

- Change or development in policy and practice, or method—whether it be in mental health treatments, organising of systems or quality improvement, smoking bans, trying to implement ‘reforms’ in the *Mental Health Act 2014* (Vic), with less than full service provider enthusiasm and engagement—is likely to result in unintended consequences (like ‘side effects’) even with originally good intentions. Considering consumer perspective evidence, discussion and thinking can help navigate towards new understandings.
- The mental health–physical health nexus has been a markedly under-recognised and under-resourced problem for a long time. Consumer advocates and researchers, with service provider ‘allies’ are becoming change agents in this area and efforts to address this issue are dramatically increasing.

MANY ASSUMPTIONS ABOUT CONSUMERS UP FOR CHANGING

Consumer perspective surveys and workshops have shown over decades that consumers want to be treated ‘as human beings’, with empathy, and that they who have a duty to treat, care, or support us can also ‘walk a mile in my shoes’; to be spared being viewed as some ‘other’ lesser type of person; that we have enormous, yet unfulfilled human potential; that we are capable of learning and working effectively in many ways given the right opportunities; and having different or non-typical ways of viewing the world, which may sometimes sound strange, may somehow be a source of diversity in the world and may not necessarily equate with mental illness; and many consumers speak about unfavourable experiences related to stigma and discrimination both within the system and in the wider community.

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Instead of being seen as threats to society, we will be seen as a source of wisdom that we have obtained through our recovery (Fisher, 2017).

1.4.11 MENTAL HEALTH POLICY AND EVALUATION

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The quality, effectiveness and efficiency of mental health systems are increasingly under scrutiny, not least because consumers, carers and other stakeholders are making themselves informed and are demanding systems that meet community need. Since its inception in 1992, the *National Mental Health Strategy* (the Strategy) has had a focus on monitoring and evaluation to achieve these goals, articulated in the themes of each of five National Mental Health Plans (Plans). This section provides a brief overview of the role of monitoring and evaluation in mental health policy in general, and the Strategy in particular. It provides two examples of monitoring and evaluation activities that have occurred within the Strategy—one in the specialised public mental health sector and one in the primary mental health sector.

MONITORING AND EVALUATION IN (MENTAL) HEALTH POLICY

Monitoring and evaluation are key mechanisms to enable governments to report to stakeholders on progress achieved under a policy or plan. Monitoring and evaluation have related but distinct functions. Monitoring the performance of a policy (or program) involves routine data collection and analysis to determine how well it is functioning, when compared against expected outcomes or processes (World Health Organization, 2013). Key performance indicators (KPIs; measures of input, output or outcome) are the basis for monitoring. Ideally, targets will also be determined for a given indicator, to enable judgements about whether intended aims have been achieved and whether adjustments in

response to observed rates of progress are required. Various health performance frameworks exist that can be used to guide the development of indicators for health policy, systems or programs. For example, Australia's National Mental Health Performance Framework sets out a suite of 15 indicators organised according to the system performance domains of effectiveness, appropriateness, efficiency, responsibility, accessibility, sustainability, capability, safety and continuity (Australian Institute of Health and Welfare, 2015b).

In contrast, evaluation is a process of systematic, in-depth examination to determine the value or effectiveness of a policy (or program; see World Health Organization, 2013b). Evaluation should play a role in each stage of the policy cycle—from priority setting and the development of options or initiatives, to implementation, to evaluation. Evaluation frameworks guiding policy and program evaluation, including the World Health Organization's *Monitoring and Evaluation of Mental Health Policies and Plans* guidance, (World Health Organization, 2007) typically distinguish three categories of evaluation (described below) with a comprehensive evaluation ideally including all three:

Content evaluation is concerned with characteristics of the policy/plan itself and how it was developed. It focuses on the activities undertaken during initial stages of the policy cycle, however its findings can also assist in the design or interpretation of implementation and impact evaluations. Content evaluations take many forms, including: review of the alignment between policy elements and the evidence base or requirements the policy was designed to address; structured comparisons of policy elements with those of other relevant policies or best practices in policy development; the extent to which key stakeholders were involved in the development process; and program logic models to identify measures against which the policy may be monitored and evaluated (Centers for Disease Control and Prevention, 2014; World Health Organization, 2007).

