



# **International Pathways to Mental Health System Transformation: Strategies and Challenges**

## **Summary**

**A Project of the California Institute for Mental Health<sup>†</sup>**

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A wide range of funding mechanisms, organizational structures, political institutions and cultural and professional traditions characterize the mental health service systems of Australia, Canada, England, Italy, New Zealand, Scotland, and the United States. Despite these differences, an analysis of policy documents and reports from these seven countries reveals a striking national-level policy consensus about the need for substantial if not radical change of their respective mental health systems. The congruence of vision, values, and priorities in their reform efforts strongly argues for the importance of ongoing international dialog and exchange. This implicit agreement on a change agenda invites opportunities for collaboration in systems design and planning, innovation and implementation, and strategies for change, along with services research.

Comparison of the national mental health system reform movements of these seven countries raises several questions: What are the elements of their reform plans? Do they share similar priorities and strategies for change? What could they potentially learn from each other?

Numerous local and national considerations have motivated the impulse for change in policy, systems organization, service delivery and clinical practice. During the past 10-plus years, three common concepts that transcend international borders have emerged as pivotal in forming the basis for consensus. They are:

- *The emergence of the recovery paradigm*
  - ◇ Evidence shows clearly that contrary to earlier beliefs, people do recover from mental illness and succeed as members of the community. The hopeful expectation of recovery should underlie the design and practice of mental healthcare services.
  
- *The rise of consumer activism*
  - ◇ Consumers and their associations are more organized, stronger and more unanimous in their voice, and have a more important role to play in designing and delivering care services and in setting the policy agenda.

- *A trend toward a more holistic and integrated view of mental and physical health as well as social care and services*

- ◊ Mental well-being is increasingly understood as a combination of biological, psychological, and social factors that should be approached in a more comprehensive manner, both in terms of treatment and in promotion and prevention.

This study of the seven nations' mental health policies strongly suggests that these three common concepts play a major role in shaping the emerging international consensus about values, priorities, and strategies for change.

The existence of other forces and trends that have influenced mental health policy development in a variety of ways also must be acknowledged. These trends include:

- increased awareness of the prevalence of mental illness and its disabling effects
- expansion of mental health services to attend to common mental health problems other than severe mental illness
- increased attention to the special needs of different age groups, particularly children and older adults
- extension of services into a range of settings, including , homes, schools, workplaces, residential facilities, and other locations in the community at large
- increased diversity of communities—characterized by divergent traditions and cultural beliefs about mental health and illness—requiring tailored and culturally sensitive and competent services
- scientific discoveries related to the functioning of the brain
- growing awareness among consumers of the availability of effective treatments and services.

This study is based on a review of national policy papers and expert reports, as well as consultation with in-country collaborators and interviews with policy-makers involved in reform efforts. While England, Australia, New Zealand and Italy began producing national mental health plans in the 1990s, other countries—notably, the United

States and Scotland—have only recently undertaken this work, and Canada is still in the process of elaborating national recommendations<sup>†</sup>.

The basic framework for the analysis and comparison of the mental healthcare systems of these countries was derived from *Improving the Quality of Health Care for Mental and Substance-use Disorders*, a study published in 2006 by the U.S.-based Institute of Medicine (IOM). The comprehensive research and consultation process of the study employed a three-step model of analysis:

1. examination of the core values on which a system is built and the **vision** of the future mental healthcare system
2. the system’s operational rules and the **problems** or **deficiencies** that affect its functioning
3. the key **priorities** for reform and the **strategies** or levers to achieve transformation.

In addition, the IOM identified six priority areas for reform of the American mental healthcare system. These priorities specified the need for:

1. **patient-centered** mental healthcare and a recovery focus
2. the application of **evidence** and **quality improvement** tools to mental healthcare
3. **coordination** and integration of mental healthcare with general healthcare and other sectors
4. the use and development of **information technology** in mental healthcare
5. development of the mental health **workforce** to support necessary changes
6. development and **funding** mechanisms and market incentives to leverage change.

This international comparison is funded by the U.S.-based Substance Abuse and Mental Health Services Administration (SAMHSA) in part to better understand whether or not the IOM’s priorities for mental health systems transformation could also be found

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<sup>†</sup> A timeline of the major events in the respective national policies is summarized in Table 1

in the reform plans of other countries with very different organizational, political and financial contexts.

