

# **Evaluation of the National Mental Health Strategy**

## **Final Report**

Prepared for the  
Australian Health Ministers Advisory Council

by the

National Mental Health Strategy  
Evaluation Steering Committee

December 1997



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## Foreword

This report represents the completion of a challenging but rewarding task assigned by the Australian Health Ministers Advisory Council (AHMAC) in 1995. The brief from AHMAC required us to evaluate the effectiveness and appropriateness of the National Mental Health Strategy and advise on steps to be taken to continue the process of reform. For those familiar with mental health issues in Australia, and the background to the National Mental Health Strategy, it was clear that the committee's work would be complex and demanding.

The evaluation process was split into two stages. The first stage, completed in June 1996, reviewed progress in the implementation of the Strategy over its first three years. In that phase, we examined the extent to which the policy was being converted to action and identified barriers to its successful achievement. Our report of this stage concluded that the National Mental Health Strategy provided a strong policy framework that facilitated actions at the State, Territory and national levels. Three years into the Strategy, it was clear that major structural change had commenced in the majority of jurisdictions but the pace and scale of developments was varied. No information was available at that stage on whether these changes had produced better outcomes from the perspective of consumers and carers.

The second stage of the evaluation addressed the more complex issue of policy outcome, or the extent to which the Strategy has been effective in meeting its objectives. Our approach to this issue involved considerable consultation and independent research studies conducted throughout 1997.

Over the two and a half years in which it operated, the Committee learned a great deal about the National Mental Health Strategy, both its strengths and weaknesses. It had the benefit of reviewing the many reports generated under the Strategy as well as meeting with a wide

range of groups and experts who appeared before it. We have also had the opportunity to gain insights about mental health in Australia from the independent research projects specifically commissioned to address the Terms of Reference.

We have been genuinely impressed with the level of activity generated under the National Mental Health Strategy as well as the many talented people who have been mobilised to solve long standing problems. We have been particularly impressed by the courage of consumers and carers whose lives have been deeply affected by the experience of mental illness, and who are now taking the opportunities created under the Strategy to change things for the better. We have been very mindful of our responsibilities to adequately reflect the contributions made by these groups to the evaluation.

On behalf of the Committee, I am very pleased to now present this final report to the Australian Health Ministers Advisory Council. The report summarises the committee's key findings and brings together the conclusions and recommendations that we formed during our two and a half years of activity. It has been prepared in as simple a form as possible, to synthesise the key messages emerging from our investigations. Supplementary reports of the independent research studies commissioned by the Committee have been prepared as separate documents that contain the range of data considered in preparing this report.

In presenting the report, I wish to convey the Committee's sincere appreciation to all those who contributed their time to the evaluation. This involved many hundreds of health professionals, mental health consumers and carers as well as others not directly engaged in the mental health industry. The evaluation could not have been completed without their efforts.

I also wish to express my gratitude to the members of the Committee who worked tirelessly in coming to grips with the task and resolving a wide range of complex issues. Finally, I wish to convey our appreciation to the staff of the Mental Health Branch of the Department of Health & Family Services who provided not only the secretariat support to the Committee, but also the benefits of their national perspective and experience of the Strategy since it began.

A handwritten signature in black ink that reads "Harry Eagleton". The signature is written in a cursive style with a horizontal line underneath the name.

Harry Eagleton  
Chair  
National Mental Health Strategy  
Evaluation Steering Committee

Sydney, December 1997

## Overview

This evaluation considers the effectiveness and appropriateness of the National Mental Health Strategy since its inception in 1992. It draws evidence from a number of sources and points to five 'overarching' observations.

First, substantial change has occurred in the structure and mix of public mental health services in Australia over the period of the National Mental Health Strategy. The direction of change is consistent across all jurisdictions and in keeping with the national objectives.

Second, there is broad consensus that the range and quality of mental health services available in 1997 have improved substantially over those that existed in 1992. They are seen to be more responsive, more community oriented and better integrated with general health care than five years ago.

Third, there is a widely shared belief that the National Mental Health Strategy has been instrumental in producing, or at least, accelerating the change process.

Evidence provided by the States and Territories to the Commonwealth for the *1996 National Mental Health Report* strongly supports this view. It shows that funds made available under the Strategy have been critical in expanding mental health services into the community and encouraging innovation.

Fourth, the Strategy has provided leverage to change human service systems operating outside the traditional mental health boundary, which have been previously reluctant to accept responsibility for mental health clients. Most important are initiatives taken to provide quality housing and employment, both critical in the promotion of mental health and well being.

Finally, despite the many positive developments, there is widespread dissatisfaction with many aspects of mental health services in Australia in 1997. Consumers continue to report problems with access to services, poor service quality and stigmatising staff attitudes. Many believe they have been disenfranchised by the new focus on 'serious mental illness'. Carers feel they have been left behind in service developments, while providers struggle to find ways of responding to an apparent escalation of demands upon their limited resources.

Outside the boundaries of the industry, primary care practitioners complain of the insularity of mental health providers, both public and private. They argue that little assistance is available to them in managing the burden of mental health problems in the community which do not 'qualify' for specialist psychiatric care.

For the community, the mental health system remains relatively feared and unknown and, according to consumers, continues to stigmatise and discriminate against those affected by mental illness.

A simple conclusion is that the mental health system in Australia at the commencement of the Strategy was in a poor state. While significant gains have been made, these need to be viewed against the historical backdrop. The National Mental Health Strategy has raised awareness of previously hidden problem areas and encouraged an expectation, if not a demand, that 'things should be better than this'.

It is the view of the committee that much work remains to complete the mental health policy agenda commenced five years ago.



# Introduction

In 1992, all governments in Australia endorsed the first National Mental Health Strategy, foreshadowing a major reform process over the next six years in the way services are provided to people affected by mental illness. This agreement defined both a national direction and a framework for governments to work together to change a system that was widely acknowledged as inadequate and long neglected by policy makers.

The Strategy was articulated in four major documents.

- The *National Mental Health Policy*<sup>1</sup> outlined the new approach to mental health care, promoting a move from an institutional to a community-oriented approach. The Policy, endorsed by Health Ministers in April 1992, defined the broad aims and objectives to guide the reform process.
- The *National Mental Health Plan*<sup>2</sup> charted the 'action plan' and described how Commonwealth and State and Territory governments would implement the aims and objectives of the *National Mental Health Policy*.
- The *Mental Health Statement of Rights and Responsibilities*<sup>3</sup> embraced the principles of the United Nations Resolution 98B (Resolution on the Protection of Rights of People with Mental Illness) and outlined the philosophical underpinning of the National Mental Health Strategy on civil and human rights. The Statement of Rights and Responsibilities was agreed by Health Ministers in 1991.
- The *Medicare Agreements* set out the Commonwealth, State and Territory roles in achieving reform of mental health services and defined the conditions for the transfer of Federal funding to assist in the reform.

**Table 1: Priority areas for reform under the National Mental Health Strategy**

1. Consumer rights
2. The relationship between mental health services and the general health sector
3. Linking mental health services with other sectors
4. Service mix
5. Promotion and prevention
6. Primary care services
7. Carers and non-government organisations
8. Mental health workforce
9. Legislation
10. Research and evaluation
11. Standards
12. Monitoring and accountability

Overall, the Strategy identified twelve policy areas as priorities for reform (Table 1) as well as defining specific objectives and strategies for implementation.

The changes advocated were ambitious by international standards. Although governments in other countries have charted similar policy courses for their mental health services, many are seen to have failed in achieving the intended goals. The overseas experience highlights that good intentions do not translate easily to good outcomes in the mental health field. Successful policy requires change in many systems that operate beyond the boundaries of the traditional mental health industry.

Misconceptions and stigma about mental health issues add to the difficulties faced by governments in promoting an accurate understanding of what is being attempted. While there is much scope for improvement in mental health reform, the risks for government of controversy and failure are high.

It is significant therefore that the Australian governments' agreement to the National Mental Health Strategy included a strong commitment to evaluate both the progress and outcomes of the

various initiatives through two principal means.

First, progress would be reported annually through the publication of a *National Mental Health Report*. The report, prepared by the Commonwealth using data provided by the States and Territories, aims to monitor the yearly progress of each jurisdiction in implementing the Strategy. National Mental Health Reports have now been produced for each of the first three years of the Strategy (1993, 1994 and 1995), with the fourth report due for release early in 1998.<sup>4, 5, 6</sup> These reports make a major contribution to understanding the changes in Australia's mental health services.

Second, Ministers agreed that an independent evaluation would be conducted, to complement the annual reporting process by focusing on the Strategy's overall impact and outcomes. An Evaluation Steering Committee was appointed by the Australian Health Ministers' Advisory Council (AHMAC) in June 1995 to plan and direct the evaluation.

The committee's terms of reference split the evaluation process into two phases.<sup>7</sup> The first phase, completed in June 1996, reviewed progress in the implementation of the Strategy.<sup>8</sup> The final phase reviewed the outcomes of the Strategy and addressed:

- how effectively the Strategy has met its stated objectives;
- whether the processes of reform were the most appropriate for meeting the policy objectives; and
- the strategies required to continue the process of mental health reform.

A wide range of information was reviewed to inform the final evaluation phase. This included data available in existing national collections and new research data gathered through independent studies commissioned by the committee.

The current report summarises the key findings of the evaluation and brings together conclusions and recommendations formed by the committee during its two years of activity. Consistent with the committee's brief, it presents a national view of the changes introduced under the Strategy rather than individualising the performance of each of the States and Territories.

Reports on each of the research streams are being released together with this report, providing full details of the method and results of the evaluation.

## Approach to the Evaluation

Evaluating the outcomes of Australia's first National Mental Health Strategy presented a formidable challenge. Questions at the core of extensive worldwide research and debate – such as how services should be delivered, what works for whom, and under what conditions - underlie the national reform process. The committee was mindful that its evaluation needed to be focused, and identify the essential policy messages for the future.

The twelve policy areas for reform outlined by the National Mental Health Strategy provided the starting point for the evaluation. The approach taken by the committee sought to build upon the findings of its earlier report and conduct a selective review of those policy areas that would inform about the effectiveness of the Strategy more broadly.

### **Evaluation Focus Areas**

Four areas were selected as evaluation focus areas on the basis that they are illustrative of the key elements of the national strategy and goals for mental health. The policy areas selected for review were:

- promotion and prevention;
- linkages between mental health services and other sectors;
- service mix; and
- the rights of consumers and carers

These four areas cover 15 of the 38 objectives defined in the National Mental Health Strategy. Of the objectives not addressed specifically within the focus areas, the committee's earlier evaluation reported substantial progress to have been made in many of these by June 1995, and identifiable initiatives had commenced for the remainder.<sup>8</sup> The outcomes of these latter initiatives will not become evident until after the con-

clusion of the National Mental Health Strategy.

