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A New Economic and Social Paradigm for Funding Recovery in Mental Health in the Twenty First Century

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1. Introduction

Mental illness is a significant factor in disease related disability throughout the world. About 16% of the global burden of disease not attributable to communicable disease has been attributed to mental disorders (Prince et al 2007) with substance abuse disorders contributing to a further 4% of this burden (ibid). In Australia, "Mental Disorders" were considered to be the third major cause of health loss (behind cancer and cardiovascular disease) in 2003 but were estimated to increase at a significant rate to move ahead of cancer and become the second major cause of "health loss" by 2013 (Begg et al 2008). This burden of mental illness is particularly pronounced in the youth of Australia with disability-adjusted life years (DALY's) for mental illness calculated to be above 90,000 (compared to the next highest of 48,000 DALY's due to injury) for the 15 to 24 year old age group in 2003 (Eckersley 2011). Along with the current burden of disease attributed to mental illness, there is a number of challenges facing societies in the developed and developing world that are likely to lead to an increase in mental illness. Sartorius (pers comm) has recently outlined some of these challenges. They include: weakening of community resilience mechanisms, increasing awareness of gaps and unreachable opportunities, migration of people, talents and capital with the subsequent loss of social capital in some societies, the challenges of increased urbanisation on community supports and family structures, the changing nature of privileged families in developed society with less children, longer life spans and more fragile family structures, the decrease of middle class "norms" in developed countries and the additional increase of the middle class in developing countries with potential economic and social alienation from less privileged groups, the changing role of women and the implications that this has for child care and care of the elderly and the changing paradigms of medicine itself with increasing use of technology in addition to evolving ethical issues such as euthanasia.

The severity of personal disability from mental illness is pervasive.

The poetry of Anne Sexton in the poem "Sickness unto Death" (1977) helps describe some of this inner experience for severe mood disorder:

*“God went out of me
As if the sea dried up like sandpaper,
As if the sun became a latrine
God went out of my fingers,
They became stone
My body became a side of mutton
And despair roamed the slaughter house...”(Porter 1991)*

The recent poem by Sandy Jeffs (2009) describes her life affected by schizophrenia.

*“I am many things, in many places
Fool that I may be, mad that I may be.
I am, in all my precarious guises
The creation of a cruel mind”*

People suffering from severe mental illness currently face significant levels of poor health (Symonds & Parker 2007), high levels of unemployment (Dunne E et al 2008), homelessness (Browne & Hemsley 2010), alienation from family members (Druss et al 2009) and services (Luhmann 2008). The economic cost of these issues to society generally is significant with people affected by schizophrenia estimated to have provided a direct cost to the United States economy of \$62.7 billion in 2002 (Wu et al 2005)

2. Primary health care

The above issues have gained increasing importance against a background of increasing international recognition about what should constitute the ideal of health for individuals and communities. The Declaration of Alma-Ata (1978) defined health as “a state of complete physical, mental and social wellbeing and not merely as the absence of disease and infirmity” as a fundamental human right. The Declaration further called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors”. The Ottawa Charter for Health Promotion (1986) built on the initial foundations of the Declaration of Alma-Ata. The Charter reported that health “is therefore seen as a resource for everyday life, not the objective for living” and “as a positive concept emphasizing social and personal resources as well as physical capacities”. The Charter goes on to define the prerequisites for health as: “peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity”.

The Declaration of Alma-Ata was produced in the context of a new “global approach” to health developed initially through the creation of the World Health Organisation (WHO) as a key agency of the United Nations and then the broad visionary strategy of the drive to “Health for All by the year 2000” by the then WHO director, Hafldan Mahler. This coincided with the increasing involvement of the World Bank as the major external funder for health sector development in developing countries and it has been noted that the Bank has “positioned itself operationally and intellectually at the fulcrum of international health development” (Walt 2006).

In the context of the above initiatives mental health is currently defined by the World Health Organisation as “a state of well being in which the individual recognises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (Herrman et al 2005)

3. Amartya Sen and the concept of human agency

Apart from health, there has also been an appreciation of economic opportunities associated with the empowerment of human agency, ideas further developed by Amartya Sen, who was awarded the Nobel Prize for Economic Science in 1998. Sen (1999) defines “agency” as “someone who acts and brings about change and whose achievements can be judged in terms of their own values and objectives, whether or not we assess them in terms of some external criteria as well”. Sen then goes on to discuss the way that *instrumental effectiveness* of freedom may enhance this potential for agency. “This instrumental role of freedom concerns the way different kinds of rights, opportunities and entitlements contribute to the expansion of human freedom in general and thus to promoting development”. Sen then defines his instrumental freedoms as (1) political freedoms (civil rights), (2) economic freedoms (the opportunities to utilize economic resources for the purposes of consumption, production and exchange), (3) social opportunities (arrangements for education, health care etc), (4) transparency guarantees (transparency and trust in personal interaction) and (5) protective security (unemployment benefits, famine relief etc). These instrumental issues then underpin *substantive freedoms* for humanity such as political and civil liberty, social inclusion, literacy and economic security. The work of Sen is having a significant impact on individuals concerned with enhancing the agency of deprived groups such as those people affected by severe mental illness and this will be further discussed later in the chapter. Henry (2007) further defines the issues that Sen promotes “Sen also notes that a second subset of other relevant capabilities of considerable interest to the classical economists – such as the capability to live without shame, the capability to participate in the activities of the community, and the capability of enjoying self-respect – provides a basis for relative poverty comparisons....policy makers should be concerned with opportunities. Specifically, they should be concerned to ensure that individuals are endowed with capabilities that allow them the *freedom* to choose to live their lives in ways that have real meaning and real value....”.

The concepts that Sen defines have been usefully applied to Indigenous disadvantage in Canada and Australia (as described below). They may have also particular importance in supporting strategic policy initiatives to develop a mental health Recovery framework.

4. Effective funding models for primary health care: The indigenous paradigm in Canada and Australia

The broad spectrum of disadvantage experienced by those afflicted by severe mental illness is to a degree, similar to the current predicament of the Indigenous populations of Australia and Canada. Recent innovative government policies to redress this disadvantage have been based on the definitions of Primary Care previously described in addition to policies based on the desire to enhance substantive freedoms as promoted

In Canada in 2002, First Nations tribes constituted 976,305 people or about 3 percent of the population (Indian and Northern Affairs Canada Communications Branch 2004) Kirmayer et al (2000) note that First Nations Tribes have had contact with European culture since the sixteenth century. They comment “ the history of European colonisation of North America is a harrowing tale of the indigenous peoples’ decimation by infectious disease, warfare and active suppression of culture and identity that was tantamount to genocide (ibid). Kirmayer et al note that it is likely that 90% of an original population of 7 million Canadian First Nations people died as a direct and indirect result of European contact (ibid). The authors

comment that First Nations people were removed to settlements that were chosen by government or mercantile interests rather than by the Indigenous Canadians themselves. This often resulted in major social dislocation for the community structures. In addition, from 1879 to 1973, there was a Government policy of removing First Nation children from their homes to church run boarding schools where their heritage was denigrated and suppressed. In addition, these children were subject to physical, emotional and sexual abuse (ibid).

