism and the constitutionally-based division of powers. Since the strategy has no binding force on the provinces, real investment in mental health has not been prioritized, despite increased federal fiscal health transfers. |
| *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* | 2020 | Provincial | Conservative Party | • Detailed a plan to build a connected mental health and addictions system.<br>• Plan is "client-centred, evidence-based and ensures Ontarians will be able to access high-quality services, where and when they need them."<br>• Identified four pillars: improving quality: (1) enhancing services across Ontario; (2) expanding existing services: investing in priority areas; (3) | • $3.8 billion over 10 years to develop and implement a comprehensive and connected mental health and addictions system for Ontarians. Of this, $20M was invested into Mindability (first ever initiative to provide cognitive behavioural therapy). |

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| | | | | implementing innovative solutions: filling gaps in care; (4) improving access: a new provincial program and approach to navigation. | • Established the Mental Health and Addictions Centre of Excellence. |
| *Toward and Integrated and Comprehensive Framework for Mental Health Policy and Programming: Needs Assessment Report* | 2023 | Federal | Liberal Party | • The new (IDEALSS) framework incorporates key aspects of intersectionality, decolonization, health equity, anti-racism, lived and living experience and recovery, sex- and gender-based analysis plus (SGBA+), and the social determinants of health. | • Developing a toolkit to help guide organizations in policy and programming implementation. |
| **United Kingdom** | | | | | |
| *National Service Framework for Mental Health:* Modern Standards and Service Models | 1999 | State<br><br>Department of Health | Labour Party | • Describes the policies announced in the White Paper – Modernising Mental Health Services.<br>• Based on consultations with stakeholders.<br>• Guiding values and principles include involvement of service users and carers in planning and delivery of care; non-discriminatory supports and services; offer choice in services; provide continuity of care; services that are accountable to the public. | • Offered a blueprint for mental health service reform in England.<br>• Government commitment to provide an extra £700 million over this year and the next two years in mental health services.<br>• From 1999-2008, investment in mental health increased by over £2 billion. |
| *A Future Vision for Mental Health* | 2009 | State<br><br>Future Vision Coalition of the NHS England | Labour Party | • Coalition comprised of national organisations who came together in 2008 to discuss what the future of mental health policy should look like. Chaired by the Mental Health Network, part of the NHS Confederation. | • Contributed to the Health Department's New Horizons programme on the next stage of mental health policy in England. |

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| | | | | • Moral and business case for investing in mental health.<br>• Result of extensive consultation with service providers, mental health professionals, policy experts, service users and carers over past year.<br>• Four principles: mental health and well-being is everybody's business; promotion, prevention, and early intervention; supports to gain a good quality of life; new relationships between users and services. | |
| *New Horizons:* A Shared Vision for Mental Health | 2009 | State<br><br>Department of Health | Labour Party | • Built on/Replaced the NHS Framework for Mental Health (1999)<br>• Goal to promote equality – acknowledging inequalities in mental health and in access to services.<br>• Broad consultation with stakeholders.<br>• To main aims: improve the mental health and well-being of the population and improve the quality and accessibility of services for people with poor mental health.<br>• Key themes: prevention and public mental health; stigma; early intervention; personalised care; multi-agency commissioning/collaboration; innovation; value for money; & strengthening transition | • Concerns whether the new 10-year strategy was too ambitious regarding its aim to promote good mental health and wellbeing while improving mental health services for people who need them amid the financial climate. |
| *No Health Without Mental Health* | 2011 | State<br><br>Department of Health | Conservative and Liberal Democrat Coalition | • Aimed to mainstream mental health and establish parity of esteem between mental and physical health services<br>• Detailed documents accompanied the strategy including strategies for | • The government committed £400 million over four years to ensure the availability of psychological therapies for individuals across England, with expanded services |

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| | | | | delivering better mental health outcomes, an economic case for improving efficiency and quality in mental health, and various impact assessments and analyses related to equality and the effects of talking therapies | for "children and young people, older people, people with long-term physical problems and those with severe mental illness."<br>• Proposed "a new architect and approach for the NHS," including an outcomes-based approach; establishment of Public Health England within the Department of Health and Social Care to address health inequalities; and HealthWatch England, an autonomous consumer advocate within the CQC. |
| *The Five Year Forward View for Mental Health* | 2016 | State<br><br>NHS England | Conservative Party | • Marked the first time an approach to improving mental health outcomes within the health and care system was developed in collaboration with health arm's length bodies<br>• Over 20,000 people met with the Taskforce and discussed the changes they wanted to see<br>• Provided comprehensive recommendations for both the NHS arms-length bodies and the government to achieve by 2020/21 | • The government accepted the recommendations in entirety and committed an extra £1 billion in funding for mental health with the aim of providing high quality services to an additional one million people by 2020/21 |
| *The NHS Long Term Plan* | 2019 | State<br><br>NHS England | Conservative Party | • New offer to restructure community mental health services into integrated, place-based care that unifies primary and secondary care services<br>• New offer for community-based care includes "access to psychological therapies, improved physical health, employment support, personalised and | • Pledged to increase the proportion of the NHS budget allocated to mental health<br>• New ringfenced local investment mental health fund of at least £2.3 billion annually by the 2023/24 fiscal year. This includes yearly increases in all CCGs baseline |

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| | | | | trauma-informed care, medicines management and support for self-harm and coexisting substance use … [and] maintaining and developing new services for people who have the most complex needs and proactive work to address racial disparities" (p. 69).<br>• Increasing the supply of social prescribing link workers by deploying 1,000 social prescribing link workers by the end of 2020/21<br>• Increase access to talking therapies for up to 1.9 million adults | funding for adult and older adult community mental health; STPs/ICSs receiving a proportionate distribution of the central/transformation funding, projected at £1 billion per year by 2023/24<br>• As of February 2023, primary care networks employed 3,161 full-time equivalent social prescribing link workers and as of 2022/23 were contractually obliged to provide a proactive social prescribing service<br>• In the fiscal year 2021/22, services for talking therapies commenced for 1.24 million individuals, with 688,000 completing their therapy |
| *Advancing Mental Health Equalities Strategy* | 2020 | State<br><br>NHS England | Conservative Party | • Outlined measures the NHS, alongside the Advancing Mental Health Equalities Taskforce, plans to implement to address disparities in mental health services across different communities. | • Introduced the Patient and Carer Race Equality Framework for mental health trusts to better collaborate with minority ethnic communities in combating stigma and inequalities across the sector. |
| *Major Conditions Strategy – Interim Report* | 2023 | State<br><br>Department of Health and Social Care | Conservative Party | • Sets out a comprehensive approach to addressing ill-health in England.<br>• Mental health is one of the five focal areas of the final report, which aims for greater alignment and integration between physical and mental health services.<br>• Government opted for an integrated approach rather than a separate mental health strategy. | • The Mental Health Foundation in collaboration with other charities including Mind, Rethink Mental Illness, and Samaritans, expressed criticism regarding the government's decision to forgo a dedicated mental health strategy, advocating for the urgent need of a specialized mental health plan. |

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| *NHS Long Term Workforce Plan* | 2023 | State<br><br>Prime Minister (Rishi Sunak) and NHS England | Conservative Party | • The plan anticipates a deficit of more than 15,800 full-time equivalent mental health nurses by 2036/37 (p. 35). | • The plan aims for a 93 percent increase in mental health nursing training spots, targeting over 11,000 positions by 2031/32.<br>• Outlines the creation of over 1,000 yearly training opportunities for clinical psychology and child and adolescent psychotherapy until 2028/29. |
| **Australia** | | | | | |
| *National Mental Health Policy* | 1992 | Federal | Labor Party | • Endorsed by the Health Ministers of all Australian States, Territories, and the Commonwealth.<br>• The Policy recognized the high prevalence of mental health problems and the impact on consumers, carers, families, and society as a whole.<br>• Focus on prevention and promotion; reducing disparities; and ensuring the rights of people with mental and psychosocial conditions.<br>• The Policy endorsed: service mix (provision of comprehensive mental health services working with the private sector, nongovernment carer and consumer organisations); mainstreaming mental health services with health services; integration (linking community, acute inpatient, and psychiatric hospital care); intersectoral links (developing links with other social and disability services). | • A National Mental Health Plan followed the release of the Policy.<br>• Transitional funding in the 1992/93 federal budget (to continue over six years) was provided to shift services from institutions to local communities. |