In fact, the national plans and policy statements across virtually all of the seven study countries include six major common themes of vision and values<sup>‡</sup>:

1. Mental health must be considered a critical component of well-being, and mental health problems should not be a source of stigma or discrimination.
2. Community-based services constitute the preferred service setting or mode, and systems ought to achieve an appropriate balance between inpatient, residential and facility-based and community-based services in order to respond to different degrees of the individual's needs, stages in recovery, and preferences.
3. Mental healthcare should be based on a therapeutic-healing partnership between clinician(s) and consumer; the foundation for this alliance is respect of dignity and rights, choice, independence and autonomy, involvement, empowerment, and recovery.
4. Mental healthcare must be personalized and individualized, taking into consideration the unique needs, preferences, and diverse cultural beliefs of each person served. Services, therefore, should be appropriate and responsive to ages, development, gender and sexual orientation, ethnic and racial background, and other defining characteristics of each person served.
5. Mental healthcare must be integrated and coordinated through linkages with primary care and other traditional social services (including housing, employment, and education) or any other community resource (such as self-help, consumer-operated services, or befriending). As a consequence, care should be performed by a workforce that is multidisciplinary and able to work in teams across agencies and systems.
6. Mental healthcare must be based on evidence, focus on effective treatments, and best practices, and result in measurable outcomes.

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<sup>‡</sup> Key words describing the visions of reformed mental health systems in each country are reported in Table 2

In addition, all seven countries, independent of their particular financing and organizational mechanisms, have identified a very similar set of problems and deficiencies<sup>§</sup> that impact their systems and influence their plans for change. Those commonly reported problems and deficiencies include:

1. a lack of focus on mental health
2. inadequate system capacity and workforce resources and competencies to respond to the demand for services, often resulting in an insufficiently diversified range of services and barriers to equitable access
3. insufficient involvement of consumers and caregivers in service planning that is fully responsive to individual needs and preferences and appropriately coordinated with other social and rehabilitation activities
4. great variability in service provision and in the quality and effectiveness of care provided, complicated by a lack of coordination among agencies
5. delays in application of evidence-based practices, quality improvement tools and information technology.

In response, the seven countries have individually established priorities<sup>\*\*</sup> for reform that attempt to resolve those principal problems. Review, integration and synthesis of all the reports and planning documents reveal a perhaps surprising consensus on six international priorities:

1. making mental health a public priority, promoting mental well-being, and diminishing the stigma and discrimination associated with mental illness
2. improving access and enhancing the range of available services
3. assuring an adequate, competent and skilled mental health workforce
4. making consumer involvement, response to individual needs, and recovery and wellness the focus of mental healthcare
5. integrating and linking mental healthcare with general healthcare and other sectors and services

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<sup>§</sup> The main problems and deficiencies affecting the respective mental health systems are summarized in Table 3

<sup>\*\*</sup> Details of priorities for mental health reform in each country are reported in Table 4

6. promoting evidence-based, measurable, and accountable mental healthcare.

Despite the lack of direct point-to-point correspondence, a significant convergence between the United States IOM's findings and the issues identified in the six other countries is obvious.

This study also examined the various strategies, the levers of change, and the organizational solutions proposed and/or adopted by the seven countries in order to achieve change. The aim of this study is to identify trends and convergence or divergence in the approaches taken to put the priorities into practice. The common (but not necessarily universal) strategies for each priority can be articulated in six groupings:

*1. Making mental health a public priority, promoting mental well-being and diminishing the stigma and discrimination associated with mental illness*

- promoting mental health as critical to well-being as physical health
- central commitment and leadership
- activation of cross-government mental health promotion and prevention programs
- long-term national education campaigns.

*2. Improving access and enhancing the range of available services*

- expansion and specialization of mental health services beyond severe mental illness
- increased public funding
- grants for innovative projects
- financial incentives and earmarking of mental health funds
- training in mental health for healthcare workers at system entry points
- strengthening the role and capability of primary-care physicians to respond to mental health needs.

*3. Assuring an adequate, competent and skilled mental health workforce*

- initiatives to build capacity, including pipeline strategies to meet anticipated as well as existing needs

- development and application of recovery-oriented core competencies
- revisions to curricula and re-training of the existing workforce
- training and employing increasing numbers of consumers and family members
- increasing the racial and ethnic diversity of the workforce to better reflect the communities served and promote culturally competent systems
- creation of national occupational standards.