To complement the detailed evaluation within each of the four focus areas, the committee also reviewed available data relevant to all national objectives. Appendix 3 presents a summary of the committee's assessment of progress against all 38 national objectives.

### **Defining outcomes**

The committee's brief for the evaluation required the outcomes of the Strategy to be measured against two criteria – effectiveness and appropriateness.

'Effectiveness' criteria relate to how well a particular program has met its stated aims and objectives. In most areas of public policy, this means assessing the difference made to society as a result of the policy – that is, whether it has made things better or worse. Extending this approach to the mental health field, the effectiveness of a national policy might be judged by indicators such as reduced prevalence rates of mental illness and disability, improved quality of life for mental health service consumers, increased employment rates, reduced suicide prevalence and so forth.

However, most of the objectives defined in the National Mental Health Strategy are concerned with the process and structure of reform. This emphasis, on *how reform would be progressed* rather than *what it achieved*, reflects the stage of mental health reform in Australia at the time the Strategy was devised.

The committee considered that monitoring the extent to which these objectives have been met, as occurs in the *National Mental Health Report*, was a necessary element of the evaluation but not sufficient to build a picture of outcomes at the community and individual consumer levels. To achieve this, the objectives defined in the Strategy needed to be translated into terms which

express the intended benefits for the community.

Similar interpretation of the concept of 'appropriateness' was required. Evaluating the appropriateness of a national reform program requires judgements to be made as to whether particular actions are 'right' or 'suitable'. In essence, this requires a decision as to whether the actions taken were the best options available to meet the stated objectives, as well as consideration of the positive and negative consequences of those actions.

Decisions about appropriateness must also consider the context in which a particular policy is implemented. For the National Mental Health Strategy, aspects to consider include the inadequate state of services at the commencement of the Strategy, the brief, five year timetable given to achieve the objectives, the relative newness of the Commonwealth-State partnership on

mental health services and the lack of international precedents for a National Mental Health Policy.

Finally, appropriateness and effectiveness criteria are not necessarily in agreement. To take an example from the mental health field – relocating a stand alone inpatient unit to a poor quality general hospital would achieve the objective of mainstreaming, but may be deemed inappropriate if it is unacceptable to consumers and carers. Clearly, complex issues need to be examined when assessing whether a national policy is both appropriate and effective.

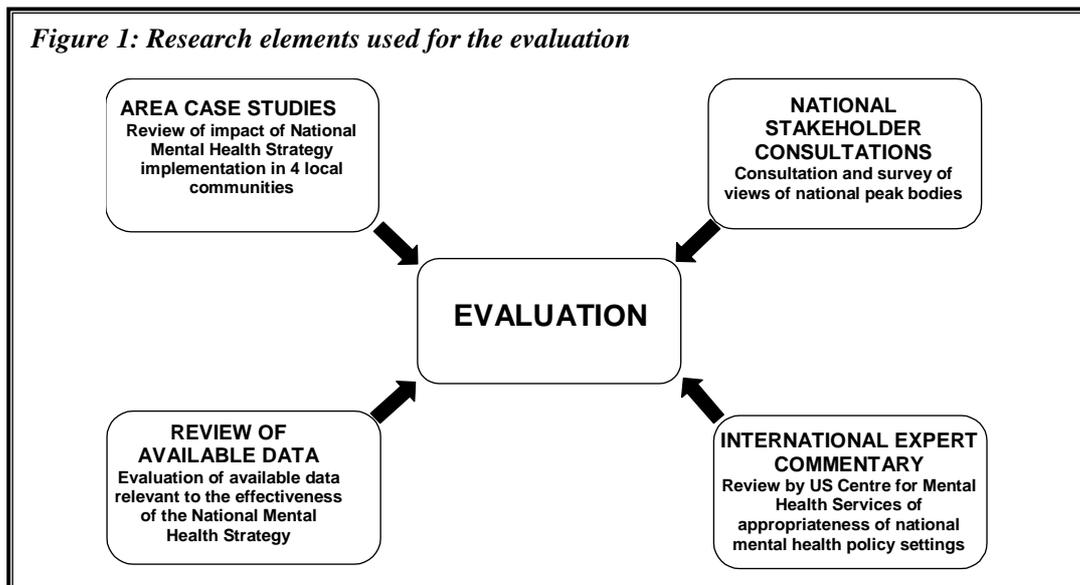
The committees' approach integrated effectiveness and appropriateness issues into a set of key 'outcome questions' that were used to drive the evaluation.

The focus areas and the key evaluation questions associated with each are listed in Table 2.

**Table 2: The four evaluation focus areas and key outcome questions**

<b>Evaluation Focus Area</b>	<b>Evaluation aimed to establish: "Has the Strategy ..."</b>
Rights of consumers and carers	<ul style="list-style-type: none"> <li>generated improved respect for the rights and dignity of people affected by mental illness?</li> <li>strengthened the support available to carers?</li> <li>enabled consumers and carers to participate in mental health service planning at the individual and policy levels?</li> </ul>
Service mix	<ul style="list-style-type: none"> <li>produced a mix of services that:               <ul style="list-style-type: none"> <li>promotes high standards and quality in service delivery?</li> <li>meets the range of needs of people affected by mental illness?</li> <li>leads to improved outcomes for consumers of those services?</li> </ul> </li> </ul>
Linkages between mental health services with other sectors	<ul style="list-style-type: none"> <li>led to improvements in access by people affected by mental illness to programs and services needed to participate more fully in community life?</li> <li>improved access to employment and quality housing?</li> </ul>
Promotion and prevention	<ul style="list-style-type: none"> <li>facilitated community understanding about mental illness and reduced stigma and discrimination directed at people affected by these illnesses?</li> <li>reduced community prevalence rates of mental disorder?</li> <li>reduced the impact of mental disorder through early intervention and promotion programs?</li> </ul>

*Figure 1: Research elements used for the evaluation*



### Research components

Outcome data that could inform the evaluation are not collected routinely by Australian mental health services, although, as indicated later, steps towards this have been initiated under the Strategy. As a result, little of the data gathered to monitor the National Mental Health Strategy directly addresses the key outcome questions.

The Steering Committee recognised that no single approach would address adequately the key outcome questions. Four supplementary research studies were therefore commissioned, each contributing a unique perspective to the evaluation. These comprised the building blocks for the current report (see Figure 1).

#### ► Area Case Studies

These were 'in depth' studies of local populations, designed to assess the impact of services changes at the 'ground level'.

Previous reviews of mental health services have sampled the views of a wide range of stakeholder groups about the National Mental Health Strategy, but these have been drawn from disparate areas throughout Australia. The new element introduced through the Area Case Studies was to evaluate the ap-

propriateness and effectiveness of the Strategy from the various perspectives of stakeholders living within the same local community.

Four sites were chosen from separate areas throughout Australia, each of which was served by an integrated area-based mental health service. The areas selected for the study represented 7% of the Australian population in 1997.

Specific criteria used to select the four study sites were designed to identify sites which approximated the type of service models promoted by the Strategy, rather than being typical of the 'average' service currently available. These criteria are summarised in Table 3.

In each area, qualitative and quantitative data were gathered to examine the impact of service changes on consumers, carers, staff and external organisations. Data collection methods comprised a combination of consultations, one-to-one interviews and written surveys with key stakeholders. In each of the sites, consultations were conducted with:

- management and staff of the local mental health service;
- consumers and consumer organisations;

**Table 3: Criteria used for selection of sites in Area Case Studies**

<u>Criterion</u>	<u>Description</u>
'Area service network'	<ul style="list-style-type: none"> <li>• Services organised on the basis of a service network, serving a defined catchment population.</li> </ul>
'Comprehensive services'	<ul style="list-style-type: none"> <li>• Site has all basic elements of a comprehensive service in place, approximating the levels of service provision advocated in papers commissioned under the National Mental Health Strategy.</li> </ul>
'Average resource levels'	<ul style="list-style-type: none"> <li>• Sites were neither 'rich' nor 'poor' relative to Australian resource levels.</li> </ul>
'Availability of data'	<ul style="list-style-type: none"> <li>• Sites were required to have in place a basic information system.</li> </ul>
'Consent to the evaluation'	<ul style="list-style-type: none"> <li>• Study sites were invited to participate, not 'conscripted'.</li> </ul>
'State and Territory balance'	<ul style="list-style-type: none"> <li>• Study sites were drawn from four different States and Territories.</li> </ul>
'Urban-Rural mix'	<ul style="list-style-type: none"> <li>• 25% of the site sample was based in rural areas.</li> </ul>
'Mix of development stages'	<ul style="list-style-type: none"> <li>• Collectively, the site sample included services at different stages of reform.</li> </ul>

- family members, carers and carer organisations;
- private medical practitioners;
- providers of accommodation and employment services;
- police and ambulance services; and
- other key informants.

In all, the Area Case Studies consulted over 400 individuals drawn from these varied backgrounds. In addition, approximately 900 people responded to the written survey.

The Canberra-based consulting group, Purdon Associates Pty Ltd, was contracted to conduct the Area Case Studies during the period April to August 1997.

► **National Stakeholder Survey and Consultation**

Complementing the local perspectives on change gathered in the Area Case Studies, a separate round of consultations and surveys was conducted with organisations providing national representation of one or more key groups.

Organisations approached included national peak bodies representing health professionals, consumers and carers, State and Territory peak mental health consumer bodies and groups with lead agency responsibilities under the Strategy. A total of 182 organisations were

invited to participate through one of three means.

First, organisations were requested to complete a survey instrument on their perception of changes that have occurred over the period of the National Mental Health Strategy. Using a set of statements that reflected the outcome aspirations of the Strategy in each of the four focus areas, organisations were asked to rate the situation as they saw it in 1992, the beginning of the Strategy, and again for 1997.

Second, organisations were invited to prepare written submissions to elaborate their views of the appropriateness and effectiveness of the Strategy, and their views about future priorities.

Finally, approximately 15% of the organisations were invited to discuss directly with the committee their views on the National Mental Health Strategy.

The Centre for Health Program Evaluation, a unit of the University of Melbourne Department of Public Health and Community Medicine, was commissioned to assist with this aspect of the evaluation. Consultations and surveys were conducted between May and August 1997.

### ► Review of National Data

Available data collections held at the national level were reviewed to determine whether they could contribute to the evaluation.

Most important here were the source data gathered by the Commonwealth used to report progress of the Strategy in the annual National Mental Health Reports. Although not released at the time the Committee prepared this report, the Commonwealth gained State and Territory consent to make available the most recent data relating to the 1995-96 year, due for publication in the *1996 National Mental Health Report*.

Review of this data was managed within the committee, with input from Bill Buckingham & Associates, the consultant engaged to assist the committee in supervising the overall evaluation research program.