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| *The National Mental Health Strategy (First Plan)* | 1992-1997 | Federal | Labor Party | • Mainstreaming of psychiatric services<br>• Mainstreaming of funding for psychiatric services<br>• Development of continuity of care between inpatient and community services<br>• Targeting of services towards those with severe mental health problems<br>• Increasing use of other social services, including NGOs<br>• Consistency in mental health legislation<br>• Greater evaluations of service delivery | • Deinstitutionalization of the chronic population<br>• Closure of standalone psychiatric hospitals and greater use of services attached to general hospitals<br>• Extension of services in the community, particularly ambulatory services<br>• Greater use of non-governmental service providers<br>• Establishment of the National Consumer Advisory Group |
| *The Second National Mental Health Plan* | 1997-2003 | Federal | Liberal (Coalition) Party | • Promotion/prevention focus<br>• Development of partnerships in service reform<br>• Improving the quality and effectiveness of service delivery | • Public education through the media<br>• Partnerships with general practitioners<br>• Funding for shared care programs<br>• Consumer outcome measures<br>• Greater consumer and carer involvement in overseeing services<br>• Development of national service quality indicators |
| *The Third National Mental Health Plan* | 2003-2008 | Federal | Liberal (Coalition) Party & then Labor Party | • Population mental health<br>• Service responsiveness and early intervention<br>• Consumer rights and participation<br>• Workforce education<br>• Research and evaluation leading to greater accountability | • Greater use of general practitioners to provide primary care<br>• Funding for evidence-based research into treatment options |
| *COAG National Action Plan on* | 2006 | Federal | Liberal (Coalition) Party | • Identified key reform strategies and outcomes. Including: reducing the prevalence and severity of mental | • New Commonwealth mental health funding of $1.9 billion over a five-year period; these funds |

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| *Mental Health 2006-2011* | | | | illness; reducing the prevalence of risk factors that contribute to mental illness; early intervention; community supports (i.e., employment, education, housing).<br>• Outlined nine individual implementation plans, including one for the state of Victoria. | were in addition to existing Commonwealth funding |
| *National Mental Health Policy 2008* | 2009 | Federal | Labor Party | • Built on the 1992 National Mental Health Policy<br>• Reaffirmed the commitment of the COAG for continuous improvement of the mental health system.<br>• Emphasized a seamless, consumer-focused, and recovery-oriented care system that supports community participation.<br>• Highlighted the collective benefits of prioritizing preventative measures and early intervention.<br>• Called for cooperation across various service sectors, spanning both government and private sectors.<br>• Stressed the need for a skilled workforce to provide evidence-based quality services that are "continually monitored and evaluated" (p. 6).<br>• The policy also acknowledged Indigenous people's culture and heritage, recognizing their distinctive rights to status and culture, aiming to "close the gap on Indigenous disadvantage" through "mutual resolve, respect and responsibility" (p. 7). | • Followed by the federal 2011-12 budget that invested $2.2 billion for mental health |

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| *Because Mental Health Matters:* Victorian Mental Health Reform Strategy 2009-2019 | 2009 | State | Labor Party | • Based on consultations with 1200 stakeholders and over 240 written submissions<br>• The strategy sets out eight reform areas with key proposals for each specifying actions that require funding and negotiation with the Commonwealth government and other partners.<br>• The eight reform areas: (1) promoting mental health and wellbeing; (2) early in life; (3) pathways to care; (4) specialist care; (5) support in the community; (6) reducing inequalities; (7) workforce and innovation; & (8) partnership and accountability. | • Financial initiatives totalling $128 million over four years funded in the 2008-09 State Budget. |
| *The Fourth National Mental Health Plan* | 2009-2014 | Federal | Labor Party & then Liberal (Coalition) | • Promote mental health and wellbeing and prevent mental illness<br>• Reduce impact of mental health problems and stigma<br>• Promote recovery<br>• Protect the rights of the mentally ill to allow them to participate in society meaningfully | • Shifted the focus to recovery-based services and social inclusion through promoting access to housing, education, and employment opportunities.<br>• Greater focus on integrated community care, with Medicare Locals (non-profit companies principally funded by the federal government) providing leadership for integration at the regional level. |
| *Victoria's 10-year Mental Health Plan* | 2015 | State | Labor Party | • Provided a vision to improve mental health and services and outcomes for Victorians.<br>• Over 1,000 Victorians contributed to the development of the plan, including people experiencing mental distress, | • Accompanied by $117.8 million in the 2015-16 State budget.<br>• Led to the first program to integrate peer support workers into clinical settings in 2016. As well, as the establishment of the |

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| | | | | their families, caregivers, healthcare providers, and various community.<br>• Outlines specific outcomes to direct efforts toward fostering the best possible conditions for the mental health of Victorians.<br>• Government pledged to foster a healthier, more equitable, and inclusive community.<br>• Committed to grow the peer workforce.<br>• Criticized for not delineating the roles of various organizations involved in each proposed outcome and associating specific workforce measures with these outcomes; insufficient detail regarding the government's investment plans for each outcome and improvements for each outcome. | Consumer Workforce Development Group. |
| *The Fifth National Mental Health and Suicide Prevention Plan* | 2017-2022 | Federal | Liberal (Coalition) | • Strategy for collaborative government action aimed at improving the delivery of integrated mental health and related services.<br>• Rooted in the consultations conducted by the National Mental Health Commission in 2014<br>• Acknowledged and integrated findings from Mental Health Australia (2014); including the wider community perspectives.<br>• Focus on regional organization for primary mental healthcare.<br>• Focus on suicide prevention, Indigenous mental health, and services for more severe and complex mental health issues. | • Coincided with rollout of NDIS & shift from Medicare Locals to PHNs |

| | | | | | |
|---|---|---|---|---|---|
| *Vision 2030: Blueprint for Mental Health and Suicide Prevention* | 2020 | Federal | Liberal (Coalition) | • Engaged with over 3000 Australians to gather insights on their experiences with the current mental health system, as well as their hopes for an improved one.<br>• The Commission recognized that while the "principles of person centred care delivered in community have been the focus of advocacy by many over a number of years," Vision 2030 sets forth the systemic changes required to actualize these principles (p. 4). | • Called for funding models that aligned with vision – acknowledging the role of social determinants and one's environment as equally important to clinical supports. |
| *Productivity Commission's Inquiry into Mental Health* | 2020 | Federal | Liberal (Coalition) | • Commission, an agency of federal Treasury, was tasked with proposing strategies to improve population mental health, with the aim to actualize long-term economic and social participation and productivity benefits.<br>• Revealed that mental distress costs Australia up to $220 billion annually, or $600 million daily.<br>• Highlight the 'missing middle.'<br>• Emphasis on regional planning for mental health.<br>• Role of psychosocial support and extending the duration provided.<br>• Assigns responsibility to a 'revamped' National Mental Health Commission to lead change. | • In July 2021, the Commonwealth Psychosocial Support Program for people with severe mental distress was established providing funding for people not part of the NDIS. The 2023-24 budget provided $253.9 million to extend the program until June 2025. |
| *Royal Commission into Victoria's Mental* | 2021 | State | Labor Party | • Report came after two years of inquiry and resulted in 65 recommendations detailed across six volumes and spanning over 3,000 pages. | • Victorian government pledged to adopt all the recommendations, dedicating $3.8 billion in the 2021- |

| | | | | | |
|---|---|---|---|---|---|
| *Health System – Final Report* | | | | • Recommendations center around four key features of the future mental health and wellbeing system: a responsive and integrated system, with the community as its core; a system that promotes inclusion and addresses inequities; renewed public trust through a focus on priority setting and collaboration; services that are modern and adaptable to changing needs.<br>• The comprehensive report informed an extensive redesign of the mental health and wellbeing system in Victoria through a 10-year vision. | 22 budget for mental health reforms. |
| *National Mental Health Workforce Strategy for 2022-2032* | 2023 | Federal | Labor Party | • Acknowledges that the "mental health workforce is spread across health and social service domains in a range of roles, in paid and unpaid capacities, and is complemented by alternative therapies, friends, family and others" (p. 8).<br>• Goals to cultivate and sustain a skilled and motivated mental health workforce to meet the future demands of the mental health system. | • As part of the 2023 federal budget the government committed to addressing critical workforce shortages and identifying priority areas for action. |