Implementation evaluation is concerned with monitoring whether the options or initiatives outlined in the policy/plan were implemented as intended. Implementation evaluations are typically descriptive in

design, and may include: mapping the extent to which initiatives have been implemented (as measured by, for example, the elements put in place, associated resources or expenditure, timeliness of implementation, and geographic or target population coverage); comparing variations in implementation across geographical areas or other meaningful units; and gathering qualitative data to explore factors that facilitate or hamper implementation or that contribute to variation (Centers for Disease Control and Prevention, 2014; World Health Organization, 2007).

Impact evaluation is concerned with assessing the objectives of the policy or outcomes of interest, and the extent to which these can be attributed to the implemented options or initiatives. Outcomes may be defined in terms of health-related characteristics in the target population or associated costs or cost-benefits. Examples of impact evaluations include: experimental and non-experimental studies that examine changes in measures of outcome over time or between groups (Centers for Disease Control and Prevention, 2014; World Health Organization, 2007).

MONITORING AND EVALUATION OF AUSTRALIA'S NATIONAL MENTAL HEALTH STRATEGY

The Strategy has been implemented via five National Mental Health Plans spanning the period 1993–2022 (Australian Government, 2017; Australian Health Ministers, 1992a, 1998, 2003, 2009). From 1993 to 2011, the *National Mental Health Report* (Department of Health and Ageing, 2013) was the key means of publicly monitoring and reporting progress towards agreed goals and initiatives under the Strategy. Data on Australia's mental health system are currently published in several other reports including: the *Mental Health Services in Australia* report series (Australian Institute of Health and Welfare, 2014a), prepared annually by the Australian Institute of Health and Welfare; the Productivity Commission's annual *Report on Government Services* (Productivity Commission, 2014), the National Mental Health Commission's *National Report Card on Mental Health and Suicide Prevention* (National Mental Health Commission, 2013), and the *Roadmap for*

National Mental Health Reform 2012–2022 (Council of Australian Governments, 2012). In addition to ongoing monitoring and reporting, the first three plans were subject to specific evaluations or reviews of varying scope (Grace et al., 2017), which have informed its ongoing directions.

Evaluation of the effectiveness and appropriateness of the First Plan (1993–1998; Australian Health Ministers, 1992) in 1997 involved review of the Strategy's impact in four local communities (including consumers, carers, mental health professionals and other professionals), consultation and survey views of national peak bodies (from 182 national organisations representing health professionals, consumers and carers), review of source data collected for the first *National Mental Health Report* (Australian Government, 1994) and expert review by the US Centre for Mental Health Services of appropriateness of national mental health policy settings (National Mental Health Strategy Evaluation Steering Committee, 1997). The evaluation reported improvements in the relative mix of inpatient and community services, and intersectoral links between mental health and housing and employment services (National Mental Health Strategy Evaluation Steering Committee, 1997). It also identified a need to expand the scope of reform from a focus on specialised mental health services to incorporating a broader population-focused approach, inclusive of primary care and less severe mental disorders (National Mental Health Strategy Evaluation Steering Committee, 1997). As a result, the scope of the Second Plan (Australian Health Ministers, 1998) was expanded to encompass a broader range of services (including mental health promotion, mental illness prevention and destigmatisation) and high prevalence disorders (depression and anxiety).