*4. Making consumer involvement, a response to individual needs, and recovery and wellness the focus of mental healthcare*

- promoting shared decision-making between clinician(s) and consumers
- personalizing care through individual recovery plans
- removing inequities often faced by racial and ethnic minorities
- empowering consumers as peer service providers, service planning, design and policy (as part of boards and commissioning teams), and in the education of the mental health workforce.

*5. Integrating and linking mental healthcare with general healthcare and other sectors and services*

- promotion of integrated care plans and case management to enable transitions across care settings and among service providers
- psychiatric consultation, training of GPs in mental health, and co-location of primary-care physicians and mental health professionals
- shared assessment and information systems aimed at assisting the coordination between mental health services and general healthcare and primary care
- integration of mental health with social services, such as supported employment, housing, education, and welfare benefits
- programs designed to reduce the social exclusion of consumers

- creation of new forms of local partnerships and collaborations at the level of service planning and commissioning.

#### 6. *Promoting evidence-based, measurable, and accountable mental healthcare*

- international collaborations
- evaluating and compiling databases of evidence-based practices and programs in mental health
- disseminating guidelines and monitoring their adoption
- use of routine health outcome measurements at care delivery level, and through service standards and minimum mental health data sets
- definition of state, regional and national performance indicators related to mental healthcare.

The national mental health reform movements in Australia, Canada, England, Italy, New Zealand, Scotland, and the United States reflect a high degree of similarity and convergence—although each nation may have its own emphasis or focus that is subject to change over time. The systems in these countries experience problems and difficulties in common, and likewise the leaders in these countries have developed a common or parallel vision of future mental healthcare. Based on this vision, they have set priorities for reform and adopted a broad spectrum of strategies. Critical ingredients in their approaches have included:

- a renewed focus on mental health within the larger public health agenda
- creation of cross-government and advisory committees dedicated to mental health
- increasing investment of public money in the redesign of mental health systems
- creation of new types of partnerships for service planning and commissioning
- efforts to improve the capacity and competency of the mental health workforce.

This strong commonality should compose a fertile ground for exchanges and collaborations among the countries considered in this analysis, along with joint evaluations of their efforts.

Summary Table 1.

**Milestones in mental health reform**

<b><i>Australia</i></b>	<p><b>1992</b> National Mental Health Policy</p> <p><b>1992</b> First National Mental Health Plan</p> <p><b>1996</b> National Mental Health Standards</p> <p><b>1998</b> Second National Mental Health Plan</p> <p><b>2003</b> Third National Mental Health Plan</p>
<b><i>Canada</i></b>	<p><b>2004</b> Three reports of the Senate Committee on Mental Health</p> <p><b>2005</b> Creation of the Mental Health Commission</p> <p><b>2006</b> Final report of the Senate Committee</p>
<b><i>England</i></b>	<p><b>1998</b> Modernizing mental health services</p> <p><b>1999</b> National Service Framework for Mental Health (18–65 yrs.)</p> <p><b>2001</b> NSF for older people (Standard 7)</p> <p><b>2004</b> NSF for children, youth and maternity services (Standard 9)</p>
<b><i>Italy</i></b>	<p><b>1994</b> First National Mental Health plan</p> <p><b>1998</b> Second National Mental Health plan</p> <p>Regional Mental Health Plans</p>
<b><i>New Zealand</i></b>	<p><b>1994</b> Strategic directions for mental health services</p> <p><b>1997</b> First National Mental Health Plan</p> <p><b>1997</b> National Mental Health Standards</p> <p><b>1998</b> Blueprint for mental health services</p> <p><b>2005</b> Second National Mental Health Plan</p>
<b><i>Scotland</i></b>	<p><b>1997</b> Framework for mental health services</p> <p><b>2003</b> National Programme for Improving Mental Health and Well-being</p>
<b><i>United States</i></b>	<p><b>1999</b> Report of the Surgeon General on Mental Health</p> <p><b>2003</b> Report of the New Freedom Commission on Mental Health</p> <p><b>2005</b> The Federal Action Agenda</p> <p><b>2006</b> Report of the Institute of Medicine</p>

Summary Table 2.