**Table 2.1.** Mental Health Targeted Incentives – Canada

| Year | Federal law, policy, or agreement | Incentive: implication for mental healthcare |
|---|---|---|
| Canada | | |
| 1948 | Contribution to mental health: Annual grant ($7 million) | • Asylum system expanded |
| 1957 | HIDS Act: Shared-cost funding for hospital care | • Excludes psychiatric hospitals. Limits hospital psychiatric care to <10 percent beds |
| 1966 | MCA: Shared-cost funding for physician services | • Excludes community-based nurses, psychologists, case managers, substance-use therapists |
| 1977 | Established Programs Financing (EPF): Block funding | • Excludes community-based nurses, psychologists, case managers, substance-use care from the terms |
| 1984 | Canada Health Act | • Excludes community-based mental healthcare (community-based psychologists, case managers, substance-use care) from the terms; hospital psychiatric care limited to < 10 percent beds. Excludes psychiatric hospitals |
| 1995 | Canada Health and Social Transfer: Merges EPF and Canada Assistance Plan. Reduces federal grants to 9 percent of healthcare expenditures | • Mental health spending declines as a proportion of health spending |
| 2004, 2005 | Health Accords: $1 billion (2004–5); $2 billion (2005–6) fund homecare. A fraction funds mental healthcare | • Limited mental health program funding (2-week case management, crisis services) |
| 2004 | Canada Health Transfer, Canada Social Transfer increase health funding by 6 and 3 percent annually, respectively | • No targeted funds for mental healthcare. Only 1 in 3 adults; 1 in 4 children who require mental healthcare have access to services. Mental health spending declines to 7 percent nationally |
| 2017 | Health Accord: Targets $5 billion for mental healthcare over 10 years | • Youth wellness hubs, psychological/substance-use services, early intervention for psychosis, housing. Agreements and deliverables for each province were not made public. |
| 2023 | Federal Budget | • $2.5 billion annually over 10 years spread across four healthcare spending priorities, including mental health, through bilateral agreements with the provinces and territories. |
| Ontario | | |
| 2020 | *Roadmap to Wellness* provincial mental health and addictions strategy | • $3.8 billion over 10 years to develop and implement a comprehensive and connected mental health and addictions system for Ontarians. Of this, $20M was invested into Mindability (initiative to provide cognitive behavioural therapy) |
| 2021 | 2021-22 Ontario budget | • Additional investment of $175 million for the 2021-22 fiscal year to enhance mental health support; lacked detail on how the investment would support the 2020 *Roadmap to Wellness* strategy. |

| | | |
|---|---|---|
| 2022 | 2022-2023 Ontario budget | • $204 million building on the *2020 Roadmap to Wellness* strategy to expand existing services, implement innovative solutions, and improve access to mental health and substance use services. |

(Source: adapted from Wiktorowicz et al., 2020, p. 5)

**Table 2.2.** Mental Health Targeted Incentives – England

| Year | Federal law, policy, or agreement | Incentive: implication for mental healthcare |
|---|---|---|
| 1999 | NSF-MH | • Investments increased by over £2 billion from 1999-2008<br>• An extra £700 million over this year and the next two years in mental health services |
| 2000 | NHS Plan | • Accompanied by £300 millions of new funding for mental health |
| 2011 | No Health Without Mental Health Strategy | • £400 million over four years to ensure the availability of psychological therapies |
| 2016 | The Five Year Forward View for Mental Health | • £1 billion in funding for mental health with the aim of providing high quality services to an additional one million people by 2020/21 |
| 2019 | The NHS Long Term Plan | • £2.3 billion annually by the 2023/24 fiscal year; ring-fenced for local investment in mental health |

**Table 2.3.** Mental Health Targeted Incentives – Australia

| Year | Federal law, policy, or agreement | Incentive: implication for mental healthcare |
|---|---|---|
| Australia | | |
| 1998 | Second National Mental Health Plan | • Commonwealth outlays increased its share of total national spending on mental health from 27 percent in 1992-93 to 35 percent in 1999-2000 |
| 2003 | Third National Mental Health Plan | • Between 2002-03 the Commonwealth spent $3.2 billion in mental health |
| 2006 | COAG National Mental Health Plan | • $1.9 billion over a five-year period |
| 2011-12 | Federal Budget | • $2.2 billion to mental health, prioritizing early intervention and prevention, targeted at delivering innovative youth support services |
| 2021-2022 | Federal Budget | • $2.3 billion over four years to the *National Mental Health and Suicide Prevention Plan*; the National Mental Health and Suicide Prevention Agreement was signed by the Commonwealth government and all state and territory governments in March 2022 and is underpinned by bilateral agreements committing joint investments in mental health and suicide prevention services. The bilateral agreements prioritize investments in community-based services to address gaps in the mental health and suicide prevention system and includes varying commitments across demographics and service types. |

| | | |
|---|---|---|
| 2022-2023 | Federal Budget | • $547 million for mental health reforms – Medicare bulk billing for psychologists in rural and remote regions; integration of expanded telehealth services into MBS arrangements |
| 2023-2024 | Federal Budget | • $586.9 million expanding mental health projects - allocation of $7.5 million to establish two national lived experience mental health peak bodies; psychological supports for people outside of NDIS scope; 20 headspace centers in remote and underserved areas |
| Victoria | | |
| 2009 | *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019* | • $128 million over four years funded in the 2008-09 State Budget |
| 2015 | *Victoria's 10-year mental health plan* | • $117.8 million in the 2015-16 State budget towards mental health initiatives. This included $5 million to community organizations aimed at improving mental health support and access in the community, particularly for individuals facing complex challenges such as homelessness. |
| 2021-2022 | State Budget | • $3.8 billion to implement reforms outlined by the Royal Commission's Final report |

**Table 3.** Sources of New Community Funding – Victoria

| *Source of funding* | *Financial year* | | | | |
|---|---|---|---|---|---|
| | *1993–1994* | *1994–1995* | *1995–1996* | *1996–1997* | *1997–1998* |
| National strategy | 1.8 M | 9.3 M | 10.3 M | 11.0 M | 17.4 M |
| New State funds | 0.0 M | 0.0 M | 0.6 M | 6.7 M | 2.7 M |
| Savings from institutions | 13.8 M | 30.9 M | 98.2 M | 115.5 M | 137.6 M |

The table indicates savings from the closure of psychiatric hospitals between 1993-1998 in Victoria. As well, sources of funding for new community mental health services.

(Source: Meadows & Singh, 2005, p. 65).

**Table 4.** Payment Methods for Healthcare Providers – Financial Risks and Incentives

| **Payment Mechanism** | **Risk Borne by Payer or Providers** | **Impact on Medical Decisions and Costs** |
|---|---|---|
| Fee-for-service | - All risk borne by payer; none by provider | - Providers favour this method<br>- Increase of quantity of service per patient<br>- Quality may decrease due to over-treatment and overuse of drugs |
| Capitation | - All risk borne by provider up to a given cap; above capped ceiling risk borne by payer | - Reduces unnecessary services<br>- Improves efficiency<br>- May lead to under-treatment of patients<br>- Risk selection by providers |

(Adapted from Roberts et al., 2008).