A two-stage review (Australian Health Ministers' Advisory Council, 2003; Thornicroft & Betts, 2002) of the Second Plan's (1998–2003; Australian Health Ministers, 1998) appropriateness, progress and effectiveness involved consultations with 350 stakeholders, including consumers, carers, non-government organisations, mental health professionals and their representative organisations, state, territory

and Commonwealth officials, researchers, and a range of service providers. The first stage engaged international expertise (Thornicroft & Betts, 2002) and expert commentary from the United States and UK. The second stage involved national community consultation, a review of available data and a review of mental health in the Australian Health Care Agreements (Australian Health Ministers' Advisory Council, 2003). Evaluation findings presented a paradox. It reported both that significant progress had been made in mental health reform, but also that consumer dissatisfaction and unmet need were still high. The review also identified that further work was needed to ensure full and meaningful participation for consumers and carers, continuity of care, and a focus on priority populations, and, significantly, on service quality and monitoring. These findings led to the adoption of a population health approach in the Third Plan (Australian Health Ministers, 2003), which focused on reform in the areas of promotion and prevention, access and responsiveness (particularly for Indigenous populations, forensic populations and people with complex needs), strengthening service quality and fostering innovation (Australian Health Ministers, 2003).

Summative evaluation of the Third Plan (2003–2008; Australian Health Ministers, 2003) considered whether Australia had continued to make progress implementing the objectives of the Plan, and whether implemented programs or actions had affected reform of the mental health sector (Curie & Thornicroft, 2008). It involved a review of key documents, targeted consultations with 90 stakeholders about the effectiveness and appropriateness of the plan (Curie & Thornicroft, 2008). The evaluation made key recommendations for the development of the next mental health plan, including on workforce development, service models, consumer and carer participation, recovery orientation and a coordinated whole of government approach (Curie & Thornicroft, 2008). It also repeated calls for improvements in performance monitoring. Evaluation findings influenced the Fourth Plan which specified priorities for collaborative government action, identifying 34 reform actions to be undertaken across five priority areas, namely: social inclusion and recovery; prevention and early intervention; service

access, coordination and continuity of care; quality improvement and innovation; and accountability (Australian Health Ministers, 2009).

There has not been a formal, public evaluation of the Fourth Plan (2008–2014; Australian Health Ministers, 2009).

In 2014 the National Mental Health Commission conducted a *National Review of Mental Health Services and Programmes* which examined the efficiency and effectiveness, and overall investment and spending, of Commonwealth-funded services and programmes (National Mental Health Commission, 2014c). The review recommended shifting funding priorities from hospitals and income support to community and primary health care services that increase service access to decrease preventable hospitalisations and support people to live contributing lives (National Mental Health Commission, 2014c). Consequently, commencing in July 2016, the Australian Government tasked its 31 Primary Health Networks (PHNs) with leading mental health planning and integration at a regional (area-based) level in partnership with state and territory governments and non-government organisations (Australian Government Department of Health, 2015). PHNs received a flexible funding pool to redesign the primary mental health system using a stepped care model intended to efficiently match service intensity with individual need (Australian Government Department of Health, 2015). Services are intended to target Aboriginal and Torres Strait Islander people, people at risk of suicide, people with severe and complex mental illness, and youth (Australian Government Department of Health, 2015).

The Fifth Plan (2017–2022; Australian Government, 2017) identifies eight priority areas influenced by the National Mental Health Commission's review (National Mental Health Commission, 2014) and the Australian Government's response (Australian Government Department of Health, 2015) to the findings of the review. The priority areas are: (1) achieving integrated regional planning and service delivery, (2) suicide prevention, (3) coordinating treatment and supports for people with severe and complex mental illness, (4) improving Aboriginal and Torres Strait Islander

mental health and suicide prevention, (5) improving the physical health of people living with mental illness and reducing early mortality, (6) reducing stigma and discrimination, (7) making safety and quality central to mental health service delivery, and (8) ensuring that the enablers of effective system performance and system improvement are in place (Australian Government, 2017). Indicators for measuring change are described for each of the eight priority areas, but specific targets are not defined. The Fifth Plan indicates that the National Mental Health Commission will deliver an annual report on the Plan's implementation progress and 'performance against identified indicators once baselines have been established' (Australian Government, 2017, p.17). At the time of writing, 17 of the 24 indicators could be reported on in some form; the remaining seven are not currently reportable but could be potentially reported within the life of the Fifth Plan, contingent on investment and data development. The Fifth Plan also notes that it will be evaluated in its final year using annual reporting and targeted consultations with stakeholders (governments, consumers, carers, mental health sector; Australian Government, 2017).