**Key words describing vision of reformed mental health systems**

<p><b><i>Australia</i></b></p>	<ul style="list-style-type: none"> <li>• balanced mix between community and inpatient services</li> <li>• linked with housing, employment, training, community, and domiciliary care services</li> <li>• primary care</li> <li>• participation of consumers and communities</li> <li>• shared decision-making</li> <li>• rights</li> <li>• personal growth and recovery</li> <li>• individual need</li> <li>• early intervention, prevention, and promotion</li> </ul>
<p><b><i>Canada</i></b></p>	<ul style="list-style-type: none"> <li>• community-based</li> <li>• well coordinated, integrated</li> <li>• patient-centered recovery-focused</li> <li>• individual needs, personalized care</li> <li>• culturally competent workforce</li> <li>• right mix of skills</li> <li>• timely</li> <li>• accessible</li> <li>• high quality</li> <li>• information databases, technology, and research</li> <li>• accountability and performance measurement</li> <li>• early diagnosis</li> </ul>
<p><b><i>England</i></b></p>	<ul style="list-style-type: none"> <li>• sound</li> <li>• full range of services accessible 24 hours daily and 365 days a year</li> <li>• effective and cost-effective</li> <li>• coordinated care process</li> <li>• health and social sectors, access to employment, education, housing, and welfare</li> <li>• primary care</li> <li>• effective information flow</li> <li>• supportive</li> <li>• individual needs</li> <li>• autonomy</li> <li>• choice</li> <li>• mental health promotion</li> <li>• safe</li> <li>• good risk management modern legislative framework</li> </ul>

<b>Italy</b>	<ul style="list-style-type: none"> <li>• proactive</li> <li>• anticipate needs</li> <li>• home, schools, workplaces</li> <li>• evidence-based</li> <li>• NGOs and voluntary organizations</li> <li>• integrated social and health sectors</li> <li>• employment, housing and social inclusion</li> <li>• primary care individualized care</li> <li>• participation</li> <li>• shared decision-making</li> <li>• self-help and caregivers</li> <li>• mental well-being promotion</li> <li>• anti-stigma, community solidarity</li> </ul>
<b>New Zealand</b>	<ul style="list-style-type: none"> <li>• comprehensive and integrated range of services</li> <li>• collaborative approaches</li> <li>• best practices</li> <li>• cost-effective</li> <li>• best outcomes</li> <li>• integrated at all levels</li> <li>• recovery approach</li> <li>• consumer rights</li> <li>• respect</li> <li>• equality</li> <li>• service users as partners</li> <li>• empowerment</li> <li>• compassionate and competent workforce</li> <li>• different groups of consumers</li> <li>• cultural safety and awareness</li> <li>• safety</li> </ul>
<b>Scotland</b>	<ul style="list-style-type: none"> <li>• good practice</li> <li>• effectiveness</li> <li>• quality-driven</li> <li>• multi-agency strategy</li> <li>• good housing, education, paid employment</li> <li>• appropriate workforce education and training</li> <li>• joint training</li> <li>• multi-disciplinary and inter-agency basis</li> <li>• primary care</li> <li>• privacy</li> <li>• dignity</li> <li>• independence</li> <li>• choice</li> <li>• homely setting</li> <li>• individual needs individual care programs</li> <li>• involvement of service- users families, caregivers</li> <li>• mental health promotion</li> <li>• against stigma</li> </ul>
<b>United States</b>	<ul style="list-style-type: none"> <li>• easy and continuous access</li> <li>• current treatments and best support services</li> <li>• timely and accurate information</li> <li>• recovery-oriented</li> <li>• full partnership between clinician and consumer</li> <li>• choice</li> <li>• shared decision-making</li> <li>• individualized plan of care</li> <li>• equitable</li> <li>• promoting resilience</li> <li>• scientific and technological progress</li> </ul>

Summary Table 3.