Indigenous First Nations Canadians have high unemployment rates (25%) compared to the general Canadian population (10%) with particularly high rates on reservations (31%) (MacMillan et al 1996). First Nations people generally live in poor housing and only a limited number of communities have adequate water and waste disposal (ibid). They have high infant mortality rates of 13.8 per 1000 live births for all Canadian Indian infants compared to 7.3 for all Canadian infants. Age standardised mortality ratios for Canadian First Nation women is almost double that for Canadian women generally whilst the aged standardised mortality rates for First Nation men is about 50% above that for Canadian men generally with higher death rates for men on reserves. The leading cause of death for Canadian First Nation people between 1986 and 1988 was injury and poisoning that accounted for 31% of all deaths in this population compared to 7.5% of all Canadians (ibid).

Suicide rates for Indigenous Canadians are two to three times higher than Canadians generally. There is a particularly high suicide rate for the Inuit people with the suicide rate in Inuit youth being up to 5 times the rate of Canadian youth generally (ibid). Canadian First Nation communities also report high rates of alcohol abuse, other substance abuse and family violence (ibid) that are probably relevant in respect to the high suicide rates. Solvent abuse, including petrol, glue and cleaning products in isolated First Nation communities (ibid, p1576). Kirmayer et al (2000) also report that there are generally high rates of mental illness in many Indigenous Canadian communities. They note “the high rates of suicide, alcoholism and violence and the pervasive demoralisation seen in Aboriginal communities can be readily understood as the direct consequences of a history of dislocations and the disruption of traditional subsistence patterns and connection to the land”. However, conversely, the First Nation communities with more “cultural control” factors such as employment of First Nations people in key positions in the community (such as the police) and with increased community governance appear to have less suicide (Chandler & Lalonde 1998).

A response to the significant disadvantage of Canada’s First Nations Peoples, very much developed in the spirit of primary health as outlined in the Ottawa Declaration was the Canadian Aboriginal Horizontal Framework (Canada’s Performance 2005). This government policy was co-ordinated between the Canadian Federal government and Provincial governments to address the disadvantage in Canadian First Nation social determinants across a “wide front”. Leadership from the top was a key initial factor in the development of the Framework with the then Canadian prime minister Paul Martin committing to a round table discussion with all levels of Canadian government and First Nation leaders. A policy retreat with members of the Canadian Committee on Aboriginal Affairs and First Nations leaders followed. There was also a commitment to the development of an Aboriginal report card to track progress with the Canadian health strategy.

The Canadian Aboriginal Horizontal Framework was then developed as a strategic guide to funding priorities and co-operation between the various levels of government as well as allowing the establishment of performance indicators. The Framework appears to place the

“pillars” of health at equal value. The “pillars” were: Health, Lifelong Learning, Safe and Sustainable Communities, Housing, Economic Opportunity, Lands and resources and Governance and Relationships. Each of the “pillars” of the Framework was then be divided into “sub pillars”. As an example, Safe and Sustainable communities were divided into: Community Infrastructure, Social Support and Community Well-being and Community Safety and Justice. Unfortunately, the policy appears to have been wound back following the election of the Conservative Government in Canada in 2006. However, the policy remains an important example of the way that a government can enact policy to remedy the broad range of disadvantage with financial “strategic pillars” attached to the relevant issues of “Primary Health” as outlined in the Ottawa Charter.

In Australia, Archaeological evidence suggests that Aboriginal people have been present for the last 45000-50,000 years. The ethnographic evidence from early contact suggests that Aboriginal people who survived infancy were relatively fit and disease free (Flood 2006). Further, Australia’s native foods supported a nutritious, balanced diet of protein and vegetables with adequate vitamins and minerals with little salt sugar and fat. Life on the move kept people physically fit (ibid).

In terms of “mental health”, traditional Aboriginal culture had a number of strong reinforcing factors that have been well defined by Professor(s) Helen and Jill Milroy (Milroy et al 2003). Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. The culture also provided for everyone through sharing rules and relationships and kinship were of prime importance, defining social roles. Aboriginal people were also given a sense of meaning and understanding of life experience through their connection to country and their Dreaming. Spiritual beliefs offered guidance and comfort and offered a sense of connectivity and belonging despite distress, death and loss. Lore, the body of knowledge that defined the culture and the tribal elders who contained and interpreted the Lore were highly valued. Customary law defined rules and consequences. Over 200 traditional languages and other methods of communication allowed a rich expression of interaction in the above social context and formal ceremony allowed a method of dealing with life’s transitions thought birth, initiation and death. Men and women had defined economic and cultural roles within the tribe. Children were well protected within the group with a range of “aunties” and older siblings able to take over the child care role if the mother was stressed.

Franklin and White (1991) describe the elements of destruction of this optimum physical and mental good health of the Aboriginal people following the British colonization of Australia in 1788. These elements were the introduction of new diseases, the removal of ancestral land which led to psychological distress and spiritual despair and the herding of Aboriginal people into reserves and settlements, destroying lifestyle and leading to marginalisation and poverty. Other specific policies such as the Stolen Generations from the 1930s to the 1960s where Aboriginal children were forcibly removed from their parents and raised in Mission settlements reinforced government social Darwinist ideology and led to the destruction of family life with resulting emotional desolation for many individual Aboriginal people.

The current significant disadvantage of Aboriginal health and social determinants is well recognized. Hospitalization rates for cardiovascular disease in Aboriginal and Torres Strait Islander was 80% higher than for other Australians in the North West of Australia in 2002 to 2004. (AHMAC 2006) Rheumatic heart disease was nine times more common for Aboriginal and Torres Strait Islanders than other Australians (ibid). Diabetes and renal failure also figure prominently in Aboriginal health issues. In 2004-2005, three times as many Aboriginal

and Torres Strait Islanders were reported to have diabetes compared to other Australians (ibid). Hospitalization rates for Aboriginal and Torres Strait Islander people with diabetes are six times higher than for other Australians (ibid). End Stage Renal Disease, often the consequence of poorly controlled diabetes was eight times higher for Aboriginal and Torres Strait Islander peoples than other Australians (ibid). Given these alarming health statistics, it is not surprising that life expectancy for Aboriginal and Torres Strait Islander people is 17 years less than for other Australians (ibid), an issue now well recognized in the "CLOSETHEGAP" (HREOC 2008) agenda.

Aboriginal and Torres Strait Islander disadvantage is also apparent in other social indices. The 2002 National Aboriginal and Torres Strait Islander Social Survey estimated that 26% of the Aboriginal and Torres Strait Islander population over 15 were living in overcrowded housing. The overcrowding becomes more apparent in remote areas where it is estimated that 62% of Aboriginal and Torres Strait Islanders live in overcrowded housing (AHMAC 2006). In respect to education, the National Schools Statistics Collection reported that the retention rate of Aboriginal and Torres Strait Islander students in Year 7/8 to Year 10 was 88.3% compared to 98.6% for other students. Unfortunately, the retention rate for Aboriginal and Torres Strait Islander students from Year 7/8 to year 12 of high school was only 39.5% compared to 76.6% for other students (ibid). Given this trend in education, the accompanying statistics of significant Aboriginal and Torres Strait Islander disadvantage in employment and income to the rest of Australia are no surprise along with data from the prisons that shows that Aboriginal and Torres Strait Islander people are twelve times more likely to be in prison compared to the remainder of the Australian population (ibid).