MONITORING AND EVALUATION OF SELECTED MENTAL HEALTH POLICY INITIATIVES

Routine outcome monitoring and reporting in Australia's specialised public sector mental health services

From the outset, the Strategy sought to advance routine outcome measurement (ROM) and casemix classification as a means of monitoring the quality, effectiveness and efficiency of mental health services. Australia was the first country to implement ROM comprehensively within publicly funded mental health services.

In the late 1990s, under the Second Plan, bilateral agreements between the Australian Government and all states and territories were signed. These committed the states and territories to routinely collect and submit outcome and casemix data in their specialised public sector mental health services and the Australian Government to support the development of necessary

infrastructure (Burgess, Coombs, Clarke, Dickson, & Pirkis, 2012). A National Outcomes and Casemix Collection (NOCC; Commonwealth of Australia, 2018) was progressively implemented in all inpatient and community-based services in this sector from 2001. The NOCC protocol specifies a suite of clinician- and consumer-rated measures to be completed at set points in the consumer's episode of care (i.e., admission, review and discharge), depending on the service setting (inpatient, residential and ambulatory), and the age group of the consumer (children and adolescents, adults and older persons). These arrangements are now firmly embedded; in 2012-13, 85% of services were collecting routine outcome data (Department of Health and Ageing, 2013).

Since 2003, the Australian Mental Health Outcomes and Classification Network (AMHOCN) consortium has undertaken data management, training and development, and analysis and reporting of the NOCC on behalf of the Australian Government. One area of focus has been the development of approaches to public reporting, informed by best practice principles (Burgess et al., 2012). AMHOCN regularly reports outcome data at national and jurisdictional (i.e., state/territory) levels, partitioned by age group and service setting. Reporting was initially via a suite of 'paper-based' standard reports and later via an online 'reports portal' which provides users with greater flexibility to tailor reports to their requirements. AMHOCN has supported states and territories to utilise their own outcome data and to benchmark against each other to identify opportunities for system improvement (Burgess et al., 2012). Given the complexity of the NOCC data, and the potentially sophisticated questions that can be asked of it, a Reporting Framework was developed to provide users with guidance on generating and interpreting reports at a local level. An online Web Decision Support Tool (wDST) provides a user interface to assist a greater range of stakeholders to query the NOCC data at national and state/territory levels. The wDST has evolved over more than a decade in response to the changing needs of users with respect to its functionality and utility. The most recent developments allow for the results of multiple queries to be displayed simultaneously. For example, scores on clinician- and consumer-rated measures can be displayed side-

by-side, which provides an opportunity to promote engagement with the consumer/family around different perspectives on mental health status. (Details of these reporting approaches are at: AMHOCN, 2020; NOCC Reporting).

AMHOCN has also played a role in the monitoring of mental health policy through the development and operationalisation of KPIs measuring the effectiveness of mental health services (Burgess et al., 2012). For example, 'Change in mental health consumer's clinical outcomes (MHS KPI 1)' is one of the 15 KPIs developed under the National Mental Health Performance Framework (Australian Institute of Health and Welfare, 2018a) and is one of the 24 indicators (PI 14) for monitoring the Fifth Plan. For this indicator, pairs of baseline and follow-up scores on the Health of the Nation Outcome Scales are measured separately for adults, children and adolescents and older people. The key clinician-rated measures in the NOCC are classified as 'significant improvement', 'significant deterioration' or 'no significant change' using the effect size metric, and reported separately for three groups of consumers (consumers discharged from hospital, consumers discharged from ambulatory care, and consumers in ongoing ambulatory care). Such analyses have demonstrated that people in contact with public sector mental health services do achieve significant improvements, and documented how outcomes vary according to service setting and between collection occasions (Burgess, Pirkis, & Coombs, 2006).