**Table 5.** Comparison of Mental Health Act Legislation – MHA (1990) Ontario; MHA (2007) England; MHA (2014) Victoria

*indicates difference between states

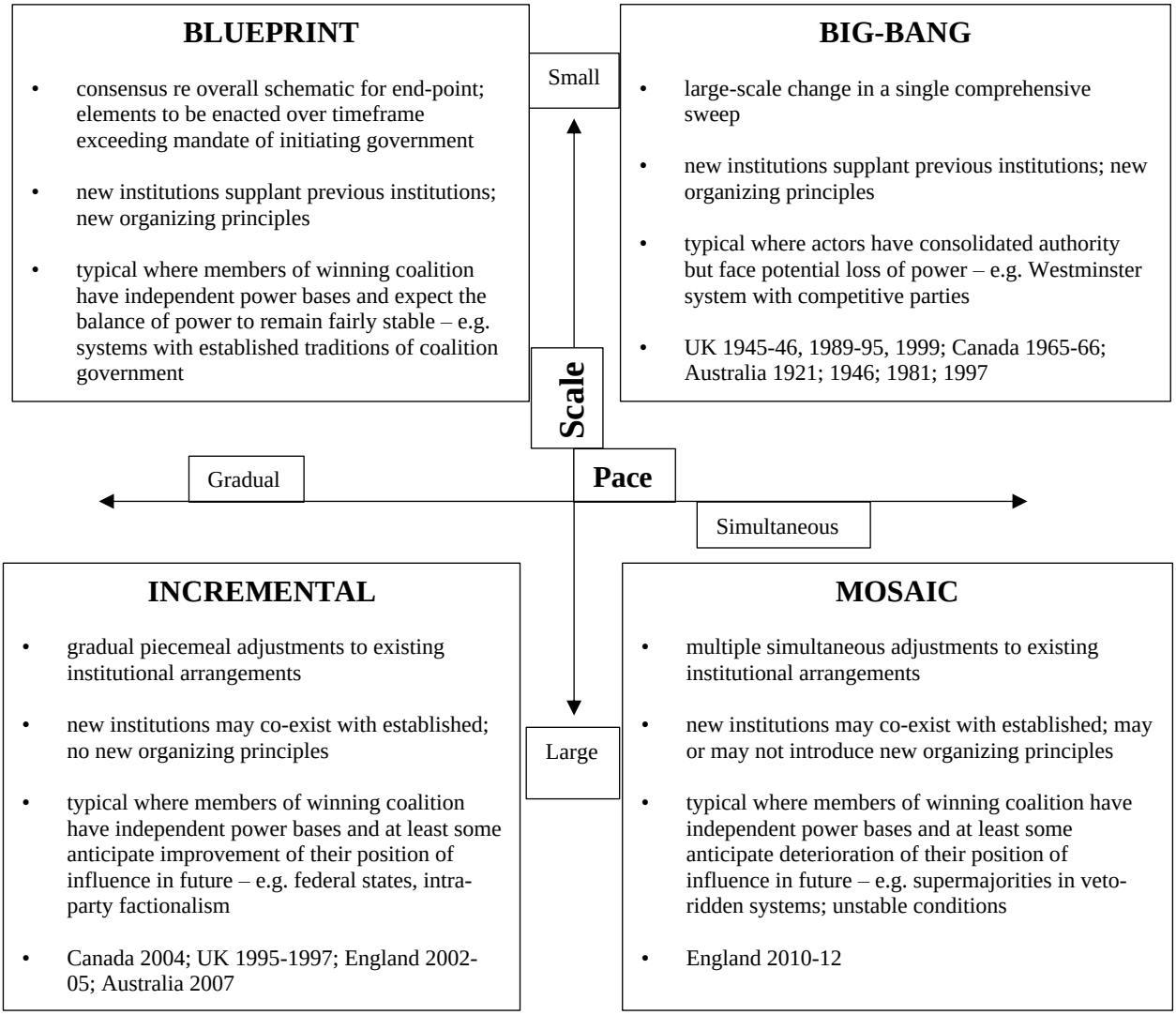
| | **Ontario (1990)** | **England (2007)** | **Victoria (2014)** |
|---|---|---|---|
| Diagnosis of a mental disorder required | Yes | Yes | Yes |
| Personality disorder included as a mental disorder | Yes | Yes | Yes |
| Alcohol or psycho-active substance dependence included as a mental disorder | No | No | No |
| Risk to self or others required | Yes | Yes | Yes |
| *A lack of capacity explicitly required | Yes | No | No<br>"Impaired Judgement" |
| *Patient requires treatment | Not mandatory for all patients | Yes | Yes |
| *Assessment Orders (AO) utilized | No | Yes | Yes |
| *Possible applicants for a patients' involuntary detention | Not required | Nearest relative | Not required |
| *Recommendation | 1 Medical practitioner | 2 registered medical practitioners | A MHP and medical practitioner |
| *Recommendation period | 7 days | 28 days | 72 hours |
| Deciding authority for order | Medical | Medical | Medical |
| *Signing of AO | Physician | Approved clinician | MHT |
| *Types of AO | Certificate of involuntary admission | Emergency detention order<br>Admission of assessment<br>Admission for treatment | Assessment order<br>Treatment order |
| Mandatory inclusion of patient counsel | Yes | Yes | Yes |
| *Assessment period in hospital prior to completion of AO by consultant psychiatrist | 72 hours | 28 days | 24 hours with extension of up to 48 hours |
| *Duration of Renewal Orders | 2 weeks<br>4 weeks<br>2 months | 4 weeks<br>3 months<br>6 months | 6 monthly |

| | | | |
|---|---|---|---|
| | 3 monthly | 12 monthly<br>Or if a CTO<br>6 monthly<br>12 monthly | |
| *MHT | Automatic | Patient request | Patient request |
| *Detention time before tribunal (maximum) | 28 days | 14 days | 7 days |
| *Tribunal board members | Psychiatrist or medical doctor, solicitor or barrister, lay person | Psychiatrist, solicitor or barrister, medical professional | Psychiatrist, solicitor or barrister, lay person |
| Appeal detention order | Yes | Yes | Yes |
| Appeal process | Board Appeal: Appeal to Victorian Civil and Administrative Tribunal, Supreme Court | Yes: Upper Tribunal | Yes: Superior Court of Justice |

(Adapted from Cronin et al., 2017).

## Appendix B: Figures

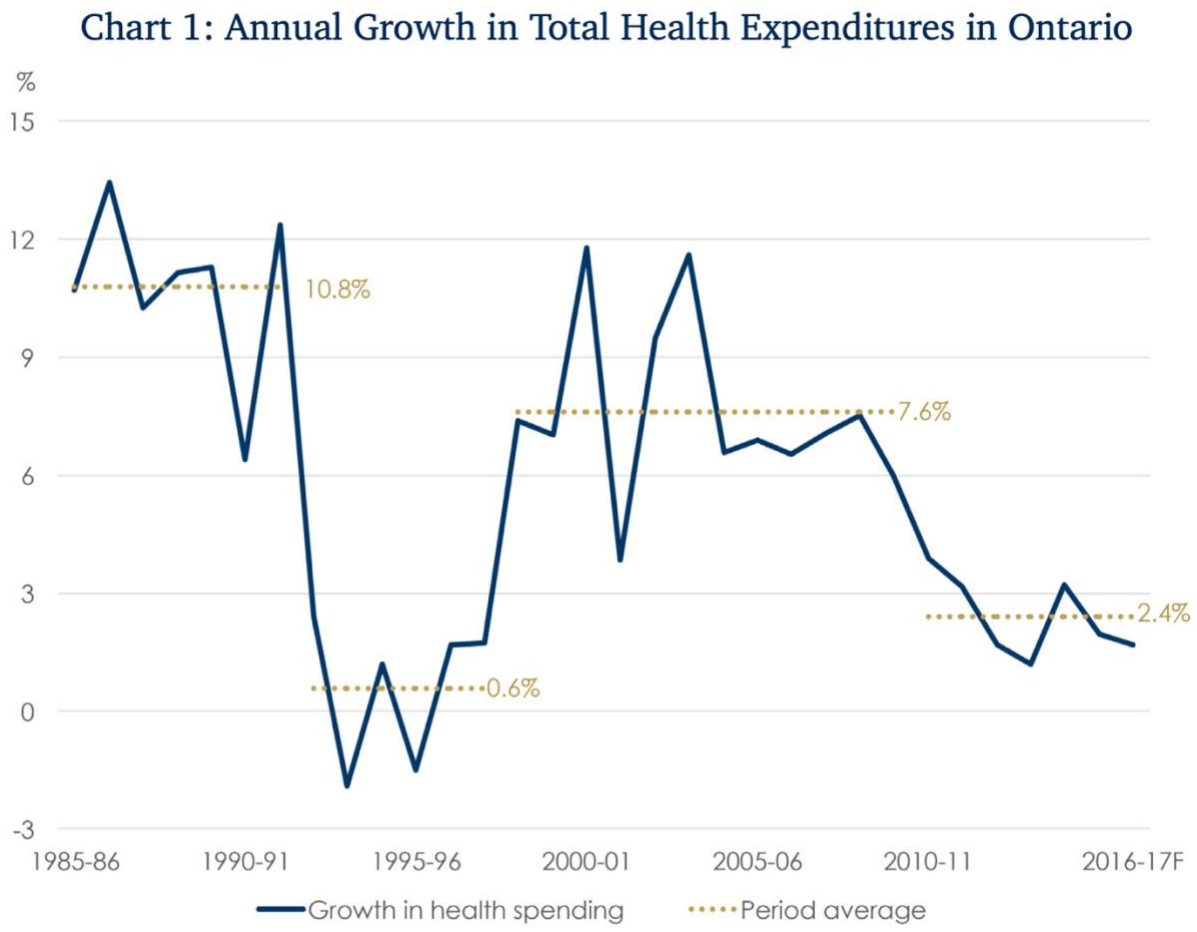
**Figure 1.** Characteristics of Four Strategy Types and Associated Strategic Domains




Members of a potential winning coalition may find themselves in one or four possible strategic domains in windows of opportunity for major change.