Poverty and racism also provide a framework for the above statistics. Walter & Saggars (2007) point to the significant association between poverty and adverse health outcomes. They note that a significant proportion of Australia's Indigenous population live in a situation of "absolute poverty" as defined by the United Nations where they have severe deprivation of basic human needs including food, safe drinking water, sanitation facilities, health, shelter education and information. Some diseases such as scabies and diarrhea are directly related to inadequate sanitation and living conditions (ibid). The issues of Indigenous poverty appear particularly marked in rural areas. In addition, the failure of a recent plethora of policies to advance Aboriginal health has been attributed to a pervasive culture of "welfare colonialism", an aspect of continuing poverty. "Welfare Colonialism" (Anderson 1997) affects Aboriginal communities where most Aboriginal populations rely heavily on the provision of public sector resources. Over time, the mechanisms to deliver these overlie the traditional methods of Aboriginal governance, reducing the capacity of the communities to develop leadership in the solutions to their problems. In addition, the continuing experience of widespread racism against Aboriginal people generally within the Australian community appears to have a continuing negative effect, particularly on the mental health of Aboriginal people (Paradis 2007).

The Australian government policy environment has also recently produced a number of innovative solutions in respect of government approaches to the above Aboriginal and Torres Strait Islander disadvantage leading to the formal Council of Australian Governments financial funding strategy, the National Indigenous Reform Agreement. The Agreement in 2008 was prefaced by a paper written by Ken Henry, Secretary of the Australian Treasury. Henry (2007) suggested a broad based approach across Australian Government Departments to address Aboriginal and Torres Strait Islander health disadvantage, similar in some ways to the Canadian Framework. Henry described three key

interdependent foundations to current Aboriginal and Torres Strait Islander disadvantage in Australia. Poor economic and social incentives, the underdevelopment of human capital and an absence of the effective engagement of Aboriginal and Torres Strait Islander Australians in the design of policy frameworks that might improve these incentives and capabilities. Henry commented that he and other Secretaries in the Australian Government Secretaries Group on Aboriginal and Torres Strait Islander Affairs had identified seven platforms that need to be prioritized within a framework of Aboriginal and Torres Strait Islander capability development. These included: basic protective security for women and children, early childhood development, a safe and healthy home environment, an accessible primary care health service, ensuring that incentives in the welfare system do not work against promotion of investment in human capital, real job prospects as a result of education and governance systems that support political freedom and social opportunities of local Indigenous people to be engaged in policy development.

The proposal by Henry resulted in the formation of the Council of Australian Governments National Indigenous Reform Agreement in 2008. The building blocks of the strategic financial agreement between the Australian Federal and State Governments were based on the primary care principles outlined in the Ottawa Charter. The Building Blocks outlined by the Agreement are: Early Childhood (early learning, development and socialization opportunities), Schooling (infrastructure, workforce, curriculum, student literacy and numeracy achievement, and opportunities for parental engagement and school/community partnerships), Health (access to effective, comprehensive primary and preventative health care), Economic Participation (real jobs, business opportunities, economic independence and wealth creation), Healthy Homes (adequate water and sewerage systems, waste collection electricity and housing infrastructure), Safe Communities (improved, accessible law and justice responses, effective policing, "safe houses", child protection and alcohol policy) and Governance and Leadership (capacity building so that Indigenous Australians can play a greater role in exercising their rights and responsibilities as citizens) (COAG 2008). The Agreement also has specific funding of \$ 4.6 Billion overall for the "Building Blocks" to allow their progression by the Australian Commonwealth and State governments. COAG continues to monitor the progress and outcomes of the funding strategy.

The above discussion of government programs for the Indigenous peoples of Canada and Australia shows that government is able to construct realistic funded policy initiatives based on the accepted international principles defining primary health.

5. The Recovery Movement in mental health

The Recovery Movement in mental health has gained increasing momentum in recent years. Leff & Warner (2006) note that "the model refers both to the subjective experiences of hope, healing, empowerment and interpersonal support experienced by people with mental illness, their carers and service providers and to the creation of recovery-oriented services that engender a positive culture of healing and a support for human rights". The authors add that, as a result of the Recovery Movement, there is renewed interest in fighting the stigma that leads people with mental illness to lose their sense of self, to provide access to the services and education that give consumers the knowledge and skills to manage their illness, empowering consumers to share responsibility with providers in the healing process and providing access to peer support that validates the possibility of recovery (ibid). Recent discussion about the Recovery Movement has also focused on the "capabilities" approach of

Amartya Sen. Davidson et al (2010) note “the capabilities approach diverts our attention away from the possession of resources to the exercise of freedoms. This shift is not meant to deny the crucial role that resources play in social and political life but rather places emphasis on the fact that the usefulness of wealth lies in the things that it allows us to do—the substantive freedoms it helps us to achieve”. The authors go on to argue that Sen’s concepts of active agency and freedoms should apply to the “here and now” in respect to people’s choices on a daily basis rather than some theoretical ideal future. In addition, the pursuit of agency generates diversity as each individual will pursue such agency according to individual need and a supporting system needs to accommodate such diversity (ibid). The end result should be to “increase the access of people with serious mental illness to opportunities and supports that allow them to live a decent and self determined quality of life” (ibid). Sen’s economic concepts are also closely aligned to emerging discussions of social capital that are discussed later in the chapter.

Piat et al (2010) review a range of government initiatives to develop the recovery model. The US President’s New Freedom Commission identified a fragmented health system and gaps in care as obstacles to recovery and this led to all 50 US States adopting recovery mission statements and implementing at least one evidence-based service. In New Zealand, discrimination and stigma were identified as most problematic and this led to a significantly enhanced role for psychiatric patients (consumers) within the system with good consumer-provider being identified as a key indicator for recovery orientated services (ibid).

Unfortunately, the economic basis of supporting effective recovery does not appear to have matched the theoretical process of empowerment and particularly so in the developed world. The observation that people suffering from schizophrenia often have a better outcome from disease in the third world (Warner 1986) may be related to the situation where economic opportunity (such as having meaningful work on a family farm or in a family kitchen) along with a place to sleep and adequate diet may be much easier to provide within the economic restraints and social supports of third world countries. Warner (ibid) has also commented on the nature of work in less developed countries that may be protective for someone suffering from severe mental illness. He notes that the person’s family is less likely to emotionally smother the individual and the tasks allocated to the individual are likely to be geared to the level of performance that the person can actually achieve. In comparison, the costs of providing adequate housing and meaningful employment to individuals in developed countries are often significantly higher. In addition, it often has been difficult for governments to provide coordinated sustained funding for such programs across a range of different government departments that have responsibility for each program. The difficult task of addressing the above issues in the developed world is exemplified in a recent evaluation of the cost of mental illness in Canada in 2003. The review found that the cost of undiagnosed mental illness was about 28% of a total cost of \$50,847 million dollars with direct medical costs of treating mental illness contributing only about 10% of this amount with the remainder being attributed to lost productivity (Lim et al 2008).