### ► International Expert Commentary

This final element of the methodology sought an international perspective on Australia's National Mental Health Strategy. The aim was to seek expert mental health commentary on:

- the appropriateness of the Strategy as a framework for reform when compared to developments overseas; and
- the most and least successful aspects of the National Mental Health Strategy, in terms of conception and policy development.

This element of the methodology put Australian developments in a broader context, to determine whether the policy framework is consistent with current international thinking and research about mental health services.

The review was conducted by Dr Ronald Manderscheid, Deputy Director of the Centre for Mental Health Services, a central unit of the United States Department of Health and Human Services.

The Centre is the lead organisation on a range of mental health projects auspiced by the World Health Organisation.

Extensive documentation relating to the Strategy was initially forwarded by the committee to the Centre, supported by a number of teleconferences.

Dr Manderscheid visited Australia in September to meet with the Evaluation Committee and a wide range of individual providers, consumers and carers prior to preparing his report.

### **Summary of method**

The methodology aimed to bring together complementary views of the National Mental Health Strategy that would:

- identify the main changes since the commencement of the Strategy in each of the focus areas;
- determine which aspects of the Strategy were working effectively and which were not, from the perspective of those who have a national view;
- assess the extent of 'on ground' support for the types of changes advocated by the Strategy in local communities where these have been implemented; and
- determine whether Australia's policy settings for mental health are in keeping with 'best practice' approaches emerging overseas.

The evidence gathered through this process illustrated many examples of innovation and service improvement in Australia's mental health services arising from the National Mental Health Strategy. It also highlighted areas in which the Strategy has made minimal progress or failed to deliver expected results.

Based on this work, the following sections summarise the committee's principal observations and conclusions in each of the focus areas. The report concludes with a summary statement of the issues the committee considers to be the main priorities for the future national mental health action.

As a final report, this paper does not attempt to summarise the evidence, but rather draws together conclusions based on the information gathered in the research studies commissioned for the evaluation. As indicated earlier, each of the commissioned studies is published as a separate volume of the evaluation report.

## Consumer and Carer Rights

Improving the rights of consumers and carers is a pivotal theme of the National Mental Health Strategy. The commitment to empower the users of mental health services provides a stark contrast to the neglect and gross human rights abuses that characterise mental health services over the past century. It sends important messages both to the community and the industry that consumer and carers should be valued for their intrinsic worth.

Beyond the moral imperative, there is also an economic argument for the initiatives taken, based on the idea that 'good process leads to good outcomes'. Research evidence indicates that there is greater prospect for maximal recovery and less dependence on long term mental health system support when consumers and carers are included as genuine and respected partners in the treatment process.

A broad consensus was evident in the evaluation, across both the national stakeholder and local area consultations, that the structural changes designed to include consumers and carers, introduced under the Strategy, are among its most important achievements. These include:

- the establishment of peak bodies at the national, State and Territory levels to represent the interests of mental health consumers and carers;
- the allocation of funds to a range of consumer and carer-led projects, designed to strengthen their voice in the mental health market place;
- amendments enacted to mental health legislation of most States and Territories to incorporate the principles contained in the 'Mental Health Statement of Rights and Responsibilities' paper;

**Table 4: Consumer and Carer Rights Policy Objectives**

- To have the rights contained in the Australian Health Ministers 'Mental Health Statement of Rights and Responsibilities' and in the United Nations 'Resolution on the Protection of Rights of People with a Mental Illness' affirmed in mental health legislation.
- To ensure that the Commonwealth and all States and Territory Governments have mechanisms for protecting those rights.
- To support the development and expansion of non-government organisations to assist carers and promote self-help and consumer advocacy, through information provision, opportunities to participate in mental health service decision-making and funding.
- To expand community-based support for carers.

- the inclusion of carers and consumers in all working groups established on national strategic issues;
- release in 1996 of the 'National Standards for Mental Health Services'<sup>9</sup> which included relevant service delivery standards for ensuring protection of consumer rights; and
- the commencement of the Community Awareness Program, a high profile national media campaign designed to increase understanding of mental health issues and reduce stigma.

Perhaps for these reasons, it is not surprising that carers and consumers emerged in the evaluation as the strongest supporters of the National Mental Health Strategy.

Data gathered for the *National Mental Health Report* indicates that there has been some 'trickle down' of the national developments to local mental health services.

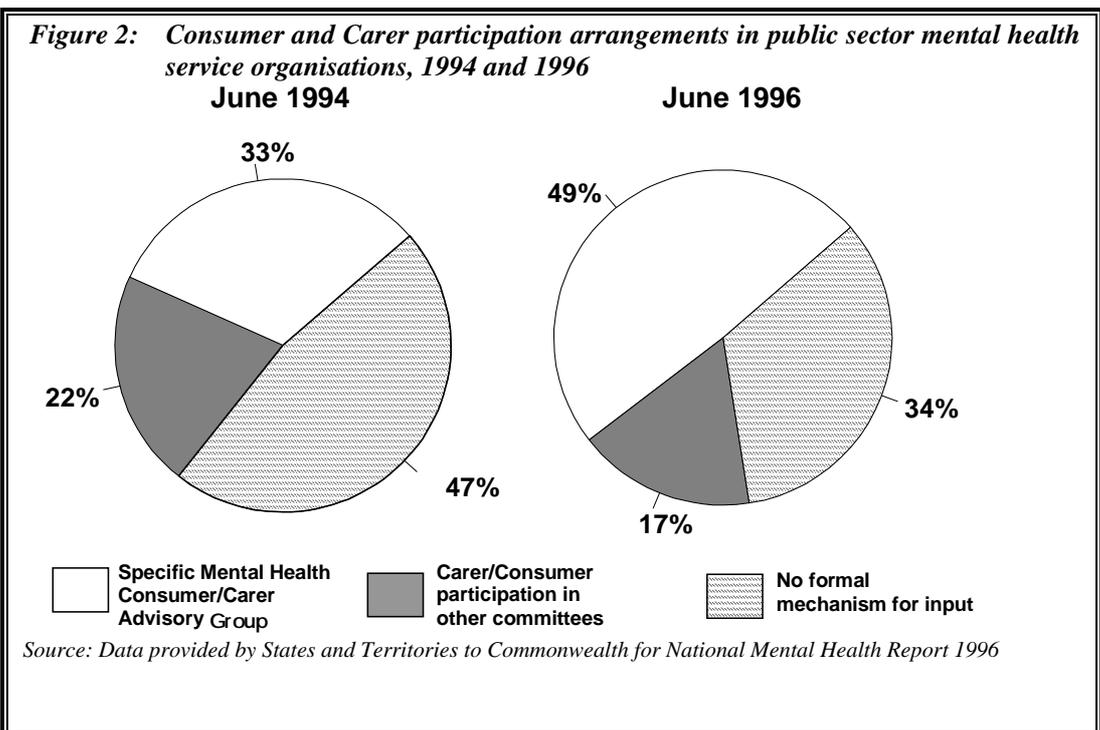
In 1994, two years into the Strategy, only 33% of public sector local mental health service organisations had established a specific, formal mental health consumer and carer group to advise on service planning and delivery (see Figure 2). By 1996, this figure had increased to 49%. However, one third of all organisations remained without any formal process for consumers and carers to contribute to service development.

The Area Case Studies provided insight into consumer, carer and service provider perspectives on changes at the service delivery level.

- In general, all groups were positive about the new roles for consumers and carers in local service planning, with some important differences. Staff employed in hospitals were more cautious about the value of consumer and carer involvement than community-based staff.
- Providers at all four sites were increasingly willing to involve consumers and carers in individual treatment decisions and plans. Significant benefits were seen to flow from this. For the consumer, treat-

ment could be adjusted by negotiation, or varied to suit personal needs. For the provider, collaborative involvement was more time consuming but led to better outcomes in the longer term. Carers valued the opportunity to add their personal knowledge and learn about how they could best assist the recovery process.

- Within the four study sites, this personalised approach to mental health care is not yet established as the norm. Consumers reported that providers generally do not relate to them with an emphasis on dignity, respect and privacy. The power shift entailed in collaborative work is experienced by many staff as a threat to their traditional role.
- The Area Studies revealed little training or planning has been invested in assisting the mental health workforce to make the transition to the new models of care.
- Differences between the four sites reviewed suggest that the transition has been more far reaching where management unambiguously demonstrated its



commitment to consumer and carer involvement, for example, by investing funds in consumer advocates or providing assistance to local groups with establishment costs. The notion that we 'pay for what we care about' has much merit in this context.

The existence of a National Mental Health Strategy has been an important influence on these developments. While little direct guidance has been given about how to 'change the service culture', the policy rhetoric has served to inspire innovative providers and consumers to explore new local options.

The evaluation also revealed that mental health care in Australia is a considerable distance from meeting the principles espoused in the Australian Health Ministers *'Mental Health Statement of Rights and Responsibilities'*. Four issues are of particular concern to consumers, carers and their advocates.

The first of these concerns access to treatment and what can be termed the 'ethics of rationing'. Consumers argue that the recent focus on 'severe mental health problems' and 'serious mental illness' has caused damage to people who would otherwise benefit from mental health services. In the absence of a national definition, several variations of the term have come into common usage, but are generally based on a limited set of diagnoses, primarily the psychoses.

Since the release in 1994 of *'Let's Talk About Action'* by the National Community Advisory Group<sup>10</sup>, consumers have reported consistently that many people are excluded from services appropriate to their needs as a result of overly restrictive interpretations of the concept of 'serious mental illness'. The issue was prominent in the committee's earlier report<sup>5</sup> and again emerged as a strong warning signal throughout the local and national consultations conducted for the current evaluation. Health professional groups have now also begun registering their concerns on the issue and point to the many negative consequences that may follow denial of access to treatment.

The use of the term 'serious' and its application in defining service eligibility was widely criticised for its pejorative effects, both for consumers who receive treatment and those who are denied services. Recommendations on a fairer and more open basis for targeting mental health services are discussed in the final section of this report.

The second issue relates to community attitudes to people affected by mental illness. Consumer, carers and service providers at all levels in the consultation indicated that the National Mental Health Strategy has failed to reduce the high levels of stigma and discrimination directed toward consumers by the community.

Of most concern, consumers identified mental health professionals as the main source of stigma and discrimination that they experience. Mental health professionals were often described by consumers as insensitive, poorly skilled and unable to deliver the new models of care. For consumers, the manner in which services are delivered is just as important as the type of service received. Provider groups confirmed that training is inadequate to meet the new demands. This issue is taken up in the final section of this report.