### Problems and deficiencies in mental health systems

<i>Problems with the range of services available to the population</i>	
<b><i>Australia</i></b>	<ul style="list-style-type: none"> <li>• high level of unmet needs</li> </ul>
<b><i>Canada</i></b>	<ul style="list-style-type: none"> <li>• lack of comprehensive range of services, with a continuum of adequate responses to individual needs</li> <li>• outcome indicators relevant to children</li> <li>• services for dual diagnosis patients with barriers and mechanisms to facilitate access to treatment in both the mental health and the addiction systems</li> <li>• systematic approaches and assessment tools to identify co-occurring disorders</li> <li>• adequate cross-training of the workforce in treating co-occurring disorders</li> <li>• recognition that services beyond a medical model are needed in order to support individuals' recovery</li> </ul>
<b><i>England</i></b>	<ul style="list-style-type: none"> <li>• lack of a full range of services (shortage in beds, long waiting lists for psychological interventions, lack of support after discharge)</li> <li>• lack of needs assessment at local level</li> <li>• overburdened families and caregivers</li> </ul>
<b><i>Italy</i></b>	<ul style="list-style-type: none"> <li>• high levels of unmet needs</li> <li>• a high burden on families and the not-for-profit sector</li> <li>• shortfalls in services for children and adolescents</li> <li>• shortages in residential facilities for those who need more support</li> <li>• neglect of cases of dual diagnosis and co-morbidities</li> <li>• neglect of mental health in correctional facilities</li> <li>• scarce interventions in primary and secondary prevention</li> <li>• a low turnover of patients in residential care, and lack of diversification in the types of residential care options offered to consumers</li> </ul>
<b><i>New Zealand</i></b>	<ul style="list-style-type: none"> <li>• low level of resources available to community mental health services, and inefficient allocation of funds during the process of de-institutionalization</li> <li>• lack of resources for services targeted to children and their families</li> <li>• disproportionate unmet demands for mental health services among youths, Māori people, and individuals within the criminal justice system</li> </ul>
<b><i>Scotland</i></b>	<ul style="list-style-type: none"> <li>• limited availability of emergency, crisis and specialist services, including psycho-social intervention</li> <li>• difficulty in shifting from hospital services to community-based provision</li> </ul>
<b><i>United States</i></b>	<ul style="list-style-type: none"> <li>• gaps in care for children, older people, and adults with serious mental illness</li> <li>• high number of undiagnosed, under-diagnosed and non-treated people</li> <li>• racial and ethnic disparities</li> </ul>

<i>Problems with the quality of services</i>	
<b><i>Australia</i></b>	
<b><i>Canada</i></b>	<ul style="list-style-type: none"> <li>• institutionally-driven philosophy of care that is not patient-centered</li> <li>• widespread stigma in the public and within the healthcare system</li> <li>• uneven regional distribution and quality of services, especially in rural and remote areas</li> </ul>
<b><i>England</i></b>	<ul style="list-style-type: none"> <li>• little involvement of users and caregivers in service commissioning and delivery</li> <li>• inequity in access to services</li> <li>• difficulty in retaining contact with patients, especially certain particularly isolated groups with severe mental illness</li> </ul>
<b><i>Italy</i></b>	<ul style="list-style-type: none"> <li>• a lack of consumer and family involvement in the decision-making process and of collaboration with consumer associations</li> <li>• poor adoption of evidence-based clinical guidelines</li> <li>• a lack of recognition for the need of social and rehabilitation activities</li> </ul>
<b><i>New Zealand</i></b>	<ul style="list-style-type: none"> <li>• poor coordination between community-based and hospital-based mental health services</li> <li>• lack of provider responsiveness to the needs of consumers, caregivers and families</li> <li>• poor quality of services for Māori people</li> </ul>
<b><i>Scotland</i></b>	<ul style="list-style-type: none"> <li>• a greater emphasis on short-term treatment rather than long-term recovery</li> </ul>
<b><i>United States</i></b>	<ul style="list-style-type: none"> <li>• lack of a recovery-orientation and inadequate public awareness that mental health problems are treatable</li> <li>• delays in translation of scientific knowledge into service</li> </ul>