(Source: adapted from Tuohy, 2018, p. 16)

**Figure 2.1.** Annual Growth in Total Health Expenditures in Ontario

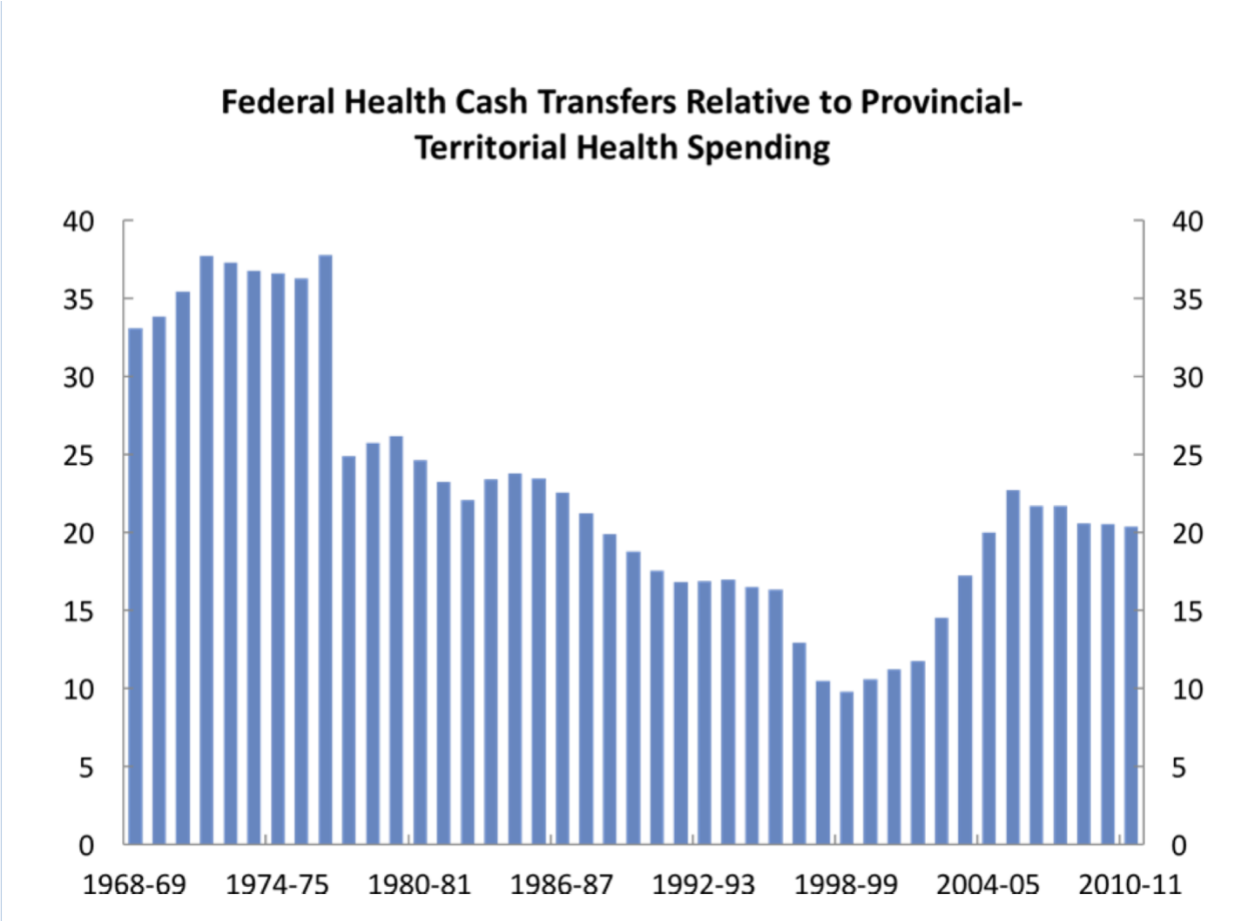



The Chart summarizes the historical healthcare spending for Ontario, Canada.

(Source: Institute of Fiscal Studies and Democracy, 2017, p. 4)

Notes: Years are in reference to fiscal years. Public and private health expenditures are reflected in the numbers.

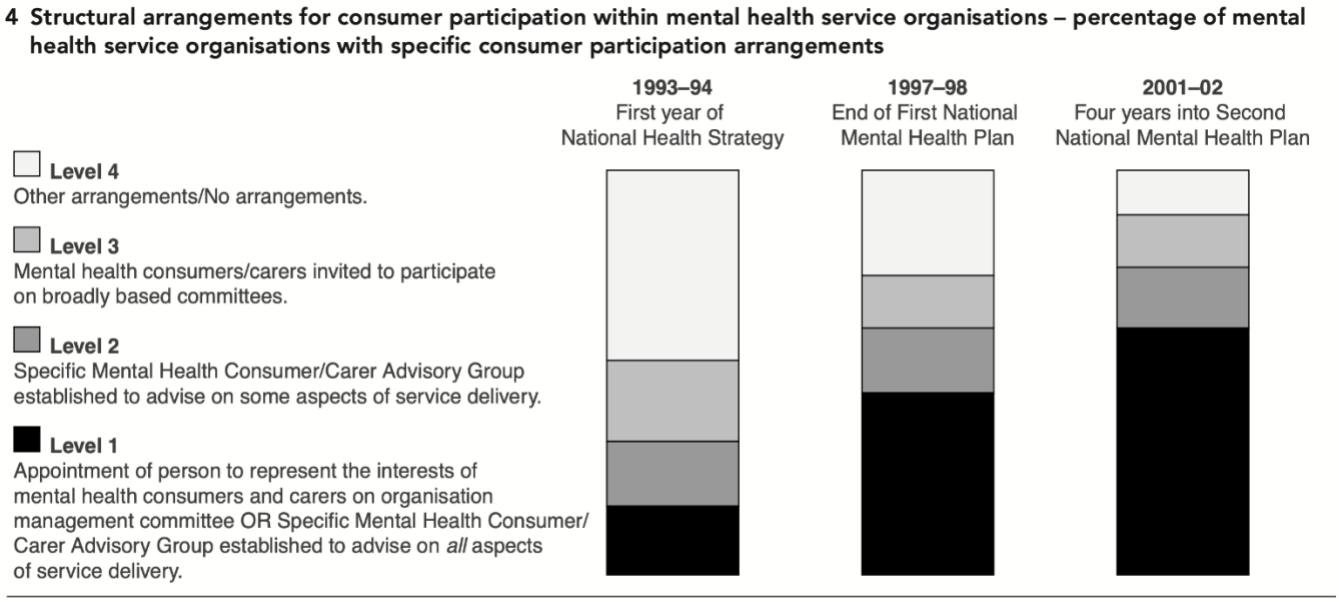
**Figure 2.2.** Federal Health Cash Transfers Relative to Provincial-Territorial Health Spending – Canada




The figure offers a historical perspective of the federal-provincial commitment to healthcare.