Third, the positive changes introduced in the public sector to promote consumer and carer involvement are yet to transfer to the private hospital sector. Representing approximately 25% of Australian specialist inpatient services, the private hospital sector plays a significant but largely unacknowledged role in mental health care. Like the public sector, it has been the target of past inquiries that have exposed gross abuses of rights in isolated pockets of the industry. Representatives of the private hospitals acknowledged that few steps had been taken to develop consultative mechanisms and this was confirmed by consumer organisations.

The National Mental Health Strategy was developed primarily to engage the Commonwealth, State and Territory funded mental health services and created no formal avenue for engagement of the private sector. This is an area that needs development in the future.

Fourth, in contrast to the development of consumer representation and support, there is broad agreement that approaches specifically designed to meet the needs of carers have been slower to develop. Where initiatives have been taken to expand support groups, these have been valued. Carers and consumer groups agreed that an unintended consequence of the alliance that has formed between the groups over the past five years was the subordination of carers' needs. They are learning to become powerful advocates for others, but not yet for themselves.

## Service mix

Central to the vision promoted by the National Mental Health Strategy is the idea that a good mental health service requires a core set of components, which place the locus of care in the community. The Strategy therefore advocated a fundamental shift in the service balance, away from the historical reliance on separate psychiatric hospitals. A range of new service elements was envisaged, which would be linked to form a single, integrated service system that emphasised continuity of care, both over time and across service boundaries.

Major structural reform was foreshadowed, designed to transfer resources to new community-based services and devolve service management from the State and Territory central health bureaucracies to the mainstream health system.

Commonwealth funds released under the Strategy were intended to facilitate the transition, and tied largely to service mix objectives. As a safeguard against cost shifting, Medicare Agreements required each party to maintain their previous level of mental health expenditure throughout the reform period.

The direction set by the Strategy has led to changes in the structure and mix of mental health services that are unparalleled in Australia's history. Key developments of the 1992-1996 period are summarised below.<sup>1</sup>

► *Expansion in the range of services beyond the separate psychiatric hospital*

Spending on non institutional care grew by 55% in real terms (\$216 million), with the majority of this directed to ambulatory services (\$135 million) and acute services in general hospitals (\$41 million; see Figure 3). Mental health service providers working in community settings

<sup>1</sup> Source data for this section has been taken from information provided to the Commonwealth by States and Territories for the 1996 National Mental Health Report.

**Table 5: Service Mix Policy Objectives**

- To ensure each State/Territory and area/region has a plan for the mix of services available to its population and that this plan is developed through a consultative process that takes account of the needs of special groups.
- To reduce the size or to close existing psychiatric hospitals, and at the same time provide sufficient acute hospital, accommodation, and community based services.
- To upgrade the remaining psychiatric facilities which are needed to provide treatment or care on a medium or long-term basis for those whose appropriate placement is in separate specialist psychiatric hospital facilities.
- To decentralise the provision of psychiatric hospital services to ensure adequate access across all areas/regions to general hospital inpatient services and community based services including crisis, assessment and treatment, rehabilitation/ support, and domiciliary and outreach services.
- To increase the number and range of community based supported accommodation services and ensure a range that provides a level of support appropriate to the needs of the consumer.
- To identify areas where the separation of Commonwealth and State funding for mental health treatment services compromises the targeting, integration, and distribution of mental health services and to introduce measures to overcome this.

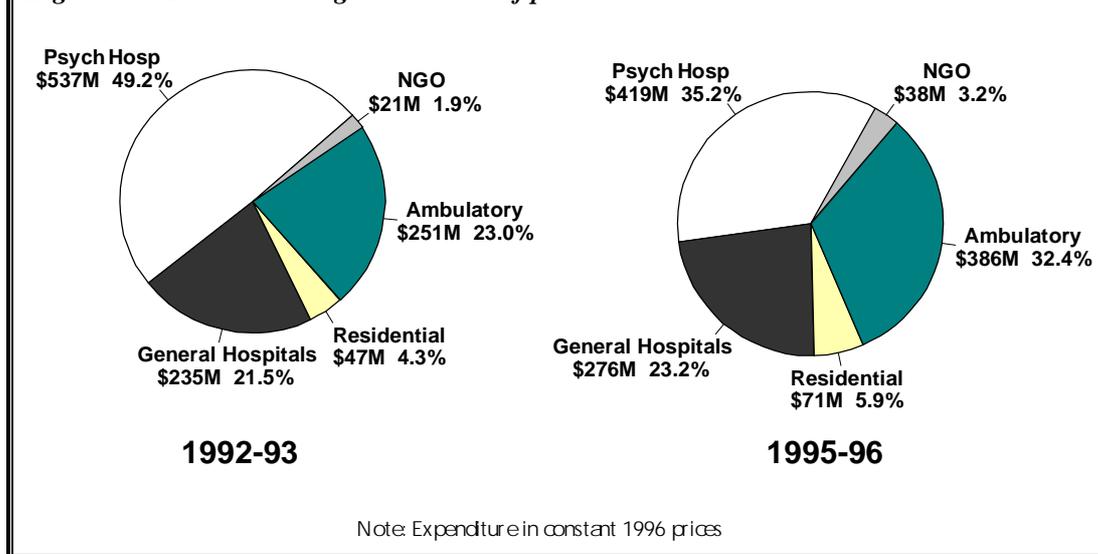
*Source: National Mental Health Policy, 1992*

increased from approximately 4,100 to 5,900 while acute beds in general hospitals increased by 20% (395 beds).

► *Reduction in psychiatric hospitals*

Approximately 1,800 beds in stand alone psychiatric hospitals – 31% of the 1992 stock – were closed in the first four years of the Strategy. The share of total recurrent expenditure allocated to these services reduced from 49% to 35%. Reductions have been targeted largely at longer-term (or 'non acute') beds, with

**Figure 3: National changes in the mix of public mental health services**



overall acute bed numbers remaining stable (see Figure 4).

► *Resource base maintained*

Estimated State and Territory spending on mental health services increased by 6.3% in real terms, and for the Commonwealth, by 61%, the latter mainly attributable to increased Pharmaceutical Benefits Scheme expenditure and allocations made under the Strategy.

► *Mainstreaming*

At the beginning of the 1990's, the majority of State and Territory mental health services operated under separate management arrangements isolated from general health care. By 1996, all jurisdic-

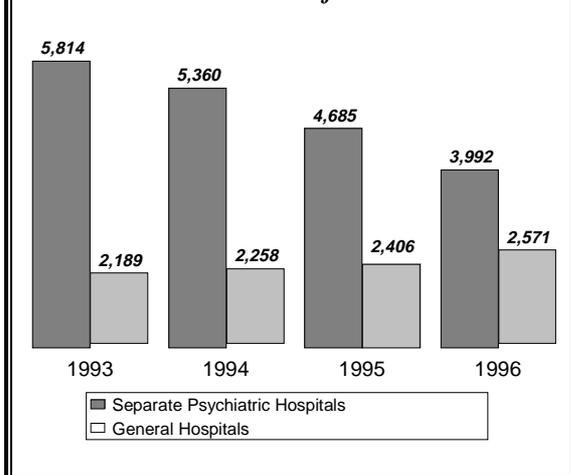
tions had fully transferred management to the same arrangements that apply to mainstream health care.

► *State and Territory mental health plans*

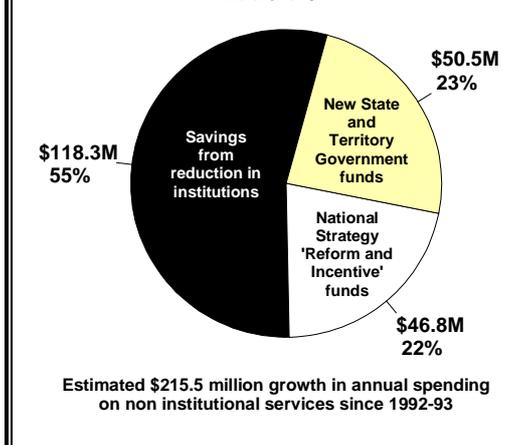
New or revised plans reflecting the national directions have been released by most of the States and Territories over the past four years.

Data collected for the 1996 *National Mental Health Report* (see Figure 5) suggest that the Commonwealth-State/Territory partnership on which the Strategy was premised has functioned as anticipated. 55% of the growth of alternative services has been funded

**Figure 4: Change in mix of inpatient services – Number of beds**



**Figure 5: Sources of funds for increased spending on non institutional services in 1995-96**



through savings returned by States from downsizing their psychiatric hospitals. Commonwealth funds have provided an important stimulus in the early period, supporting 31% of service growth in 1994 and diminishing to 22% in 1996.

This aspect of the Strategy – where mutual obligations are upheld and subjected to public scrutiny - is widely regarded as a model for Commonwealth-State reform agreements in other areas.

Beneath the national level, the scale and pace of change is not uniform across the jurisdictions. Development in several States is slow, and considerable disparity exists between regions with services in most rural areas being particularly undeveloped. All jurisdictions continue to depend on Commonwealth transitional funds and will be challenged to find alternative sources to maintain the new services when the current agreement expires in July 1998.

Broad support for the new service directions was evident across both the local area and national consultations. Where new community services have been established, these are especially valued and seen as the 'backbone' of the service.

But for many, the Strategy vision of accessible, responsive and integrated services has little resemblance to current reality. National groups responding to the evaluation most frequently identified service mix issues as the highest priority for future attention. Similarly, in the four area case studies, where local services were pursuing goals consistent with the Strategy, many problems were apparent in terms of access, continuity of care and service quality.

Key issues of concern included:

► *Service gaps*

Even in the areas where the range and level of services were substantially more developed than the Australian average, consumers and providers reported high levels of unmet need.

► *Limited access to acute beds*

Despite the maintenance of acute bed levels over the period of the Strategy, it was frequently reported that access to acute care has reduced and premature discharges increased.

► *Community services as gatekeepers*

New community teams were valued where they provided care and treatment, but too often these new resources were seen as solely directed to filtering access to the hospital acute unit.

► *Inadequate case management systems*

Both the national and local area consultations reported little improvement in continuity of care arrangements over the past four years. Insufficient use is made of case managers to coordinate care.

► *Insufficient emphasis on rehabilitation and personal recovery*

Services that emphasise the 'person not the illness' were argued as necessary to achieve a balanced care system. Greater emphasis on the role of the specialised mental health 'non government sector' was advocated.

► *Undeveloped 'special needs' services*

Although the Strategy argues for service planning to cater for special need groups, service development has mainly emphasised development of general services, targeted at people with psychotic disorders. Providers perceive that specialisation in the mental health workforce is no longer valued, and as a consequence, services for people with special needs will remain undeveloped. A range of groups has been identified as having special needs. These include, for example, children of people with mental illness, survivors of torture, trauma, or child and sexual abuse, Aboriginal and Torres Strait Islander peoples, people from non English speaking backgrounds, people with dual disabilities, homeless youth as well as others described in the professional literature.