*Problems with the infrastructure of the mental healthcare system*

<p><b><i>Australia</i></b></p>	<ul style="list-style-type: none"> <li>• isolation of mental health services from other health services leads to stigma and lower status for mental health workforce</li> <li>• lack of a national policy</li> <li>• lack of a funding focus</li> <li>• variability in the range of services and in the quality of care between states and territories, and between urban and rural areas</li> <li>• uneven distribution of mental healthcare services between public and private sectors</li> <li>• lack of consistent collection of mental health data across states and territories</li> <li>• low priority of mental health research</li> </ul>
<p><b><i>Canada</i></b></p>	<ul style="list-style-type: none"> <li>• highly fragmented system with mental health services poorly connected with general healthcare, other support services and with self-help initiatives, as well as a lack of integration with addiction services</li> <li>• an array of providers, agencies, and access points with a lack of homogeneity in information and recording systems</li> <li>• under-funding</li> <li>• human resource shortages as well as a lack of central planning and a national workforce database</li> <li>• an uneven distribution of professionals with concentration in urban centers</li> <li>• long waiting lists and delays</li> <li>• insufficient measures of accountability, with roles and responsibilities not clearly defined, and information systems unable to support coordination</li> <li>• inadequate training of primary-care physicians in mental health and addiction problems, and in early detection and intervention tools</li> <li>• limitations on the amount of mental health services that can be billed by family physicians</li> </ul>
<p><b><i>England</i></b></p>	<ul style="list-style-type: none"> <li>• inefficiencies in managing resources and under-funding</li> <li>• variations in the performance and practice of healthcare organizations and professionals with little performance improvement infrastructure</li> <li>• problems in recruiting and retaining staff, and poor staff morale</li> <li>• an outdated legal framework (with a specific reference to the Mental Health Act and the regulation of compulsory treatment in the community)</li> <li>• little use of computerized record keeping, and different systems for recording treatment and care among health and local authorities</li> <li>• the need to reduce stigma and social exclusion</li> </ul>

<i>Problems with the infrastructure of the mental healthcare system</i>	
<b><i>Italy</i></b>	<ul style="list-style-type: none"> <li>• great variability among regions</li> <li>• a lack of coordination and leadership in planning and policy implementation</li> <li>• a lack in systematic evaluation of resource investment and monitoring of spending</li> <li>• a lack of precise accountability and definition of professional roles within mental health services</li> <li>• workforce shortages and high turnover complicated by the lack of a workforce development plan</li> <li>• a lack of planning and requirements for services provided by NGOs, social cooperatives and private providers</li> <li>• a lack of joint planning with local authorities for an inter-sectorial approach</li> </ul>
<b><i>New Zealand</i></b>	<ul style="list-style-type: none"> <li>• difficulties in recruiting mental health staff-especially Māori staff and clinical specialists</li> <li>• lack of systematic recording of service utilization and lack of appropriate needs assessment</li> <li>• unclear lines of accountability between various agencies delivering mental health services</li> </ul>
<b><i>Scotland</i></b>	<ul style="list-style-type: none"> <li>• limited skill mix in treatment teams</li> <li>• frequent absence of management skills and leadership</li> </ul>
<b><i>United States</i></b>	<ul style="list-style-type: none"> <li>• lack of a national priority for mental health and suicide prevention</li> <li>• fragmentation of mental health service delivery system in different settings and across different agencies</li> <li>• unfair treatment limitations and financial requirements in mental health benefits for private health insurance</li> <li>• complex and fragmented public sector reimbursement systems with limited eligibility for benefits</li> <li>• perverse incentives for people with mental health problems to maintain social security benefits without returning to employment, and incentives for families to enter the child welfare system to access services</li> <li>• workforce issues, including a shortage of providers and a lack of competency in evidence-based practices</li> <li>• lack of training in mental health for primary care physicians and other health professionals</li> <li>• a very diversified and multidisciplinary workforce with a high prevalence of solo practices</li> <li>• different state regulations governing privacy and confidentiality and preventing easy flow of communication between patient and clinician and between clinicians</li> <li>• lack of an adequate quality improvement and monitoring infrastructure</li> </ul>

Summary Table 4.

**Priorities for reform identified in national mental health plans**

<p><b><i>Australia</i></b></p>	<ul style="list-style-type: none"> <li>• protecting consumers' rights and guaranteeing their participation in the decision-making process at individual and service planning levels</li> <li>• integrating mental health into mainstream general health services for both in-patient and community care</li> <li>• guaranteeing networks of specialized mental health services and intersectorial linkages through partnerships at clinical and policy levels</li> <li>• providing incentives for innovative projects and new resources for transfer of services to the community</li> <li>• promoting the mental health of the population and preventing mental illness</li> <li>• improving the quality and safety of care and developing tools for their measurement and evaluation</li> <li>• Increasing service responsiveness and a recovery orientation in service delivery</li> <li>• creating a coordinated and innovative mental health research agenda</li> </ul>
<p><b><i>Canada</i></b></p>	<ul style="list-style-type: none"> <li>• concentrating public and government attention on mental health as a public priority</li> <li>• increasing funding and incentives to promote the shift to a community-based system</li> <li>• guaranteeing a comprehensive range of services with specific attention to expanding children and youth, seniors, dual diagnosis, self-help, and peer-support services</li> <li>• promoting return to work, supported employment, and retention strategies for people with mental health problems</li> <li>• supporting consumers with rent supplements and developing affordable housing</li> <li>• developing a mental health agenda for Aboriginal people and guaranteeing equity of access to services</li> <li>• developing a mental health promotion and disease prevention agenda</li> <li>• establishing a coordinated research agenda and mechanisms for exchanging knowledge and best practices</li> <li>• revising and harmonizing the legal framework around privacy and consent</li> </ul>