6. The Australian mental health plans and the Canadian Mental Health Commission

Federal Governments in both Australia and Canada have attempted to develop strategies to enhance services for those people affected by severe mental illness in a variety of ways.

Since the early 1990's, the Federal, in co-ordination with the State and Territory Governments of Australia have developed four successive mental health plans through the Australian Council of Health Ministers. The most recent plan of 2009-2014 has the following five priority areas for government action in mental health:

1. Social inclusion and recovery
2. Prevention and early intervention
3. Service access, coordination and continuity of care
4. Quality improvement and innovation and
5. Accountability - measuring and reporting progress. (DOHA 2009)

The authors of the plan note that "the plan is ambitious in its approach and for the first time includes a robust accountability framework. Each year, governments will report progress on implementation of the plan to the Council of Australian Governments. The plan includes indicators for monitoring change in the way the mental health system is working for people living with mental illness as well as their families and carers. Health ministers have agreed to develop targets and data sources for each of the indicators in the first twelve months of the plan." (ibid). Although the plan stresses "A Whole of Government Approach", it is unlikely that it will develop the appropriate sustained funding strategy to support outcomes similar to that initiated by the Council of Australian Governments National Action Plan on Mental Health 2006-2011 (COAG 2006), a government response to substantial deficiencies in public mental health provision outlined in the "Not For Service" Report (MHCA 2005). This contrasts with the normal rather disorganised system of mental health funding in Australia where one recent review (AHHA et al 2008) commented "there is still no single agency, organization or level of government with the remit and responsibility for the setting of strategic mental health policy or for the oversight, monitoring or operationalisation of mental health care. Funding methodologies and funding amounts vary between jurisdictions and have traditionally not been based on population need. This and the range of agencies and providers involved in the provision of mental health care has led to inequities in access, service provision and health outcomes".

The Canadian Government established the Mental Health Commission for Canada in 2007. After extensive consultation with a range of stakeholders in Canada, the Commission published its strategy document in 2009 (MHCC 2009). The strategy has seven goals: the engagement of people suffering from mental illness in the process of recovery, mental health promotion and mental illness prevention, a responsive mental health system, recognition of the role of families, equitable and timely access to effective treatments and support, actions informed by best evidence with measurable outcomes and support for research and social inclusiveness (ibid). The Commission was allocated \$130 million by the Canadian Federal Government for 10 years in 2008 with the money being targeted towards the three key initiatives of the Commission which were to conduct a 10-year anti-stigma campaign, build a pan-Canadian Knowledge Exchange Centre, and elaborate a national mental health strategy for Canada (Government of Canada 2008). However, there does not appear to be any overall funding strategy for mental health in Canada apart from this with services being provided through its Medicare system and mental health services bundled in with other general health services through the Regional Funding Authorities within each Province (Block et al 2008). It has been estimated that funding of mental health for Canada in 2003-2004 was 5% of total health spending which was lower than most developed countries (Jacobs et al 2008). Other authors have argued that the funding models of Medicare in Canada have led to the restriction of community services and other professional services

such as psychologists for people suffering from mental illness (Mulvale et al 2007, Moulding et al 2009)

7. A new paradigm for mental health funding

Given the complexities of developing sustainable funding models for mental health, one solution would be to develop policy and funding strategies around a series of “pillars or “building blocks”, similar to the Canadian Aboriginal Horizontal Framework and Council of Australian Governments National Indigenous Reform Agreement. This would align government policy to internationally accepted principles of health care and may allow a broader government overview and responsibility for the various components necessary to develop mental health. Funding could be allocated to each “pillar” and benchmarks attached to each pillar to assess progress. The “pillars” suggested are: Physical Health, Social Inclusion, Education, Effective Treatments, Substance Abuse, Mental Health Response to Disaster, Housing and Governance. Each one of these will be discussed in turn with a view to relevance and with mention of previous and current programs that could provide a basis of funding.

8. The physical health of people suffering from severe mental illness

There is a significant amount of information that people who suffer from serious mental illness also are at increased risk of increased morbidity and premature mortality from co-morbid medical illness. Viron & Stern (2010) talk of patients suffering from severe mental illness losing over 25 years of potential life with 87% of years of potential life lost being attributable to medical illness. They further comment that the mortality gap, based on data from 1997 to 2000 is 10 to 15 years wider than it was in the early 1990's. Observations at the beginning of the twentieth century noted that physical morbidity and mortality were greater amongst psychiatric patients than in the general population. Other commentators have noted the lack of thorough medical evaluation and inadequate treatment of medical disorders amongst psychiatric patients (Felker B et al 1996) . The issue of co-morbid medical conditions is particularly prominent in patients suffering from schizophrenia. This is not surprising given the social isolation, problems with adequate housing and the lack of organisation of proper meals and poor diet reported for this group of patients (Jablensky et al 2006, Brown et al 1999). High rates of tobacco and other substance use in this group also add to the disease burden (Jeste et al 1996).

Apart from the obvious issues of significant disability related to the illness process itself, there also appear to be a number of medical and health system barriers to recognition and management of medical illness in people with schizophrenia. Such barriers include a reluctance of non-psychiatrists to treat people with serious mental illness, frequent changes of treating doctor, lack of adequate follow up due to patients' itinerancy and lack of motivation and the available time and resources for an appropriate review of medical issues of people who may be uncooperative or have trouble communicating their physical needs (Lambert et al 2003). Higher rates of poverty in those experiencing severe mental illness (d'Amore et al 2001) along with stigma related to the experience of mental illness (Barney et al 2006) may also be further barriers patients with mental illness developing an effective relationship with a General Practitioner. The atypical antipsychotic medications may also lead to an increased prevalence of endocrine disorders such as Type 2 Diabetes (Lambert & Chapman 2004), thus necessitating increased medical vigilance in this regard.

As a way of attempting to improve the co-ordination of the care of medical illness in those patients with serious mental illness, there has been a significant stimulus to develop shared care models between psychiatric specialists and general practitioners. Such models include a Consultation-Liaison model (Gask et al 1997), collaborative case discussions between specialist psychiatrists and groups of General Practitioners (Davies et al 1997) and shared care projects with extensive education for involved General Practitioners (Meadows 1998). There have also been substantive improvements in remuneration for shared care in Australia with the Medicare Plus program encouraging a collaborative care mode. The General Practice Clinic operated within a mental health service (Symonds & Parker 2007) compensates for a number of the barriers to health engagement discussed above and allows for a high quality of health care with extended clinical review times and health screening significantly above the Australian national average. Other recommendations for improved health care for people suffering from severe mental illness are: improved health screening and health promotion along with systemic models of medical and mental health care integration such as the VHA system in the USA (Viron & Stern 2010). Increased awareness by psychiatrists of the metabolic effects of psychotropic medication along with improved information to carers of people affected by severe mental illness in respect to appropriate medical care (De Hert et al 2010). Better co-ordination of a range of specialist services such as occupational therapists, pharmacists and dieticians in respect to the medical health care of people affected by severe mental illness may also be useful (Heald et al 2010).