► *Lack of skilled workforce*

As indicated earlier, consumers and providers alike believe that inadequate attention has been given to training the mental health workforce to work in the new service delivery environment. Training is needed not only to equip professionals with the necessary technical skills, but also to encourage attitudes and values that are congruent with the ideals of the National Mental Health Strategy.

Strong views were expressed that this problem is particularly apparent in inpatient services, where the transfer of senior and skilled staff to new community services has depleted the pool of expertise.

Specific mention was made of the training of nursing professionals, who make up 55% of the mental health workforce. Professional groups suggested that there has been a significant decline of the number of nurses with specialist psychiatric qualifications employed in mental health services. This may have been influenced to some extent by the transfer of nursing education to the tertiary sector and the replacement of specialist training with comprehensive nursing curricula. There is particular concern that neither the current salary schedules nor employer assistance schemes give any incentive for general trained nurses to complete specialist psychiatric qualifications.

► *Barriers between the private and public sectors*

Minimal communication between local public mental health services and private psychiatrists was seen to contribute to poor outcomes for consumers.

► *Inadequate rural services*

Much of the effort over recent years has been focused on populations in metropolitan areas. With a few notable exceptions, services in rural and remote areas are yet to benefit from the activity generated by the National Mental Health Strategy.

Overall, there is little doubt that the directions defined by the Strategy have won the support of disparate groups. While these groups acknowledged that positive change was underway, their common theme is that the direction is right, but the correct service balance is yet to be found.

The strategic message for the future is that development of the 'right mix' involves more than putting a set of service components in accessible locations. It is as much about the quality of services as it is about building blocks and geography.

The development of planning tools, workforce initiatives and assistance to organisations during the transitional period are areas where national leadership is required.

## Linkages

The historical isolation of mental health services produced a culture in which consumers of mental health services were denied access to support services in many sectors. The emphasis given by the Strategy to this area recognises that access to services such as housing, employment, social support and general health care, is essential for people with a mental illness to function in the community.

The Strategy objectives on intersectoral links (Table 6) emphasise:

- the elimination of discrimination in access to programs by people with mental disorders; and
- the development of formal policies and mechanisms to ensure access to needed programs and services in other sectors.

The 1995 *National Mental Health Report* commented that “given the complexity of the systems which need to change ... the area of intersectoral linkages is one of the most difficult facing the National Mental Health Strategy.”

Several of the critical structural steps have been taken.

- Anti discrimination legislation is in place in the Commonwealth and the majority of States and Territories, which provide protection against discrimination on the grounds of mental illness.
- Action has been taken by all jurisdictions to develop formal agreements with departments administering human service programs required by people affected by mental illness.
- At the Commonwealth level, initiatives have been targeted at improving access to employment support and tailoring social security

**Table 6: Intersectoral Linkage Policy Objectives**

- To eliminate any explicit or implicit discrimination against those with severe mental health problems and mental disorders in programs and services within and outside the health sector.
- To develop formalised policy and planning arrangements at Commonwealth, State, Territory and area/regional levels to ensure that all programs relevant to those with severe mental health problems and mental disorders adequately address their needs .
- To encourage interagency links and service delivery arrangements at the local and area/regional level to ensure access to services for people with severe mental health problems and mental disorders reflects their relative need for those services.

*Source: National Mental Health Policy, 1992*

to ensure people with mental illness are able to access entitlements.

- State and Territory initiatives have focused on improving access to public housing. The more advanced States have extended this to development of joint protocols with other key government agencies including police, ambulance authorities, corrections services and child protection.

Earlier reports of mental health consumer consultations indicated that access to housing and employment were the highest priority services for improvement. Evidence presented in the 1995 *National Report* suggests that the initiatives taken in these areas are beginning to show benefits.

- Mental health consumers increased from 10% of total clients assisted by the Commonwealth Rehabilitation Service in 1991 to 23% in 1995. Over the same period, mental health consumers increased from 2% to 15% of total persons assisted by

Commonwealth-funded disability support services which focus on employment in the open labour market

- Joint housing support initiatives commenced between the health and housing departments in at least four States, with places expected to increase over the next twelve months.

The Area Case Studies concluded that, compared with other evaluation focus areas, least progress has been made in linking mental health services with other services. This view was endorsed in the national consultations.

Building service linkages as a means of improving overall consumer outcomes is not yet regarded as core business by most local mental health services. Roles and responsibilities are not clearly defined, and relationships between mental health services and other local agencies tend to develop on an ad hoc basis.

Guidelines are needed to assist public mental health services in developing formal relationships with external agencies. Responsibilities and objectives also need to be reflected in local area plans. Only one State has prepared such materials.

For this to work, priorities are needed. In addition to housing and employment, the local area and national consultations highlighted the following additional areas as requiring greater effort than has been the case to date.

► *General practitioners*

Improving links with GPs holds the greatest potential to improve outcomes for a large number of people with mental health problems. Such links need to go beyond discussions around individual cases, and extend to broader issues of training, consultation and referral pathways that make best use of the health resources available in the area.

► *Community support agencies*

Organisations operating outside the mental health sector have potential to

play a greater role in supporting people in the community who are affected by mental illness. Relevant services include home help, family support, respite and recreation. Better access needs to be facilitated through agreements developed between the central funding authorities and linkages at the service delivery level.

► *Emergency services*

Police and ambulance services typically interact with mental health consumers in highly stressful circumstances, sometimes with associated danger. Recent well documented cases of the use by police of firearms to control a psychiatric emergency have highlighted the need for improved police training and better linkages to local mental health services.

► *Corrections and criminal justice systems*

Links between the mental health system and the legal and correction systems are essential to ensure adequate referral and treatment of people with a mental disorder who commit crimes. Current arrangements are described as inadequate.

## Promotion and Prevention

Promotion and prevention is one of the overarching aims of the National Mental Health Strategy. A number of measures are advocated, designed to "...promote the mental health of the Australian community and, where possible, prevent the development of mental health problems and mental disorders."<sup>1</sup>

The measures proposed are based on a combination of: community education to reduce ignorance and stigma; secondary and tertiary prevention strategies to minimise the impact of mental illness when it occurs; and research.

The Strategy's approach acknowledges that society's attitude to mental health affects the impact of mental illness on the individual. The intended outcome is that "those with mental disorders will be ... better understood, less feared, less discriminated against and have better access to community life."<sup>1</sup>

The Strategy also accepted that little evidence is available to show that primary prevention is effective for 'most severe problems and mental disorders'. It therefore placed greater emphasis on early intervention and rehabilitation as preventive strategies.

A number of national initiatives have been taken to progress mental health promotion objectives. The Community Awareness Program was the most ambitious. Commencing in 1995, it comprised a series of media advertisements promoting the message of 'mental illness is like any other illness.' This was backed up by the distribution of pamphlets, posters and other educational materials, along with the positioning of billboards in prominent locations in the several capital cities.

In the primary prevention area, limited initiatives were taken, mainly centred on allocation of funds to the National Health and Medical Research Council to strengthen the mental health research profile.

**Table 7: Prevention and Promotion Policy Objectives**

- To develop programs which educate the public on mental disorders, including those initiated through mainstream health promotion activities.
- To develop and evaluate primary, secondary and tertiary preventive programs as an essential component of all care provided for people at risk of mental disorder.

*Source: National Mental Health Policy, 1992*

Early intervention has been given greater focus by the Strategy. Community-based crisis teams are becoming more widespread. 'Early psychosis' services have been established in several locations, with the aim of reducing the long term impact of these disorders.

In a related initiative, the Commonwealth has made available \$31 million to be targeted at reducing suicide in youth.

The Area Case Studies suggest there is little health promotion at the service delivery level. Local activities tend to be 'one off', centred around Mental Health Week and Schizophrenia Awareness Week. Negligible activity of a primary prevention type is conducted.

Feedback from the national and local area consultations suggest that only marginal gains have been made in promoting mental health issues in the community.

- Strong support was expressed for the Community Awareness Program and its impact on raising awareness of mental health issues. Its major achievements were the validating effect it had on consumers, as well as the written materials, which continue to be used extensively by many community groups.

- The overwhelming feedback was the campaign made no inroads to changing community attitudes or behaviour towards people with mental illness. Consumers report that stigma and discrimination remain at the high level that existed prior to the Strategy.
- Opportunities for local groups to co-ordinate promotional activity with the national campaign were missed. The campaign also was not appropriate for a range of groups, including people from non-English speaking backgrounds and Aboriginal and Torres Strait Islanders.
- For mental health service providers, promotion work is a low priority. Defining what is expected of service providers, and the relative roles of primary health care in promoting broader mental health issues, is needed.
- On a positive level, better outcomes were reported when services targeted action at sections of the local community which, as a result of their attitudes, created difficulties for mentally ill people. Special campaigns of this type would benefit from national support in the form of educational materials, advice or funds.

Overall, there is a need to take the national initiatives on mental health promotion to the next stage. The committee believes that targeted projects, rather than broad use of media campaigns, will give the best returns.

On prevention issues, the Strategy is reported by national stakeholders to have had no obvious impact on the incidence or prevalence of mental disorders. Lack of relevant data on the extent of mental disorders in the community prevents validation of this view, but given no significant primary prevention programs have been conducted under the Strategy, there is little reason to challenge it.

National direction in the area of primary prevention is needed for several reasons.

First, mental health services need to be guided in clarifying responsibilities. Confusion is apparent as to what constitutes primary prevention and what, if any, activities may be effective within their sphere of control. From the providers' perspective, conflicting messages are communicated by the Strategy when it simultaneously urges primary prevention and prioritisation of 'serious mental illness'

Second, the Strategy needs to define and stimulate development of special programs for 'at risk' groups. As indicated earlier, a range of special needs groups has been identified in the professional literature.

Third, support for primary care providers, particularly general practitioners, is needed to assist them in working with people 'at risk' of developing mental illnesses.

Fourth, the National Strategy provides the best vehicle to take a position of 'moral leadership' to emphasise that all segments of Australian society share a responsibility for fostering and promoting well being. Exploratory work is needed to identify how this role can be used most effectively in promoting a public health approach to mental health.

In the area of early intervention, there are three important observations arising from this evaluation.

First, the 'culture of early intervention' is welcomed by consumers and carers but seen to be too limited in its distribution across mental health services. The approaches promoted in the new 'early psychosis' programs have relevance to all people who experience a mental illness, regardless of the type of illness or whether they are suffering their first or a subsequent episode.

Second, the use of the term 'serious mental illness' has paradoxically inhibited early intervention where it could be effective. Many consumers reported being refused admission to care because they did not meet the (unspecified) serious mental illness criteria, only to experience a full relapse shortly afterward. There are critical training implications for providers in this finding.