<p><b>England</b></p>	<ul style="list-style-type: none"> <li>• establishing a role for health and social services in mental health promotion, in fighting discrimination of individuals with mental health problems, and in promoting their social inclusion</li> <li>• guaranteeing a full range of services for both people with common mental health problems and severe mental illness</li> <li>• guaranteeing an easy and prompt access to services through all entry points, from primary care to NHS telephone services</li> <li>• reinforcing the use of care planning and making it uniform across health and social services</li> <li>• strengthening primary care with the introduction of new mental health professional roles in support to the general practitioner</li> <li>• providing support to caregivers</li> <li>• promoting social inclusion by creating coordination with employment, education and volunteering opportunities</li> <li>• supporting consumers in choosing providers</li> <li>• developing services for dual diagnosis within mainstream mental health services</li> <li>• reducing health inequalities in mental health and developing services for the black and ethnic minorities community</li> </ul>
<p><b>Italy</b></p>	<ul style="list-style-type: none"> <li>• guaranteeing a comprehensive range of services from community-based to inpatient, covering the life span</li> <li>• responding to common mental health problems in partnership with primary care</li> <li>• coordinating community and specialist mental health services under one organization, creating linkages with general healthcare and other sectors especially employment</li> <li>• improving the quality of life of consumers and families</li> <li>• strengthening of the quality improvement and information infrastructure of mental health service providers</li> </ul>
<p><b>New Zealand</b></p>	<ul style="list-style-type: none"> <li>• guaranteeing a comprehensive range of community-based services able to meet benchmarks</li> <li>• improving the quality of services by increasing consumers and caregivers' involvement in service planning, policy, purchasing and provision, and increasing responsiveness to a variety of cultures and needs</li> <li>• involving Māori people in the development of services, making mainstream services more responsive to Māori needs, developing a Māori workforce</li> <li>• developing a coordinated workforce development plan to guarantee an adequate and skilled mental health and addiction workforce, including an appropriate service user workforce</li> <li>• coordinating care within the mental health sector and with other sectors with clear lines of accountability and development of interagency agreements</li> <li>• developing a culture for recovery in every service and in the workforce</li> <li>• strengthening of primary care by developing assessment capabilities for mental health and addiction needs and linkages between PHOs and other providers of mental health and addiction services</li> <li>• developing availability of information and information systems to guarantee transparency and trust and improve service delivery, planning and monitoring of performance</li> <li>• developing a mental health promotion and prevention agenda by increasing people's awareness of how to maintain mental health and well being and by addressing stigma and discrimination</li> </ul>

<b><i>Scotland</i></b>	<ul style="list-style-type: none"> <li>• eliminating stigma and discrimination</li> <li>• preventing suicide</li> <li>• raising awareness and promoting mental health and well-being</li> <li>• guaranteeing a range of services that cover the lifespan (focus on infant mental health, children and young people and later life) in different settings (focus on workplace)</li> <li>• coordinating care and, in particular, between health and social services</li> <li>• promoting and supporting recovery</li> </ul>
<b><i>United States</i></b>	<ul style="list-style-type: none"> <li>• increasing public understanding of mental health and mental health problems, and reducing the stigma attached to seeking help for mental health problems</li> <li>• promoting recovery, resilience, employment, and community participation of consumers</li> <li>• building a consumer and family-driven system based on individualized care plans and consumer and family involvement in planning, evaluation, and delivery of services</li> <li>• developing services for early mental health screening and intervention</li> <li>• taking advantage of latest scientific evidence, research and the use of information technology</li> <li>• eliminating mental health disparities, with specific focus on racial and ethnic minorities and rural populations</li> <li>• coordinating care across public and private agencies, primary and specialist mental healthcare and aligning reimbursement mechanisms</li> </ul>