9. Social Inclusion

A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person into the community (Cappo 2002). Leff & Warner (2006) have outlined factors that lead to social exclusion for people affected by severe mental illness. These include the disabilities produced by the illness itself (such as the negative features of schizophrenia which include apathy and reluctance to engage with others), disabilities produced by professional care (including institutionalization and side effects of medication), stigmatizing attitudes of the public and self stigma of individuals (which may affect recognition of illness and ability to obtain appropriate treatment), media influences, poverty and discrimination in housing and employment.

Some of these factors are going to be considered in other sections of this chapter. The key focus on this area of social inclusion in the current context is addressing stigma and the maintenance of people suffering from severe mental illness within their social group. Sartorius (2010) discusses a range of barriers to effective campaigns to reduce stigma. He notes that anti-stigma campaigns have to be longer than a year to be effective. Sartorius comments that other factors that have been proven to reduce stigma such as legislation to effect employment and housing, ongoing promotion of useful strategies (such as education of health care professionals, public education forums for members of the public by people who have suffered from mental illness and avoidance of pejorative comments in the media) and permanent networks of interested business people, professionals, patients and their families that respond to local issues within cultures and communities.

To an extent, the *headspace* Model of Care for young people suffering from severe mental illness in Australia attempts to fulfill some of the above requirements in an organizational

sense. A principal aim of *headspace* is “to establish a highly accessible, more specialized multidisciplinary model of care to target the core health needs of young people” (McGorry et al 2007). To enable these objectives, *headspace* has developed a number of funded centers within Australian local communities with the aim of building greater awareness of youth mental health within these communities and building capacity within these communities to ensure early detection and early intervention of emerging mental illness and substance use disorders, create a youth and family friendly environment, benefit from significant improvements in access, service integration and quality through co-location, secondment of clinical staff and outreach and access evidence-based interventions for the treatment of mental and substance use disorders (ibid).

The engagement of family members of people suffering from severe mental illness in the treatment process is crucial. This is because of the therapeutic value that family members may bring to the care of the person through their knowledge of expert and longitudinally developed information about the person which is helpful for appreciation of psychosocial deficits and current mental state in addition to their involvement in any case planning for the person’s further management (Furlong & Leggatt 1996) Further evidence that therapeutic family interventions, particularly behavioural education, in reducing relapse for people suffering from schizophrenia and thus improving the cost-effectiveness of treatment (Mihalopoulos et al 2004) add emphasis to the value of family intervention in the illness.

The psychological effects of any chronic illness in relation to the family members of the person so affected are well recognised (Bloch et al 1994) Such factors include the issues surrounding the illness itself (acute onset, chronicity, acute exacerbation), the life-cycle stage of the family and the meaning of the illness to the family. Such “meaning” will be influenced by the family’s previous experience of illness and belief systems about illness (ibid). Whilst these issues are relevant in the case of family members of someone suffering from schizophrenia, there is additional evidence of the devastating additional effect of the illness on family, leading to comments such as that recently made in a textbook of mental health law that “like other service providers but perhaps more than other service providers, the family and friends of the individual will have an emotional and practical interest in the fate of that individual” (Bartlett & Sandland 2003)

The family burden of living with a person suffering from a major mental illness such as schizophrenia is well described. It has been noted that stigma associated with the illness spreads to the whole family and may cause them to avoid talking about how they are feeling or deem themselves as social outcasts, leading to barriers between them and mental health professionals (Teschinsky 2000)

Recent reviews of the pressures faced by carers of people suffering from severe mental illness describe the “Objective Burden” that involves disruption to the household routines, finances and relationships and a “Subjective Burden” which involves the psychological consequences of the individual’s illness for the family (Martens & Addington 2001, Wong et al 2008). The “Subjective Burden” of the illness appears to be higher for relatives of people experiencing first onset illness associated with schizophrenia (Martens & Addington 2001) and promotes the beneficial therapeutic value of psycho-education for the family in respect to information about the illness, illness management skills, communication skills and problem solving skills (Motlova 2007) therefore being an effective way of reducing this distress through empowerment of family members. Culture and differing family belief systems may be particularly important in this regard (Lesser 2004) The legal issues of confidentiality allowing such engagement with families are complex but can be negotiated

in legislation, such as recent Mental Health Acts in Victoria and the Northern Territory of Australia (Parker et al 2010)

Participation in the workforce is an important factor in social inclusion. Warner (1983) comments that a key factor for any work for people affected by severe mental illness is that there should be stable expectations geared to the level of performance that the individual can actually achieve and this is more difficult to achieve in industrial society where there are high productivity requirements and competitive performance ratings. Further issues that may interfere with effective workforce participation in developed countries are co-morbid substance abuse and physical illness (Cornwell et al 2009). Employment programs for people affected with severe mental illness that are integrated into public mental health services appear to be one way to improve outcomes. One example of this is the Individual Placement and Support Approach in the United States that has been found to have almost a three fold increase in employment participation (60% versus 22%) (Waghorn et al 2007). A recent collaboration between Mental Health Services and the Vocational Education Sector in New South Wales that integrates supported education along with supported employment for mental health consumers is hoping to have similar results, maximising chances for consumer choice in employment and enhanced long term employment outcomes (VETE 2011, J McMahon pers comm). Apart from the economic benefits of the participation of people affected by severe mental illness in paid employment, there are also other personal benefits for those such engaged such as increased pride, self esteem, empowerment and facilitation with coping (Dunn et al 2008).

A range of issues may assist with social inclusion of individuals affected by severe mental illness in the third world. It has been noticed that cultural mechanisms may be more accepting of mental illness in these countries (Kermode et al 2009, Postert 2010). However, Rahman & Prince (2008) note that there is a significant amount of stigma experienced by families of people affected by severe mental illness in third world countries. They go on to suggest the incorporation of mental health treatment into primary care services as a way of reducing this stigma along with the training of primary care workers in the use of psychotropic medication. It has also been noted that regular use of such medication (with a subsequent reduction of difficult behaviours) may lead to greater social function and acceptance of the person within their community (de Jong & Komproe 2006).

10. Education

It has been recognised for a considerable period of time now that education in itself leads to empowerment in health. The review by DeWalt et al (2004) displayed that patients with poor literacy had poorer health outcomes including knowledge, intermediate disease markers, measures of morbidity, general health status and use of health resources. Cutler and Lleras-Muney (2006) suggest a range of mechanisms for education to enable health behaviours. They note that the effect of education increases with increasing years of education. Education in relation to income and occupational choice has some relationship to health empowerment but that different thinking and decision making patterns as a result of increased education may also have significant effects on health behaviours.