(Source: Canadian Health Coalition & Ontario Health Coalition, 2017, p. 16)

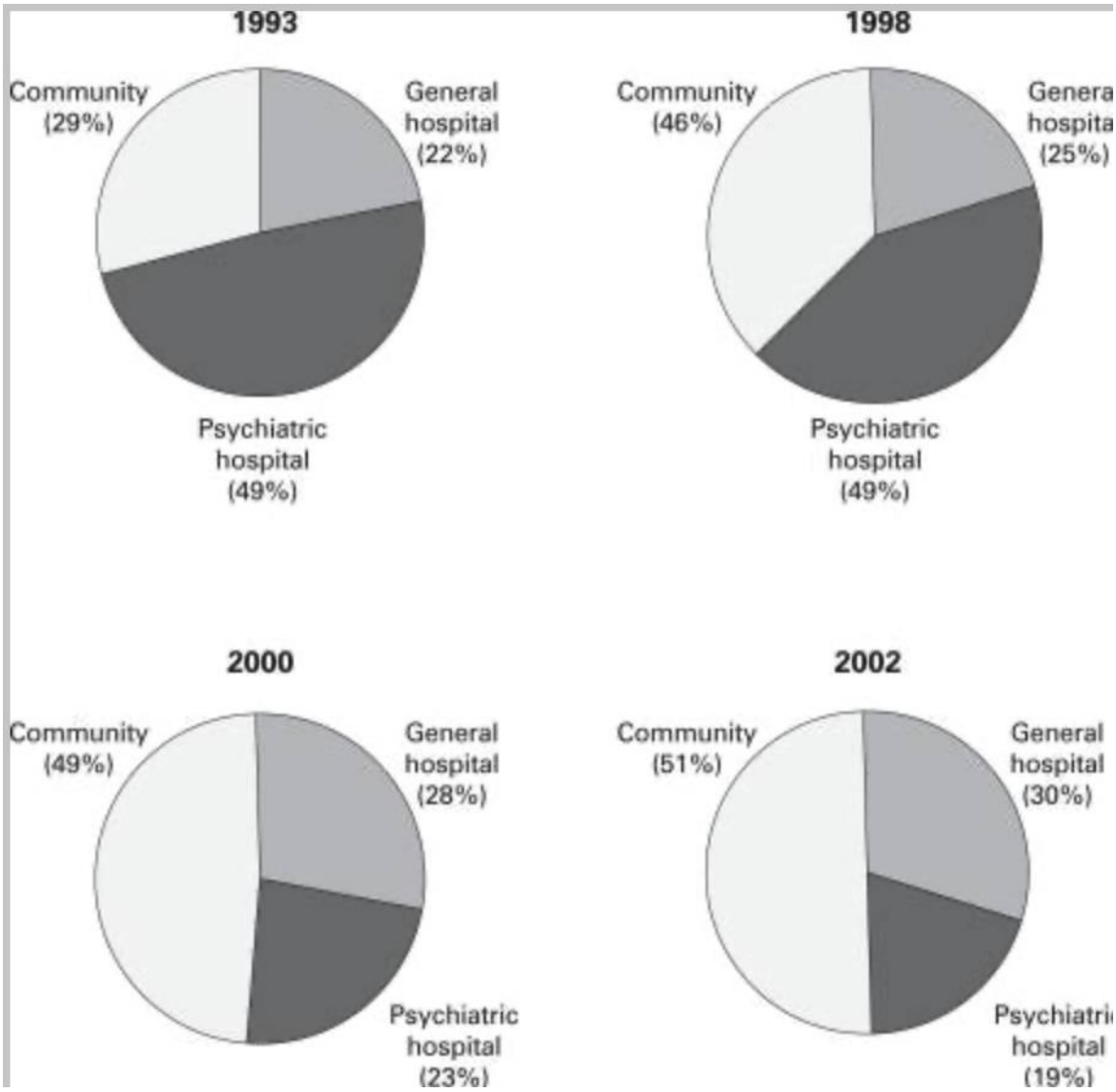
**Figure 2.3.** Increased Rates of Community Participation in Mental Health Service Organization – Australia




The illustration indicates how consumer participation increased in response to the implementation of the National Mental Health Strategy.

(Source: Whiteford & Buckingham, 2005).

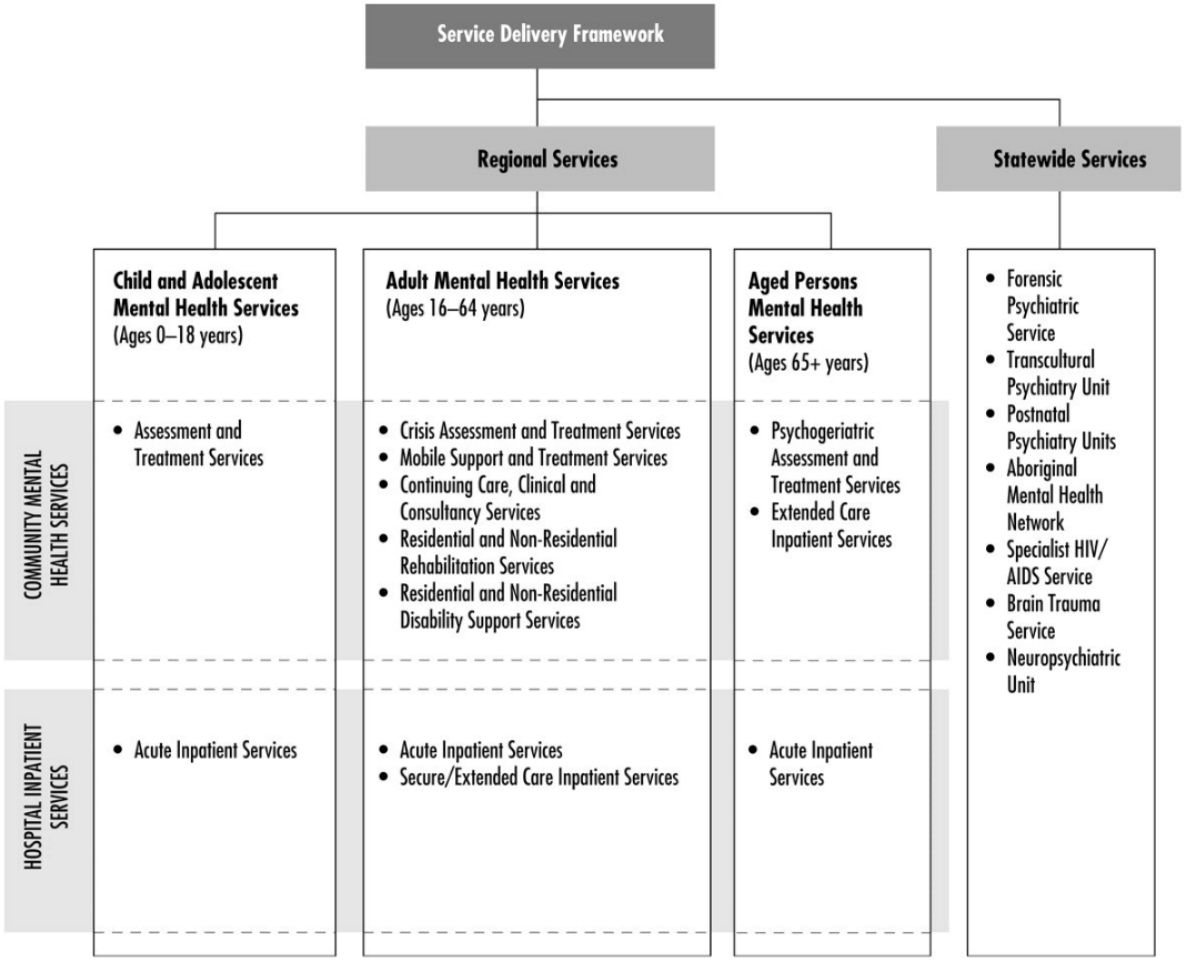
**Figure 2.4.** Changes in the Composition of Public Mental Health Expenditures – Australia Between 1993-2002.




The figure demonstrates the shift in mental health financing from psychiatric hospitals to community-based services during the first two National Mental Health Plans (1993-2003) in Australia.

(Source: Rosen, 2006).