Finally, the expansion of extended hours services in the community is valued by all stakeholders and seen to have increased the availability of early intervention services. The main issue is that such services are still only available to the minority of Australians who suffer a mental illness.



## Future directions

The international review of the National Mental Health Strategy, completed by Dr Ronald Manderscheid, Deputy Director of the Centre for Mental Health Services, US Department of Health and Human Services, summarised Australia's position as follows:

*“Australia has articulated a national mental health policy through the National Mental Health Strategy, has provided flexible resources to facilitate system transitions from an inpatient to a more balanced service delivery system, has engaged consumers and carers in focal roles and has emphasised concerns with quality and outcome as major system goals. Taken together, these four elements reflect the cutting edge of mental health at the international level...”*

*The Commonwealth, State and Territory mental health leadership are to be commended for this achievement, which has occurred in a time span of less than five years. More remains to be done, but Australia is prepared and energised to accomplish these things and even more over the next three years.”*

These comments, made by the Deputy Director of an organisation with extensive authority in the international mental health community, provide powerful endorsement of Australia's efforts to reform its mental health system.

They also reflect the view developed by the Committee during its two years of evaluating the National Mental Health Strategy. The evidence is compelling that the shape of mental health services has changed substantially over the five year Strategy period. Overwhelmingly, there is broad agreement that it has created the impetus for change and guided reforms that followed.

Equally, there is concern that current services fall far short of the Strategy vision for Australia. Service improvements are uneven, across and within jurisdictions. Many areas are yet to experience a tangible benefit from the National

Mental Health Strategy reforms, indicating the structural reform agenda is not finished. Concerns about poor service quality and client outcomes have only begun to be addressed.

The theme of 'unfinished business' is the essence of the committee's final report to AHMAC. We urge the Commonwealth, State and Territory policy makers to recognise that what has been started will need continued policy attention. Many initiatives taken, particularly those focusing on service quality and outcomes, will not deliver results for several years and will need the momentum maintained. In a number of critical areas (e.g. workforce training), action is yet to commence.

The adage that 'in the field of institutional reform the first twenty five years are the hardest' has much applicability in this context. The foundations laid in the first five years of the mental health policy provide a solid footing for building the future.

Close to the final stages of this evaluation, the Commonwealth government announced its commitment to continuation of the Strategy. Future Commonwealth funding to the States and Territories for mental health reform will be negotiated under the Health Service Agreements.

The period ahead will differ from the recent past. The change in funding arrangements underlines that the States and Territories will need to take the lead to ensure new services are maintained, and maintain momentum for further change.

The new focus should be on issues where national leadership and coordination are required. The committee proposes that the areas outlined below should be priorities in the future national mental health work program.

## **1. Service standards, quality and outcomes**

The focus of the new Strategy needs to move from the current emphasis on service inputs and structure to service standards, quality and outcomes. Much of the criticism of mental health services concerns its alleged failures in these areas.

Initial steps to develop outcome measures and service standards have been taken that, as indicated by the international review, place Australia at the forefront of initiatives in these areas. Considerable development work is required to take these to a point where they will be fully accepted and implemented in the field. It is work of this type where national leadership is essential.

## **2. Extending the role of consumers and carers**

Consumers and carers now have a place at the policy table, yet have only limited influence on local services, even when it concerns their personal treatment. It is essential that a national group of consumers and carers be maintained and extended to signal that the policy agenda is far from complete.

Guidelines and assistance to local agencies, public and private, need to be established to accelerate the empowerment of consumers and carers at that level.

## **3. Defining mental health need**

The most common concern raised throughout this evaluation relates to use of the term 'serious mental illness', and its widespread application in restricting access to services.

The 1992 *National Mental Health Policy* argued the need to set priorities for mental health to ensure that resources went to people who were most in need. It stated '*... priority in the allocation of resources should be given to people with severe mental health problems or*

*mental disorders who, because of the nature of their condition, require ongoing and, at times, intensive treatment*".

The policy also recognised that there are others in the community who require assistance with mental health problems: "*the policy also recognises the impact of mental health problems more generally on individuals, their families and the community. . . . The development of effective mental health promotion, prevention and early intervention strategies and the enhancement of training and support for primary care service providers, is fundamental to the achievement of these objectives.*"

The term 'serious mental illness' represents the simplification of these complex ideas. Once it appeared in the mental health lexicon, its use spread rapidly and was subject to variable interpretation.

The fact that no definition of mental health priorities was offered in the policy is the chief source of the problems that have arisen. Alternative phrases have been offered to capture the policy intent, such as 'serious mental health need', but these are equally flawed.

In the absence of an authoritative definition of priorities, terms such as these will be subject to local interpretation. Unless defined, they are incapable of being audited to ensure that service rationing is conducted in an ethical manner.

The problem is not unique to Australia. Internationally, mental health services struggle to respond to community demand, and embrace undefined concepts like 'serious mental illness' as tools to restrict access.

Two steps need to be taken. First, the extent of community need must be determined so that local priorities and service gaps can be properly identified. The national mental health population survey commissioned under the Strategy, due to be completed in 1998, will provide a basis for this.

However, it is essential that the implications of the national survey be translated to useable planning tools that can be applied by local services in estimating community need.

Second, a national definition of service priorities should be developed that takes into account clinical diagnosis, personal functioning and suffering. While this will not be easy, it is important to note that a definition of 'serious mental illness' has been recently legislated in the United States, balancing the concepts of illness and impairment, which may serve as a base for similar developments in Australia.<sup>11</sup>

#### **4. Defining mental health workforce core competencies**

New models of care challenge both the attitudes and traditional skills of the mental health workforce. Early in the Strategy, the *1994 National Mental Health Report* made the following observation.

*"A challenge facing those States with large institution-based workforces is to ensure that movement of staff into new community services is accompanied by programs to facilitate development of the skills required for effective community practice. These do not come automatically with changes of work location; experience elsewhere has taught that the culture of institutions can survive a hospital closure." (p122)*

This evaluation has highlighted that little has been invested at the national level to address the workforce implications of changes in service delivery.

There is considerable confusion about the values, attitudes and skills required to work in mental health, and the extent to which consumers and carers can influence these. The terms 'consumer participation' and 'consumer-carer-provider partnership' are used loosely and to some extent, tokenistically, without adequate consideration of the implications of these concepts for defin-

ing core competencies needed by mental health professionals.

Similarly, the concepts 'multidisciplinary teamwork' and 'multiskilling' are too often used interchangeably. Special skills needed to work with mentally ill and psychiatrically disabled people have been neglected in the generic training programs introduced over recent years.

The mental health industry needs to define the core competencies required, particularly staff values and attitudes, and to develop these in collaboration with consumers and carers. These then should be used in negotiations with the tertiary education sector and form the basis for professional development initiatives within the industry.

#### **5. Strengthening rehabilitation and personal recovery**

The impacts of mental illness frequently remain long beyond the acute episode. For many consumers, effective treatment of symptoms needs to be accompanied by approaches that emphasise personal recovery, integration, and rehabilitation. Where the illness is of a long term nature, or recurrently episodic, services are needed to assist the person to restore their lives as much as possible, and find ways to adapt to living with a chronic illness.

The skills required to assist consumers in these ways are under-emphasised in favour of models promoting the treatment of acute symptoms. A better balance of approaches is required to improve long term consumer outcomes.

In this area, consumers appreciate the roles played by the non government sector and advocate for their expansion. The Committee agrees with this view, while recognising that personal recovery and rehabilitation services cannot exist in isolation of treatment services. The challenge in achieving a balance of illness and rehabilitation approaches requires coordination of services rather than segmentation.

## **6. Responding to people with special needs**

A single approach to mental health service delivery cannot meet the diverse mental health needs in the Australian community. Since its introduction, the National Mental Health Strategy has argued that there are identifiable groups with special needs, for whom unique programs need to be developed. These include: Aboriginal and Torres Strait Islander peoples; people from non English speaking backgrounds; children of parents with mental illness; survivors of torture, trauma, or child and sexual abuse; people with dual disabilities; homeless youth; and others.

Service development for these groups is variable, and needs to be strengthened in future years. This will have workforce training implications and requires incentives to be established for health professionals to pursue specialist interests.

## **7. Population approaches to prevention and promotion**

Marginalisation of mental health from the broader health system has contributed to the limited effort made in the area of primary prevention and promotion. This has left mental health providers to take up the role, but they are unwilling to sacrifice their treatment responsibilities to engage in prevention and promotion activities.

The separateness of mental health has also isolated it from public health expertise and its broad approaches to improving population health.

Initiatives in the area of primary prevention need to integrate mental health with general health programs and be based on a partnership between public health and mental health experts.

Advances made in the Community Awareness Program also need to be consolidated and extended. Specific groups need to be targeted, for whom the broader campaign was not appropri-

ate. These include those from non-English speaking backgrounds, Aboriginal and Torres Strait Islanders, and those in rural areas.

To complement the community-wide approach, efforts should also be targeted in areas where new services are being established, which are compromised by local community attitudes.

## **8. The place of the mental health private sector in national reform**

Little credit can be taken by the National Mental Health Strategy for any changes in the culture and mix of service provision in Australia's private psychiatric hospitals. This service sector was not included in the original Strategy negotiations, and felt marginalised during the early period. This is now acknowledged as poor policy and recent efforts have begun to address issues relevant to the sector and its place in the overall provision of mental health services.

Issues relating to community service development, consumer participation and linkage to other mental health services should be at the forefront of these discussions. Finding new models of reimbursement will be necessary to overcome barriers to change.

Psychiatrists engaged in the private sector were similarly given little attention in the early policy period. Several reports have been commissioned under the Strategy that identified a wide range of policy options to resolve chronic problems separating private psychiatrists from public sector practice. Most of these are yet to be implemented, and should be pursued in the next policy period.

## **9. Strengthening the role of primary care**

The relationship between general practitioners and specialist mental health services is relatively undeveloped in Australia. But by contrast, considerable research has shown that general practitioners carry the burden of responding to the majority of mental health need in the community.

Barriers claimed to inhibit stronger links between the specialist mental health services and general practitioners include funding disincentives, lack of training and attitudes of mental health providers. A range of shared care and training models has been trialed over recent years that demonstrate these can be overcome.<sup>12</sup>

The task now is to move from an approach based around isolated pilots to a structured program of change.

## **10. Rural populations**

The general problems faced by rural communities in accessing health services are particularly evident when specialised mental health services are needed. A range of initiatives have been taken under the National Mental Health Strategy, and other national health programs, to improve rural access to mental health services.

It is essential that these be expanded in the years ahead. Most importantly, solutions need to be tied to broader strategies to improve health services to rural Australia, and particularly linked to relevant initiatives in primary care.