Henry (2007) comments on required “development platforms” which need to be in place for education to be effective. These include: security from violence, promotion of early childhood development, a home environment that is conducive to regular patterns of sleep and study, free from overcrowding and distraction and ready access to suitable primary health service

infrastructure. A good example of the essential nature of such platforms to improved educational outcomes has been the success of the Clontarf Foundation education programs with Indigenous male adolescents in Australia. The Clontarf Foundation, a not for profit, organisation, was established in Western Australia in 2000. It was established to improve the discipline, life skills and self esteem of young Aboriginal men so that they can participate meaningfully in society. The Foundation currently has contact with 2000 young Aboriginal men in Western Australia and the Northern Territory. The Foundation's programmes to young Aboriginal men are delivered through a network of 25 Academies, each of which operates in partnership with (but independently of) a school or college. Australian Rules Football (AFL) is used to attract the young men to school and then keep them there. In order to remain in the program, participants must continue to work at school and embrace the objectives of the Foundation. Each Academy has an individual staff member who, in addition to delivering the football program, acts as a mentor and trainer addressing many of the negatives impacting on the young men's lives. Many of the Academy staff are ex AFL players. Participation by young Aboriginal men in the Clontarf Foundation has resulted in significantly increased retention rates for the participants through to the completion of secondary education and then on to participation in the workforce. By the end of 2008, 41 (76%) graduates of the 2007 program were employed. In April 2009, 51 of the 76 graduates of the 2008 program were in full time employment (Clontarf Foundation 2010)

Examples of successful education programs in mental health are: initiatives to improve mental health literacy, education programs to empower carers of people affected by severe mental illness and mental health training for police.

Health literacy appears to be a key component of improved education and health outcomes. Health literacy has been defined as "the ability to gain access to, understand and use information in ways which promote and maintain good health (Jorm et al 1997) Jorm and his colleagues found that health literacy in respect to mental health was not well developed amongst a sample of the Australian population and that this lead to unwillingness to accept help from mental health professionals or to a lack of adherence to advice given (ibid).

A potential solution to poor health literacy are the "mental health first aid training programs" developed for the Aboriginal and Torres Strait Islander Population of Australia (Kanowski et al 2009) in addition to the wider Australian population (Kitchener & Jorm 2006) The programs aim to provide help to a person developing a mental health problem or in a mental health crisis (Kanowsky et al 2009) and are aimed at Instructors who develop the skills for staff working in Aboriginal and Torres Strait Islander primary health organisations. The programs are based on education about a range of symptoms of mental illness as well as a response to a range of potential mental health scenarios such as helping a suicidal person, a person experiencing a panic attack, a person who has experienced a traumatic event and a psychotic person who is perceived to be threatening (Kitchener & Jorm 2006). It was estimated that in 2005, 350 people who worked area health services, non government organisations, government departments or as private practitioners had completed the Instructor training in Australia (ibid).

A further, school based initiative in mental health literacy is the "Mind Matters" Curriculum that was developed for Australian Secondary Schools (Wyn et al 2000) The project is based on a model of school change developed by the World Health Organisation and involves curriculum materials about emotional and mental health issues in addition to creating a school environment that is safe, responsive to student needs and that assists students in their ability to cope with challenges and stress (ibid).

Psycho-education for the family involving information about the illness, illness management skills, communication skills and problem solving skills (Motlova 2007) has been demonstrated to be an effective way of reducing this distress. It has been shown that, as a result of the training, families become empowered to better manage their relative's mental illness and their reactions to it. A recent evaluation of formal group training provided to carers of people affected by early psychosis resulted in the carers reporting less isolation, improved confidence, greater understanding of psychosis, reduction in guilt and increased confidence in their caring role (Riley et al 2011).

Education of other professional groups who have involvement with people affected by severe mental illness is also an important aspect to the strategy to improve knowledge and skills and effect better management of these individuals. A good example of this is the Mental Health Intervention Team Course offered by the New South Wales Police Force (Donohue D et al 2009). It is recognised that police often are at the fore front of interactions with people who are severely affected by mental illness and may significantly aroused as a result. Kesic et al (2010) in a review of fatalities as a result of interaction with police in Victoria found that 54.2% (26/48) of the victims had a history of DSM IV Axis I disorder, 39.6% of the 48 events had a history of substance abuse/dependence, 10.4% had formal diagnosis of Axis II personality disorder and that 87.5% were known in some capacity to mental health services or police. It was also estimated that in any given year, Currently New South Wales Police Officers can expect to attend approximately 22,000 mental health related incidents (about 30% of total call outs per year) with some of the incidents posing the biggest risk to their safety (Donohue et al 2009).

The New South Wales Police Mental Health Intervention Team course runs over four days and includes formal education sessions in respect to mental illness, substance abuse, legal issues and available services in addition to "real situation" education scenarios such as role plays. The formal aims of the course are: to reduce the rate of injury to police and mental health consumers on interaction, improve awareness amongst front line police of the risks involved in mental health incidents, improve collaboration with other government and non government agencies in the response to, and management of mental health crisis incidents and reducing the time taken by police in the handover of mental health consumers to the health care system. An important aspect to the education is the participation of mental health consumers and carers in educating police about the way that they are affected by symptoms and the way that they would like to be approached during acute exacerbations of their illness. The effect of severe mental illness on the carers was also well appreciated by the police participants of the course that I attended and police commented that they found the sessions with mental health consumers and carers some of the most valuable learning that they took from the course. Police (ranging from Area Commanders to constables) who attend the course are awarded a course badge as a formal "police appointment" to be worn on their uniform at the conclusion of the course. To an extent, this also allows people who are severely affected by mental illness and who are in crisis to recognise that attending police, wearing the badge, have training to assist them.

11. Effective treatments

Effective treatments (underpinned by rigorous and continuing research) are an essential component of any broad strategy for quality mental health service delivery. The treatments have specific costs that obviously inform public policy in respect to what particular

economies and cultures are prepared to fund. As an example, the Tolkien II team have estimated that the average cost of treating a case of depression in Australia in 2005 was \$175,566 with psychological therapies and medication. Tolkien II Team (2006). Effective therapeutic interventions are also a major area of concern for key stakeholders of mental health services with this area being considered most important in a recent European survey of Mental Health Recovery initiatives (Turton et al 2010).

A crucial issue that informs the above economic models is the use of Evidence Based Practice as a gold standard for funding decisions. There are complexities with this issue, however. Tanenbaum (2005) defines three potential controversies and a caveat in respect to evidence base practice in mental health policy. The first controversy is how restrictive should the definition of the evidence be and whether dominant definitions privilege some forms of treatment over others. The second controversy raised by Tanenbaum is that there is a significant difficulty translating research findings into clinical practice and this relates to a larger controversy in mental health about whether practice is in fact applied science. It also focuses on a significant paradox where the 'significantly filtered' study populations of pharmaceutical trials often have little in common with the complex patients treated by clinicians (Westen 2005). Tanenbaum's third controversy is "the definition of *effective* health care and who decides the benchmarks for *effectiveness*".