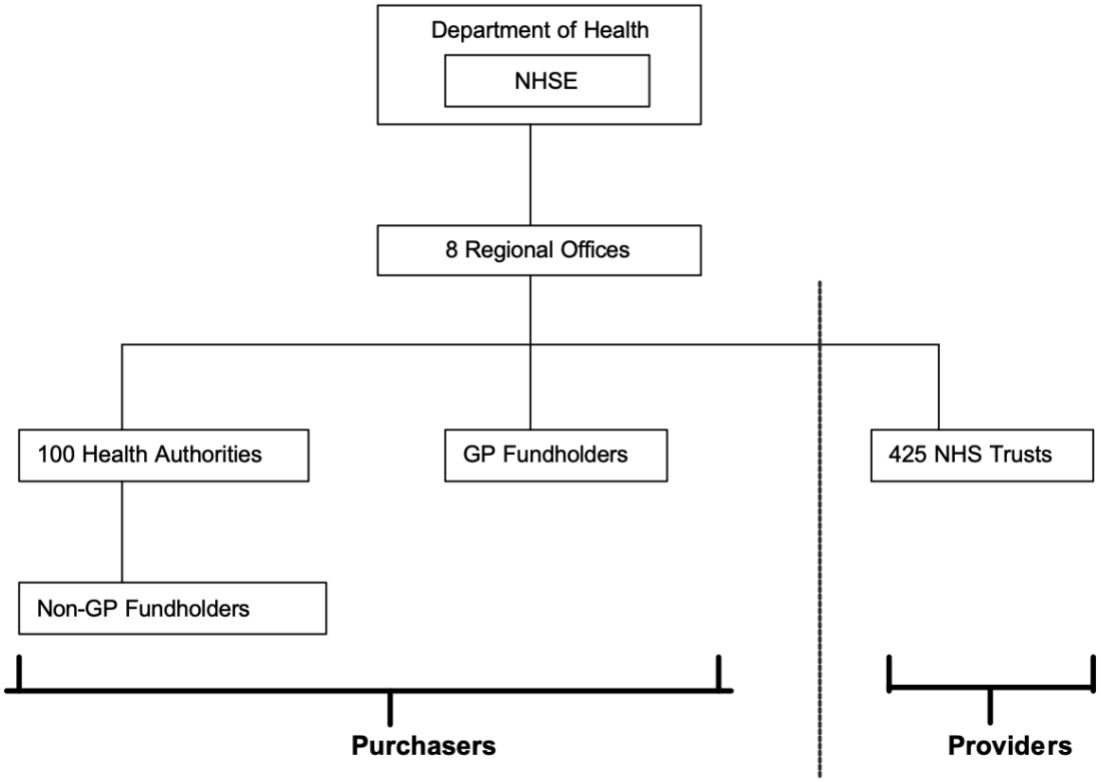
**Figure 2.5.** The Reformed System Framework – Victoria, 1994




The figure shows the service components of the new Victoria mental health service

(Source: Meadows & Singh, 2005, p. 64).

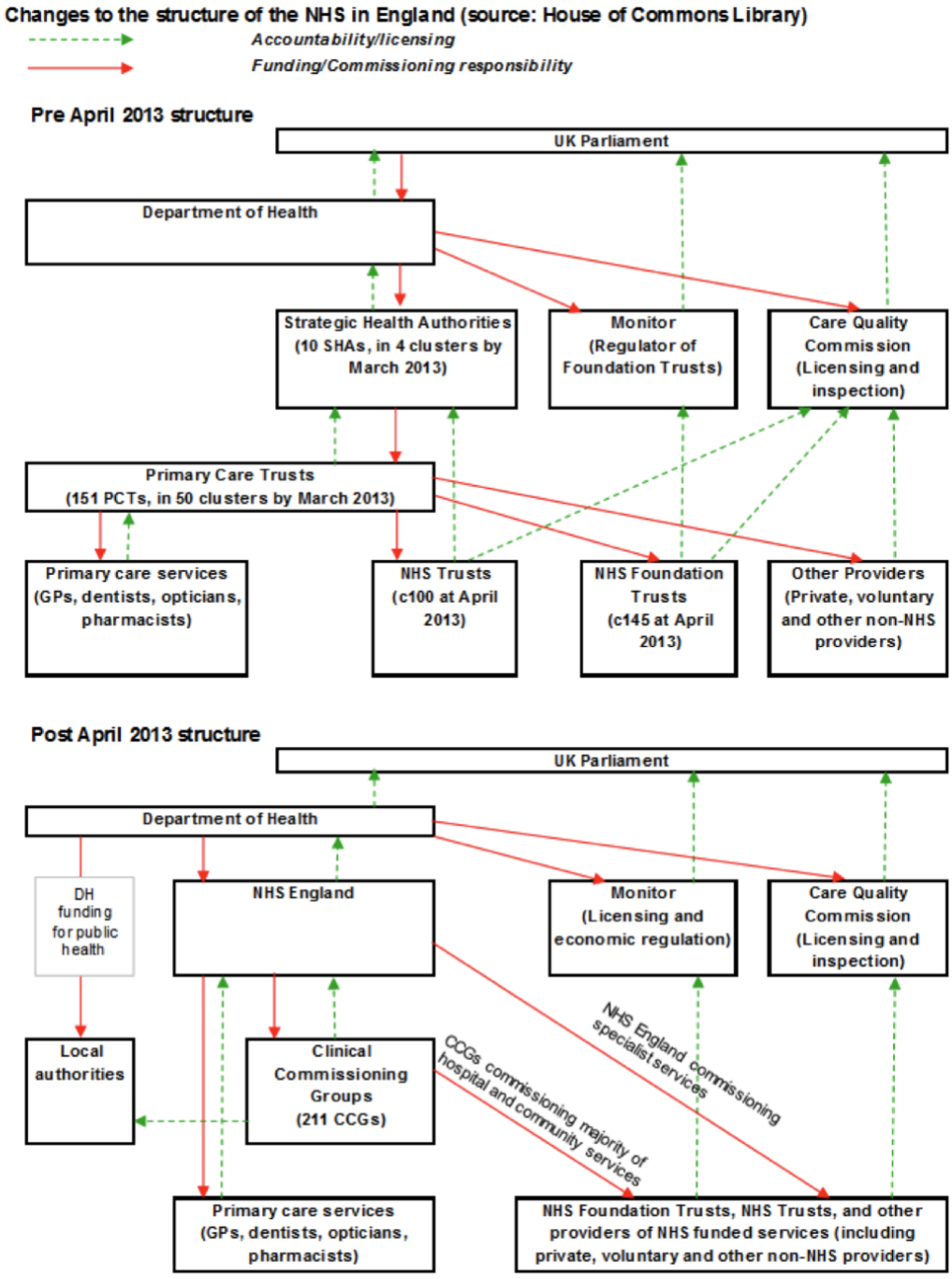
**Figure 3.1.** Structure of NHS in England, 1996




This Figure displays the changes to the structure of the NHS in England (in 1996) following the mandatory purchaser/provider split and voluntary creation of fund-holding GPs.

(Source: Greengross et al., 1999, p. 15).

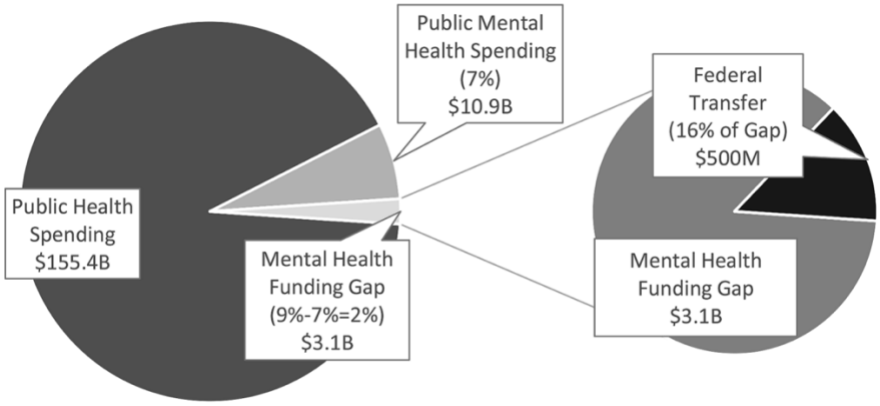
**Figure 3.2.** Pre and Post-Reform structure of the NHS in England




The figure displays the changes to the structure of health service in England introduced by the *Health and Social Care Act* (2012).

(Source: Powell, 2016, p. 3).

**Figure 4.1.** Closing the Mental Health Gap (Annual Amounts) – Canada




The figure depicts the financial requirements to increase the portion of healthcare spending on mental health from 7 percent to 9 percent, considering the 2017 federal commitment of $500 million annually. It shows that in 2015, the public expenditure on total health was $155.4 billion, with the mental health allocation at 7 percent amounting to $10.9 billion.