## **11. Developing planning and performance benchmarks**

The value of the National Mental Health Strategy lies largely in the values it espouses and its broad map of service development. From a planning perspective however, it is short on detail. For example, while it advocates a change in the balance of services, the

Strategy does not prescribe a specific service mix, leaving this to be developed in response to local needs. Similarly, the Strategy advocates monitoring of progress made in particular areas, but does not specify targets.

The Strategy implied that it was not appropriate to set benchmarks, as these would not take account of the different histories, circumstances and priorities of the State and Territory jurisdictions. This cautious approach reflected the early stage of development of mental health policy in Australia.

Lack of planning and evaluation benchmarks creates ambiguity in the field. In seeking a target against which to monitor performance, several States and Territories have adopted goals such as 'to develop a 50:50 mix of inpatient and community services', or 'to maintain expenditure on mental health'. The committee does not see these to be sufficient goals to guide a major reform program.

Service development at local level would be facilitated by nationally agreed planning targets. These would not be prescriptions but act only as guides to be refined in accordance with local population differences and resource constraints. Similarly, performance benchmarks need to be developed for use in the evaluations of all mental health services at national, State and Territory and local levels.

New Zealand has followed this course and recently published national planning benchmarks.<sup>13</sup> The committee believes that sufficient experience and consensus has been achieved in Australia for a 'first cut' of these to be defined.

## **12. Funding tools to drive change**

Mental health services largely remain funded on an historical basis and are yet to embrace models developed elsewhere that fund on the basis of outputs.

Funding policy is the vital force in driving change. Tools need to be developed that fit the requirements of mental health services, which both reward efficiency and quality, as well as emphasising continuity of care across hospital and community boundaries. Funding tools designed in the general health sector are widely recognised as inappropriate for mental health.

Innovative work has commenced under the Strategy to achieve these ends, but will need to be extended before tangible benefits flow.

## **13. Technical support for service innovation**

A role yet to be developed at the national level is the provision of training and support to agencies undertaking service innovations. Generally, both the initiative and the momentum are expected to be generated locally.

It is clear that knowledge needs to be transferred from place to place to advance the reform agenda. This includes documentation, on-site support and use of new communication tools. The National Mental Health Strategy should take the lead in this field.

## **14. An information infrastructure for mental health services**

Information in mental health is grossly undeveloped. The lack of nationally comparable data on service outputs, costs, quality and outcomes places major limitations on the extent to which the National Mental Health Strategy can achieve its objectives.

A precondition to the changes proposed above is the existence of an information infrastructure built from the clinical serv-

ices level that contributes to individual consumer care and service quality improvements as well as feeding into higher level planning and policy review. The models exist elsewhere and have demonstrated that much is possible. Putting such systems in place needs to be identified as an imperative for the next Strategy period.

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- 11 Manderscheid, R.W., *Personal Communication*, September 1997
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- 13 *Primary Care Psychiatry: The Last Frontier*. Joint Consultative Committee on Psychiatry of the Royal Australian College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists, Department of Health and Family Services, 1997

# Appendix 1: Details of Evaluation Research Components

## **Area Case Studies**

*'Evaluation of the National Mental Health Strategy: Report of the Area Case Studies'*

Purdon Associates Pty Ltd, Canberra

## **National Stakeholder Consultations**

*'Evaluation of the National Mental Health Strategy: Stakeholder Consultations'*

Jane Pirkis, Centre for Health Program Evaluation, Program Evaluation Unit, Department of Public Health and Community Medicine, University of Melbourne

## **International Expert Commentary**

*'The Australian Mental Health Strategy: Past Successes and Future Challenges'*

Dr Ronald Manderscheid, Deputy Director, Center for Mental Health Services, US Department of Health and Human Services

## **Review of National Data**

Bill Buckingham and Associates Pty Ltd, in conjunction with the Commonwealth Department of Health and Family Services

## Appendix 2.

# Summary of Progress Against National Mental Health Strategy Objectives

The following pages summarise the committee's conclusions about progress on each of the 38 National Mental Health Strategy objectives. These are drawn primarily from two sources – data provided to the Commonwealth by the States and Territories for the *1996 National Mental Health Report*, and the information collected by the committee during the course of the current evaluation.

Progress on each objective was graded on a four-point scale:

- 1 Substantial progress
- 2 Moderate progress
- 3 Minor progress
- 4 Minimal or no progress

Where the evidence is insufficient or ambiguous, a rating of 'Not known' was made.

POLICY CATEGORY	Obj No	OBJECTIVE Description	Summary of Progress
Consumer Rights	Obj 1	To have the rights contained in the Australian Health Ministers' Statement of Rights and Responsibilities and in the UN Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care affirmed in mental health legislation.	<b>Moderate progress</b> <ul style="list-style-type: none"> <li>• Mental health legislation reviewed in all States and Territories, with amendments either enacted or currently before the relevant Parliaments.</li> <li>• Anti discrimination legislation in place in the Commonwealth and the majority of States and Territories, providing protection against discrimination on the grounds of mental illness.</li> <li>• Consumer Advisory Groups established in all States and Territories and at the national level to advise governments and health authorities on planning and service delivery issues.</li> <li>• Minimum Standards for Mental Health Services released 1996, including relevant service delivery standards for ensuring protection of consumer rights.</li> <li>• Despite these changes, consumers continue to report significant stigma, discrimination and related breaches of their rights.</li> </ul>
	Obj 2	To ensure that the Commonwealth Government and all State and Territory Governments have mechanisms for protecting those rights.	
Relationship between mental health services and the general health sector	Obj 3	To expand the proportion of acute psychiatric inpatient care provided in general hospitals rather than separate psychiatric hospitals so that most acute care is delivered in general hospitals and ensure that psychiatric units in general hospitals are appropriately designed for the patient population.	<b>Moderate progress</b> <ul style="list-style-type: none"> <li>• Data provided by the States and Territories for the <i>1996 National Mental Health Report</i> indicates that in the first four years of the Strategy: <ul style="list-style-type: none"> <li>– acute psychiatric beds in general hospitals increased by 20%; and</li> <li>– acute beds in stand alone psychiatric hospitals decreased by 28%</li> </ul> </li> <li>• By June 1996, 66% of total acute psychiatric beds were colocated in general hospitals compared with 55% at June 1993</li> </ul>

POLICY CATEGORY	Obj No	OBJECTIVE Description	Summary of Progress
Relationship between mental health services and the general health sector (cont)	Obj 4	To maintain or establish an identifiable and integrated mental health program at the State/Territory and area/regional levels. This program would be responsible for the overall planning of all specialised mental health services and would advise on the allocation of resources between components of mental health services.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>By July 1996, less than half of the jurisdictions had implemented organisational arrangements consistent with the integration objective.</li> </ul>
	Obj 5	To include integrated mental health services with the mainstream organisational arrangements for general health services such as area/regional management systems.	<b>Substantial progress</b> <ul style="list-style-type: none"> <li>By July 1996, mental health services in all States and Territories were mainstreamed with the general health system.</li> </ul>
	Obj 6	To introduce systems, such as case management, which improve continuity of care and comprehensive services for people with mental disorders who receive services on an ongoing basis from numerous agencies and locations.	<b>Minimal progress</b> <ul style="list-style-type: none"> <li>Although all jurisdictions have described a range of initiatives to improve continuity of care, no evidence has yet been published to demonstrate positive impact for consumers.</li> <li>Reports of consultations with consumers in fact suggest that, at the service delivery level, minimal real progress has been made in this area.</li> </ul>
Linking mental health services with other sectors	Obj 7	To eliminate any explicit or implicit discrimination against those with severe mental health problems and mental disorders in programs and services within and outside the health sector.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>Significant progress has been made to ensure legislation promotes non discriminatory practices and prohibits discrimination on the grounds of mental illness – see comment above re anti discrimination legislation</li> <li>However, consumers report considerable implicit discrimination continues to restrict their access to human service programs.</li> </ul>
	Obj 8	To develop formalised policy and planning arrangements at Commonwealth, State, Territory and area/regional levels to ensure that all programs relevant to those with severe mental health problems and mental disorders adequately address their needs.	<b>Moderate progress</b> <ul style="list-style-type: none"> <li>Significant action taken at central administrative level by all jurisdictions to improve access and relevance of human service programs for people affected by mental illness.</li> <li>Evidence was presented in the <i>1995 National Mental Health Report</i> of movement by many general human service programs from exclusion or neglect of people with mental illness to a position where this group is included as a priority.</li> <li>Considerable consensus is evident in reports of national consultations that access to housing and employment remain the highest priority services for improvement.</li> </ul>
	Obj 9	To encourage interagency links and service delivery arrangements at the local and area/regional level to ensure that access to services for people with severe mental health problems and mental disorders reflect their relative need for those services.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>The Area Case Studies concluded that, at the service delivery level, least progress has been made in linking mental health services with other services.</li> <li>Protocols developed at central level have not yet been translated to local service delivery levels.</li> </ul>

<b>POLICY CATEGORY</b>	<b>Obj No</b>	<b>OBJECTIVE Description</b>	<b>Summary of Progress</b>
Service mix	Obj 10	To ensure each State, Territory and area/region has a plan for the mix of services available to its population and that this plan is developed through a consultative process and takes account of the needs of special groups.	<p><b>Substantial progress</b></p> <ul style="list-style-type: none"> <li>By June 1997, seven of the eight jurisdictions had released a comprehensive mental health services plan that was prepared in the context of the National Mental Health Strategy.</li> </ul>
	Obj 11	To reduce the size or close existing psychiatric hospitals and at the same time provide sufficient alternative acute hospital, accommodation and community based services.	<p><b>Substantial progress</b></p> <ul style="list-style-type: none"> <li>In the four years to June 1996 there was: <ul style="list-style-type: none"> <li>a 31% reduction in the number of beds located in separate psychiatric hospitals; and</li> <li>a 55% increase in expenditure on community and general hospital-based services.</li> </ul> </li> <li>Institutions have become less central to mental health services, reducing from 49% to 35% of total expenditure over the four year period 1992-1996.</li> <li>Spending on mental health services has generally been maintained, with savings gained from institutional downsizing used to develop alternative services.</li> </ul>
	Obj 12	To upgrade the remaining psychiatric facilities which are needed to provide treatment or care on a medium or long-term basis for those whose appropriate placement is in separate specialist psychiatric hospital facilities.	<p><b>Not known</b></p> <ul style="list-style-type: none"> <li>At June 1996, 60% of total beds remained in separate institutions.</li> <li>By February 1995, only 6 of the 25 longer term institutions had received accreditation with the Australian Council on Health Care Standards.</li> <li>However, specific data on the quality of these services is not available.</li> </ul>
	Obj 13	To decentralise the provision of psychiatric hospital services to ensure adequate access across all areas/ regions to general hospital inpatient services and community based services including crisis, assessment and treatment, rehabilitation/support and domiciliary and outreach services.	<p><b>Minor progress</b></p> <ul style="list-style-type: none"> <li>Although there is evidence of significant relocation of resources between regions, data collected for the National Mental Health Report suggest considerable disparity between communities in service availability.</li> <li>By June 1996, few of the jurisdictions had implemented a full population-based funding model to guide resource transfer.</li> </ul>
	Obj 14	To increase the number and range of community based supported accommodation services and ensure a range that provides a level of support appropriate to the needs of the consumer.	<p><b>Moderate progress</b></p> <ul style="list-style-type: none"> <li>Significant action has occurred to increase community-based accommodation.</li> <li>But the lack of housing continues to be a major source of concern voiced by consumer and carer groups.</li> </ul>
	Obj 15	To identify areas where the separation of Commonwealth and State funding for mental health treatment services compromises the targeting, integration and distribution of mental health services and to introduce measures to overcome this.	<p><b>Minimal or no progress</b></p> <ul style="list-style-type: none"> <li>Although several steps have been taken to coordinate Commonwealth, State and Territory spending on medical practitioners in mental health services, the separation of funding streams that was present at the commencement of the National Mental Health Strategy continues to be a major barrier to change.</li> </ul>
Promotion and prevention	Obj 16	To develop programs which educate the public on mental disorders including those initiated through mainstream health promotion activities.	<p><b>Minor progress</b></p> <ul style="list-style-type: none"> <li>The national campaign ('Community Awareness Program') to educate the community was initiated under the Strategy and has few precedents internationally.</li> <li>Evaluation of CAP suggests that it was well received within the community; the Area Case Studies support this.</li> <li>However, consumers and staff report that the campaign</li> </ul>