Notwithstanding the above controversies, there has been increasing emphasis in recent times on evidence based guidelines for the treatment of mental illness with initiatives such as the American Psychiatric Association Practice Guidelines (APA 2011) and the Clinical Practice Guidelines introduced by the Royal Australian and New Zealand College of Psychiatrists (RANZCP 2011)

However, research has consistently shown that education efforts alone do not appear to strongly influence healthcare provider/practitioner behaviours in comparison to a range of factors that have been demonstrated to influence such behaviours such as consumer demand for services, financial incentives and penalties, administrative rules and regulations and feedback on practice patterns (Mueser et al 2003). The authors go on to suggest six Evidence-Based Packages that may be useful in the management of people affected by severe mental illness. These are collaborative psychopharmacology, assertive community treatment, family psycho education, supported employment, illness management and recovery skills and integrated dual diagnosis treatment. Mueser et al also propose an implementation strategy for the packages that will enhance their success. These involve standardized complementary training and consultation packages for mental health centres in addition to discussion with health authorities in respect to financing, regulatory and contracting mechanisms to support the introduction of the Evidence-Based Packages (ibid). Specific attitudes of mental health providers that may need to be addressed in the adoption of Evidence-Based Packages are the intuitive appeal of the package, the strength of the requirement to adopt the package on the individual, the openness to new practice and the divergence of usual practice with research based/ academically developed interventions (Aarons 2004)

Further issues that considerably affect the implementation of evidence based practice are the pressure on policy makers to justify the allocation of resources and demonstrate add on value, the need for practitioners to have confidence in the likely success of implementing the interventions and that the people who are likely to benefit see that the program and its process of implementation are participatory and relevant to their needs. A further challenge is the application of existing evidence to good practice on the ground, particularly in disadvantaged and low income countries (Barry & McQueen 2005)

Given the above difficulties, an effective best practice model will probably be optimally provided by a knowledge of basic science, best evidence via knowledge of epidemiology and randomised controlled studies along with interpretation and individualisation related to clinical experience and available resources (Belmaker R pers comm.). However, effective treatments will continue to be a constant objective of appropriate funding priority in mental health and require a governance mechanism to review their ongoing usefulness and economic priority.

12. Substance abuse and mental illness

In the current era, no effective mental health policy can be expected to succeed without some measures to control substance abuse that precipitates and sustains mental illness. Although this area is complex and may appear somewhat overwhelming, a brief overview of a major area of practice and public health appears to show a number of factors worthy of policy intervention in a broad sense.

There is substantial evidence that children exposed to trauma in their domestic environment are at later risk of severe mental illness such as schizophrenia (Harley et al 2010) and substance abuse (ibid). There are a number of explanatory models for this with stress exacerbating genetic vulnerability to mental illness (Xie et al 2009) and people using substances to self medicate PTSD resulting from childhood trauma as well as increased substance abuse in the context of dysfunctional personalities (Jonson-Reid et al 2009) and aberrant emotional attachment (Rees 2005).

Alcohol abuse continues to be a major contributor to childhood trauma (Nelson et al 2010) with the children of alcoholic parents exhibiting higher rates of anxiety and depression (Eiden et al 2009). In addition, alcohol has further effects such as the higher rates of anxiety and depression in children affected by foetal alcohol syndrome (Hellemans et al 2009)

There is also a growing body of evidence in respect to the close association of substance abuse and mental illness, particularly in respect to cannabis and amphetamine abuse. Paparelli et al (2011) in their review article point to emerging consistent evidence between cannabis abuse and an increased risk of psychiatric symptoms and chronic illness. The authors also discuss the increased risk of psychosis as a result of repeated amphetamine and methamphetamine abuse and point to evidence of probable neuronal damage due to repeated methamphetamine abuse. The issue of brain damage related to amphetamine use was also demonstrated in a recent pilot study that appeared to show that 1:5 of young people who presented to a hospital ED in the context of amphetamine abuse had an occult brain lesion, as a result of their amphetamine abuse, on MRI scans (Fatovich et al 2010).

A range of strategies have been suggested for successful intervention with mental illness and substance abuse. Legislative measures such as increased excise on alcohol, improved policing of drink driving and reducing availability of alcohol to young people through a minimum legal purchase age have been shown to be highly effective in reducing alcohol related harm in Germany (Walter et al 2010). Recent information from Australia indicates that improved policing in respect to amphetamine abuse may have been a factor in reducing inpatient admissions from psychosis secondary to psycho-stimulants (Sara et al 2011). Innovative primary care approaches to managing cannabis abuse (Lubman & Baker 2010) and stimulant abuse (Frei 2010) have also found to be useful. Such management approaches involve improved screening for substance abuse and mental health problems, education and self monitoring for affected individuals, developing harm reduction strategies and patient empowerment through exploring options for change and negotiating a change plan.

13. Mental health response to disaster and trauma informed care

Some of the earliest written records in human history from Sumeria in 2000BC record the anguish and suffering of the population following the destruction of Nippur (Kinzie & Goetz 1996). In more modern times, there has been increasing recognition in a more rigorous scientific manner on the significant psychological and psychiatric sequelae resulting from people affected by disasters (Norris et al 2002)

This increased recognition has also occurred in the co-incident context of political recognition of high public expectation in respect to the quality of services that government in the developed world provides to its citizens involved in a disaster. As an example of this the British Foreign Secretary, Jack Straw, on the anniversary of the 2004 tsunami, apologised to British families caught up in the disaster who had not received adequate support, commenting that British citizens have “very high expectations of what the British government can deliver and fair enough” (Eyre 2008). This co-incident context is of significant concern given projected estimations that in Australia, 65% of men and 50% of women may be exposed to a traumatic event during their lifetime (Forbes et al 2007) and with the current prevalence for PTSD being 1.3%, or 20,000 cases per year (ibid).

In recent years, there also has been increased identification of the effect of historical trauma as a subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes and how this intergenerational trauma can lead to the breakdown of a functional society (Atkinson et al 2010). In this context, Professor Helen Milroy (pers comm) also describes the phenomenon of “Malignant Grief” as an end result of persistent intergenerational trauma and stress experienced in Australian Indigenous communities. Professor Milroy defines Malignant Grief as a process of irresolvable, collective and cumulative grief that affects Australian Indigenous individuals and communities. The grief causes individuals and communities to lose function, become progressively worse and ultimately leads to death. Professor Milroy further comments that the grief has invasive properties, spreading throughout the body and that many of Australia’s Indigenous people die of this grief.

Enhanced clinician skills for clinicians to assist people affected by disaster and trauma as the need arises can be incorporated into organisational development within mental health services (Guscott et al 2007). On occasion, specific programs may need to be developed to address mass population trauma such as the one organised by the Peking Institute of Mental Health to assist clinicians and volunteers working with the Chinese population effected by the Sichuan earthquake in 2008 (Parker et al 2009). In addition, enhanced education resources devoted to the appropriate response of mental health clinicians to those affected by disaster (Ursano et al 2007) can guide appropriate economic and managerial responses by governments and health organizations.