(Source: Bartram & Lurie, 2017, p. 10)

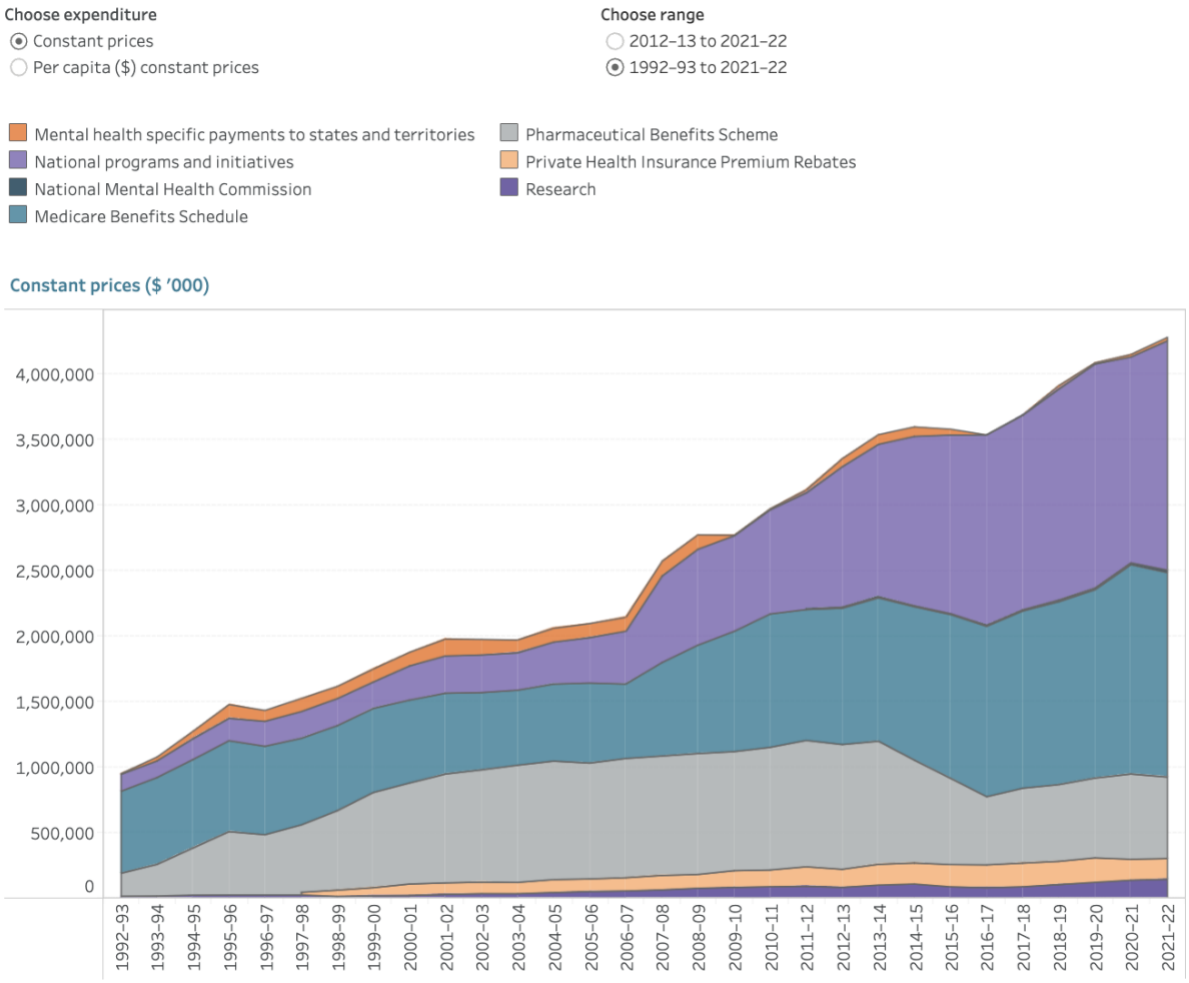
**Figure 4.2.** Proportion of Mental Health Spending Relative to all Recurrent NHS England Spending

| | 2022/23 | 2023/24 |
|---|---|---|
| Recurrent NHS baseline (£bn) | 142.4 | 153.0 |
| Total forecast Mental Health spend (£bn) | 12.7 | 13.6 |
| Mental Health share of recurrent baseline | 8.90% | 8.92% |

In the financial year 2022/23, mental health spending made up 8.90 percent of all recurrent NHS spending. In the coming financial year, the government expects this to grow by 0.02 percentage points and account for 8.92 percent of total recurrent spend as shown above.

(Source: Department of Health and Social Care, 2023)

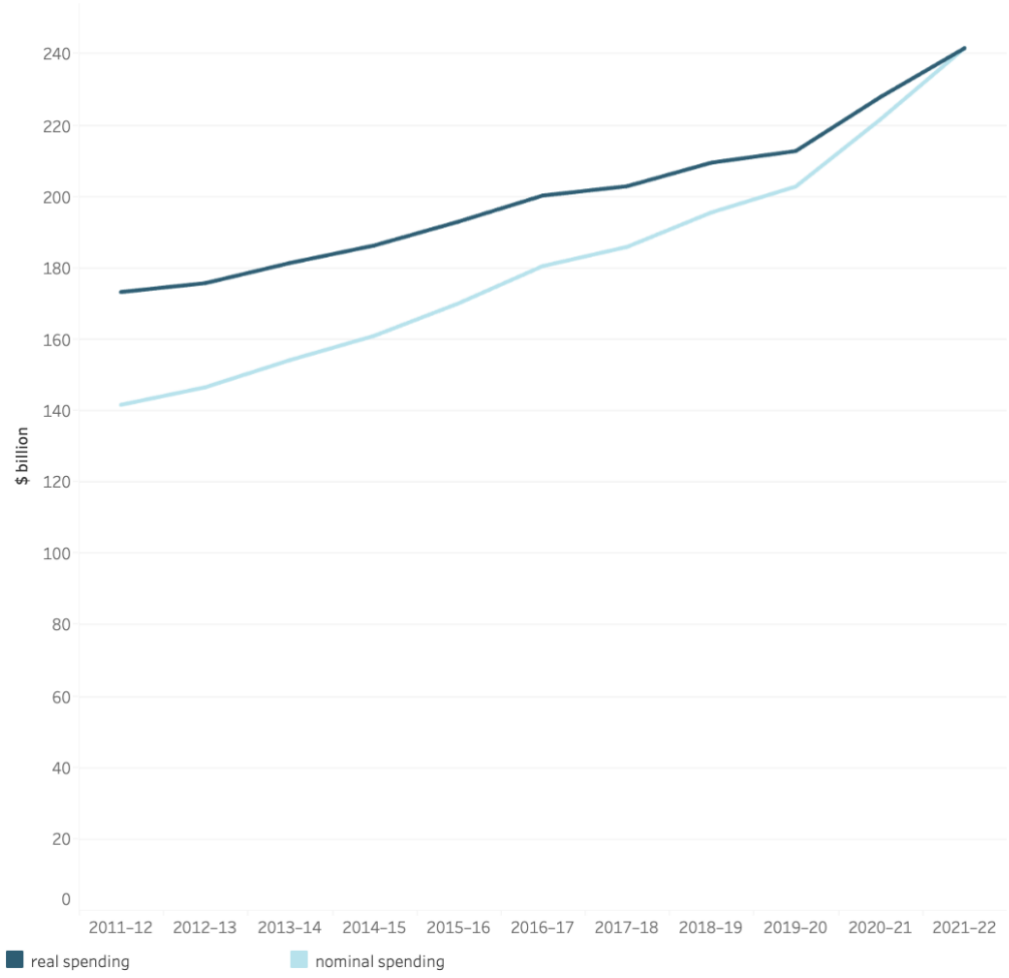
**Figure 4.3.** Government Spending on Mental Health Related Services (Constant Prices) – Australia, 1992-93 to 2021-22




The figure depicts the increase in Commonwealth government funding for mental health-related services from 1992-93 to 2021-22.

(Source: AIHW, 2024)

**Figure 4.4.** Total Health Expenditure (Nominal and Real) – Australia, 2011-12 to 2021-22




*Nominal spending refers to spending not adjusted for inflation from one year to another year.

*Real spending refers to spending accounted for inflation by removing the effect of changes in prices over year. Real health spending is in 2021-22 prices.

The figure depicts total health spending by the Commonwealth government from 2011-12 to 2021-22.

(Source: AIHW, 2023b)