POLICY CATEGORY	Obj No	OBJECTIVE Description	Summary of Progress
			made little inroad to changing community attitudes or behaviour.
Promotion and prevention (cont)	Obj 17	To develop and evaluate primary, secondary and tertiary preventive programs as an essential component of all care provided for people at risk of mental disorder.	<b>Minimal Progress</b> <ul style="list-style-type: none"> <li>Relatively minor initiatives in primary prevention have been taken. Unresolved debate continues amongst mental health professionals regarding the priority that should be given by specialist mental health services to primary prevention activities.</li> <li>Little published evidence has been produced during the Strategy as to the effectiveness of any new secondary and tertiary prevention programs introduced as a result of the Strategy.</li> </ul>
	Obj 18	To encourage further research into the causes of mental disorders and the development and evaluation of primary prevention interventions in response to emerging scientific knowledge.	<b>Moderate progress</b> <ul style="list-style-type: none"> <li>Spending on mental health research increased by 22% in the first year, although definitional difficulties reduce the reliability of this finding.</li> <li>Approximately \$11.4 million was spent on mental health research by the Commonwealth, States and Territories in 1994-95, representing 0.7% of total expenditure on mental health services. A nationally agreed target to guide mental health research investments has not been set.</li> </ul>
Primary Care Services	Obj 19	To ensure that educational programs for primary health care professionals and others with a primary care role contain, within their curriculum and continuing education programs, adequate coverage of mental health issues.	<b>Minimal or no progress</b> <ul style="list-style-type: none"> <li>Major concern was evident during the national Stakeholder consultations regarding (a) loss of mental health expertise arising from the introduction of generic training programs and (b) low skill levels amongst many mental health professional staff.</li> <li>Discriminatory and stigmatising attitudes by staff was reported by consumers to be one of the major problems inhibiting service quality improvements.</li> </ul>
	Obj 20	To provide support to primary carers by ensuring that they have access to specialist mental health resources particularly in rural and remote communities.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>The Commonwealth, States and Territories have taken specific initiatives, targeted at general practitioners.</li> <li>Other innovative initiatives also have attempted to improve access in rural and remote communities.</li> <li>Evaluative data on the impact of these initiatives is not available.</li> <li>Promising joint initiatives have begun to emerge through collaborative work between the bodies representing general practitioners and psychiatrists.<sup>12</sup></li> </ul>
Carers and non-government organisations	Obj 21	To support the development and expansion of non-government organisations to assist carers and promote self-help and consumer advocacy, through information provision, opportunities to participate in mental health service decision making and funding.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>Allocations to non government organisations specialising in the mental health area increased by 178% between 1993 and 1996 years but accounted for only 3.2% of total State/Territory mental health spending in 1995-96</li> <li>Considerable initiatives have been taken to establish peak Consumer Advisory Groups at national, State and Territory levels. However, no equivalent mechanisms for consumer/carer participation have been established in about half of Australia's public mental health service organisations.</li> <li>Consumers strongly promote the strengthening of the non government sector, due to their emphasis on 'the person not the illness'.</li> </ul>
	Obj 22	To expand community based support for carers.	<b>Minimal or no progress</b> <ul style="list-style-type: none"> <li>Carers widely report that support services have largely been neglected during the first National Mental Health</li> </ul>

POLICY CATEGORY	Obj No	OBJECTIVE Description	Summary of Progress
			Strategy
Mental health workforce	Obj 23	To achieve a better distribution of psychiatrists between States and Territories, geographic areas within States, public and private practices and within sub-specialities.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>Following many years of ongoing movement by psychiatrists from public to private sector employment, evidence presented in the 1996 National Report suggests a slowing of this trend.</li> <li>Inequities in access by rural and communities to private psychiatrists continues, averaging at 20% of the national per capita rate.</li> </ul>
	Obj 24	To ensure that the number of graduates and their level of skills from tertiary based programs of nurse education meet the service requirements of specialised mental health services.	<b>Minimal or no progress</b> <ul style="list-style-type: none"> <li>All jurisdictions report that they have introduced specialist mental health postgraduate courses for nurses.</li> <li>But professional groups report that there has been a significant decline of the number of nurses with specialist psychiatric qualifications employed in mental health services. This may have been influenced to some extent by the transfer of nursing education to the tertiary sector and the replacement of specialist training with comprehensive nursing curricula.</li> <li>There is particular concern that neither the current salary schedules nor employer assistance schemes give any incentive for general trained nurses to complete specialist psychiatric qualifications.</li> </ul>
	Obj 25	To ensure an adequate supply and a more equitable distribution of allied health staff.	<b>Not known</b> <ul style="list-style-type: none"> <li>Allied health staff in public mental health services increased by 21% between 1994-1996, but no data are available to assess their distribution in relation to community need.</li> <li>Consumers reported in the Area Case Studies that accessing to counselling and related programs usually provided by allied health workers is very difficult.</li> </ul>
	Obj 26	To encourage continuing education for all mental health professionals.	<b>Not known</b> <ul style="list-style-type: none"> <li>No data relevant to these objectives have been published.</li> </ul>
Legislation	Obj 27	To ensure that mental health legislation across Australia is consistent and that it affirms the rights contained within the Australian Health Ministers' Statement of Rights and responsibilities and UN Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care	<b>Moderate progress:</b> <ul style="list-style-type: none"> <li>See Objectives 1 and 2.</li> </ul>
	Obj 28	To ensure that legislation in other sectors is consistent with the principles set out in the National Mental Health Policy	
Research and Evaluation	Obj 29	To promote increased basic and applied mental health research and its application in prevention and intervention programs.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>See Objectives 17 and 18.</li> </ul>
	Obj 30	To institute regular review of outcomes of services provided to persons with serious mental	<b>Moderate progress</b> <ul style="list-style-type: none"> <li>Work has commenced to develop national standards for outcome evaluation.</li> </ul>

POLICY CATEGORY	Obj No	OBJECTIVE Description	Summary of Progress
		health problems and mental disorders as a central component of mental health service delivery.	<ul style="list-style-type: none"> <li>Routine assessment of consumer outcomes has been established in very few mental health services.</li> <li>Strategies directed to improving service quality and effectiveness are the priority for future years.</li> </ul>
	Obj 31	To develop a national mental health data strategy.	<b>Minor progress</b> <ul style="list-style-type: none"> <li>A National Mental Health Information Strategy has been in place since 1993 to guide information development activities.</li> <li>Agreement achieved on a minimum data set for mental health inpatient services, but not yet for community-based services.</li> <li>Information infrastructure to support service development and quality improvements is grossly undeveloped in most mental health services in Australia.</li> </ul>
Standards	Obj 32	To encourage the development of national outcome standards for mental health services and systems for assessing whether services are meeting these standards.	<b>Moderate progress</b> <ul style="list-style-type: none"> <li>See objective 30.</li> </ul>
	Obj 33	To ensure all mental health services have quality assurance programs	<b>Minor progress</b> <ul style="list-style-type: none"> <li>Several jurisdictions have introduced quality assurance as a condition of funding for mental health services.</li> <li>See also objectives 30 and 35.</li> </ul>
	Obj 34	To support appropriate professional bodies in developing protocols for clinical treatment.	<b>Minimal or no progress</b> <ul style="list-style-type: none"> <li>Few professional bodies have developed mental health clinical protocols.</li> <li>Major concerns regarding service quality suggest that this needs to be a priority in future years.</li> </ul>
	Obj 35	To encourage each mental health facility to be fully accredited by an independent and recognised accreditation body.	<b>Moderate progress</b> <ul style="list-style-type: none"> <li>By February 1996, 25% of stand alone psychiatric hospitals and 67% of colocated psychiatric units were accredited by the Australian Council on Healthcare Standards.</li> <li>New national standards for mental health services were released in 1996, covering both inpatient and community services.</li> <li>Implementation of these by the States and Territories will determine extent of progress over the next few years.</li> </ul>
	Obj 36	To ensure that all services satisfy the standards and rights contained in the UN Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care and the Australian Health Ministers mental health statement of rights and responsibilities.	<b>Minimal progress:</b> <ul style="list-style-type: none"> <li>Despite significant legislative change, consumers report that these do not ensure that treatment is delivered with an emphasis on dignity and respect.</li> <li>The need to be treated with dignity and respect was identified as the highest future priority by consumers responding to the Area Case Studies survey.</li> </ul>
Monitoring and accountability	Obj 37	To develop nationally agreed measures of performance in relation to each of the objectives in this policy and others which the Commonwealth, States and Territories regard as indications of performance in relation to this	<b>Substantial progress:</b> <ul style="list-style-type: none"> <li>Performance measures to monitor the National Mental Health Strategy were agreed in 1992. and have been regularly published in the annual National Mental Health Report.</li> <li>Accountability arrangements for the National Mental Health Strategy are often cited as a model for other</li> </ul>

POLICY CATEGORY	Obj No	OBJECTIVE Description	Summary of Progress
	Obj 38	<p>policy.</p> <p>To report annually and publicly, in a timely fashion, on the progress of the Commonwealth and each State and Territory in relation to these performance indicators and to compare them to their previous performance.</p>	<p>public policy areas.</p>