14. Housing

Homelessness amongst people affected by severe mental illness is a continuing concern. In a recent series of nationwide meetings to discuss mental health policy and service provision in Australia, the lack of appropriate housing for the mentally ill was a consistent and significant theme in the discussions amongst a wide group of stakeholders (R Irving pers comm.). It has been estimated that 46% of homeless people in the United States may have a mental illness (O’Hara 2007) with another review estimating prevalence rates of psychosis at around 10 to

13% and a prevalence of affective disorders at around 20 to 40 % in homeless people (Schanzer et al 2007) Homelessness is also associated with higher rates of readmission to inpatient units along with longer inpatient stays (ibid). Additionally, homelessness is linked with excess mortality and particularly so with homeless people who abuse substances (Morrison 2009). Poverty, disabling health, behavioural issues co morbid substance abuse, competition for available public housing stock along with complex processes in applying for such stock all limit the opportunity for the mentally ill to access appropriate housing (O'Hara 2007). In addition, conventional categorical funding streams, bureaucratic program requirements, narrow administrative approaches to resource allocation and management and staff skills not geared to supporting the mentally ill in normal housing have been thought to have limited successful involvement by mental health services in this area (ibid).

It has also been noted that housing is a significant aspect of the recovery for people affected by severe mental illness with the concept of a "home" providing "roots, identity, security, belonging and a place of emotional wellbeing" (The PLoS Medicine Editors 2008). The "home" concepts that appear to be valued by the mentally ill are considered to be markers of ontological security: namely constancy, daily routines, privacy and a secure base for identity construction (Padgett 2007). It appears that different levels of housing support may be appropriate in this regard with supervised housing being more appropriate for people with severe disability from mental illness with a graduation to independent housing in the context of recovery (Tsai et al 2010).

Apart from the humanitarian aspects of the provision of a "home" to enhance recovery for people affected by severe mental illness, there also appear to be economic benefits generally with potential savings from repeated and lengthy hospital admissions that should encourage further strategies in this area.

15. Governance

The development of effective governance processes to enable the mental health of a population should be the major concern of any government and health authority. Effective governance processes should have a continuing "flow on" effect over many years with demonstrated benefit for people affected by severe mental illness, their families and communities. Mulvale et al (2007) point to the way that historical factors can mitigate against good governance in developing a modern mental health system that reflects recovery principles. Alternatively, O'Connor and Paton (2008) elaborate key aspects of a modern clinical governance framework (safety of patients and staff, consumer and family focus and participation, a skilled and valued workforce, incidents as learning opportunities, continuous improvement of clinical care, structures of accountability) and the ways that such aspects can be supported at various levels of a health system in the developed world. Governance systems should also be underpinned by strong ethical principles in respect to the appropriate treatment for people affected by mental illness. A good example of such ethical principles is the Code of Ethics produced by the Royal Australian and New Zealand College of Psychiatrists (RANZCP 2010).

In an economic sense, it appears that the key objective of any governance system for mental health would be to maximise the potential of people affected by mental illness in respect to their human value and their contribution to their community and society in general. Porter (2010a) argues that any value in an individual's health status is measured by outputs rather than inputs and depends on actual patient outcomes, not the volume of services delivered.

Porter further notes that such outcomes should involve survival, functional status, sustainability of outcome and “others”. Eriksson (2011) comments on a number of preconditions to enhance individual social capital, a significant component of human value, which then results in enhanced health. These are a Macro Structure (Social and Political conditions, Income distribution) and Social Network Characteristics (Internalised Norms, Group Solidarity and Reciprocity) that lead to enhanced social support, social influence, social control, social participation and material resources) which lead to health benefits such as access to support, health enhancing behaviours, increased status and rewards, enhanced cognitive skills, belongingness and meaning of predicament along with improved access to health services and job opportunities. Eriksson (ibid) reports that trust and reciprocity are essential cognitive features of such collective and individual social capital and that these appear to be core elements for creating a health supporting environment, one of the five action areas for health promotion defined by the Ottawa charter. It could, therefore be argued that elements of the above should underpin any governance to enhance mental health.

Other key aspects of governance as outlined by O'Connor and Paton above is the development of appropriate mental health legislation and mental health service policies to protect patients, their carers and the community and comparative surveillance of such developments. The Mental Health Atlas (World Health Organisation 2005) reports and compares the presence in and population coverage of mental health legislation and mental health service policies in a range of world regions. The Atlas similarly reports on workforce for mental health. However, statistics do not necessarily supply the full picture of emerging trends. An example is the significant potential decline in numbers of mental health nursing workforce in Australia. Changes to nurse education in the 1980's along with the changing nature of work in psychiatric nursing appear to have significantly reduced the entry of young people into the profession. As a result, there may be major problems replacing the current workforce as they retire, leading to a severe workforce shortage in about a decade.

Mental health consumer employment within mental health services is an emerging and welcome development with consumer assisted services enhancing consumer outcomes with improved social functioning and reduced symptom severity and hospitalization (Nestor & Galletly 2008). However, it is essential that such consumer consultants be supported with training in addition to appropriate pay and conditions (ibid). The value of the role of family and carers in the management of people affected by severe mental illness is also being increasingly recognised (Parker et al 2010).

The increasing use of outcome measures to assess disability and recovery as well as benchmarking where mental health services are gauged against each other and a number of key performance indicators (Coombs et al 2011) is another emerging mechanism in governance that needs to be considered. Porter (2010b) goes on to suggest a revised tier of hierarchies that is appropriate to assessing health outcomes. Tier One is whether the patient's health status is achieved or retained. Tier Two is the process of recovery of the patient and involves the time taken to achieve recovery and best attainable function in addition to the “disutility” of the care process (complications of treatment such as missed diagnoses and the ability to work whilst undergoing treatment). Tier Three involves the sustainability of the treatment process itself as well as any new health problems related to treatment. Such work encourages different ways of viewing different aspects of recovery in mental health and may allow a more accurate estimation of the economic basis of mental health management.

16. Conclusion

The previous chapter has briefly outlined eight potential “mental health pillars of wisdom” that should be a strategic focus in any mental health funding formula to emphasise Recovery. The formula can obviously be adjusted to local economic social and cultural needs but provides a more comprehensive vision of a future for the provision of mental health. The “pillars” are also useful entities to attach specific funding priorities as well as benchmarks to assess achievement in each area.

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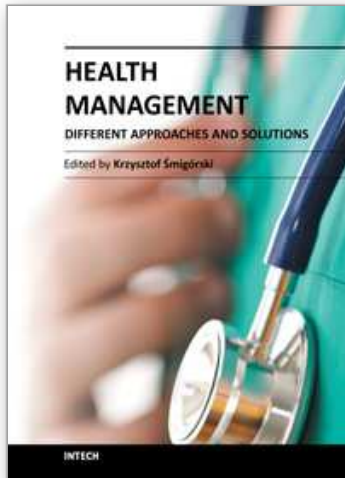
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The development in our understanding of health management ensures unprecedented possibilities in terms of explaining the causes of diseases and effective treatment. However, increased capabilities create new issues. Both, researchers and clinicians, as well as managers of healthcare units face new challenges: increasing validity and reliability of clinical trials, effectively distributing medical products, managing hospitals and clinics flexibly, and managing treatment processes efficiently. The aim of this book is to present issues relating to health management in a way that would be satisfying for academicians and practitioners. It is designed to be a forum for the experts in the thematic area to exchange viewpoints, and to present health management's state-of-art as a scientific and professional domain.

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