Evaluation of Access to Allied Psychological Services (ATAPS)

Introduced under the Second Plan, Access to Allied Psychological Services (ATAPS) was the first national policy initiative to provide community access to government-funded primary mental health care. ATAPS operated from July 2001 to June 2016 and enabled GPs (and later other providers) to refer individuals with common mental disorders (anxiety or depression) to mental health professionals for free or low-cost, short-term evidence-based psychological treatment (Australian Government Department of Health and Ageing, 2012). Services were delivered Australia-wide through capped fund-holding arrangements

that were administered by regionally based primary health care organisations (Australian Government Department of Health and Ageing, 2012). Due to the introduction of complementary primary mental health care policy initiatives (Better Access, which is larger in scale, and funded on a fee-for-service basis via the Medicare Benefits Schedule (MBS; Pirkis et al., 2011) and headspace targeting young people aged 12–25 years (Bassilios, Telford, Rickwood, Spittal, & Pirkis, 2017), new ATAPS sub-programs were introduced. These sub-programs targeted specific hard-to-reach groups or offered flexibilities service delivery (e.g., unlimited number of sessions, beyond in-person treatment options, sessions devoted to parents as part of treatment of children, leniency in requirement for formal diagnosis; Reifels et al., 2013).

From the outset, there was government commitment to evaluating ATAPS. The evaluation was unique in that it commenced with the introduction, and continued until the conclusion, of ATAPS. The evaluation focused on whether ATAPS had improved access to primary mental health services and, in turn, mental health outcomes for people with high prevalence disorders. The evaluation approach was both formative, assessing implementation processes or how the program operated, and summative, assessing the program's impact and outcomes to inform government decisions regarding the development of the program (Ovretveit, 1998). Consequently, the evaluation design was multifaceted, evolving in response to changes in the initiative and incorporating a range of data sources and analysis approaches. Quantitative program utilisation data from a purpose-designed national minimum dataset provided breadth of information and was complemented by qualitative data from stakeholder consultations to provide depth of information. Triangulation (Ovretveit, 1998; Patton, 1990) of the various data sources strengthened the evaluation by producing findings that pointed in a similar direction.

Evaluation showed that ATAPS was an integral part of the primary mental health care system in Australia. Its reach was substantial in the context of its capped funding with 530 000 treatment episodes (in 2.6 million sessions) provided from July 2013 to June 2016 (Bassilios, Nicholas, et al., 2017).

Over one-third of treatment episodes specifically targeted hard-to-reach groups—for example, of the total patients reached, 33% were males, 64% on low incomes, 8% children, 7% Indigenous people, 34% received mental health treatment for the first time, 6% were at risk of suicide and 1% homeless (Bassilios, Nicholas, et al., 2017). Improving access for these subpopulations was facilitated by the previously mentioned service delivery flexibilities (Reifels et al., 2013) that are unavailable through its uncapped mainstream counterpart, Better Access. Finally, patient outcomes, which were available for around 11% of total treatment episodes, indicated statistically significant clinical improvement (Bassilios, Nicholas, et al., 2017).

Lessons learned from the evaluation of ATAPS, together with the 2014 *National Review of Mental Health Services and Programmes* (National Mental Health Commission, 2014), have influenced the previously mentioned PHN-led policy reforms in primary mental health that commenced in July 2016 including commissioning ATAPS-like services. For example, recommendations such as rationalising the number of outcome measures, comparing interventions introduced as part of the reforms to treatment as usual, and eliciting service experience feedback from consumers (Bassilios, Nicholas, et al., 2017) have been adopted in the evaluation of the new reforms (Department of Health, 2016).

IMPROVING MONITORING AND EVALUATION

Australia is a leader in the implementation of national outcome data collection systems, such as the examples described above. However, the quality of the data and ensuring its clinical utility could be enhanced (Whiteford & Buckingham, 2005). There is also a need to embed outcome data in robust processes of systemic quality service improvement. Furthermore, not all parts of the mental health system are routinely monitored; for example, national outcome data sets do not exist for all office-based private practice psychiatry and psychology including services provided through the MBS (Crome & Baillie, 2016). Addressing such gaps in monitoring could

improve our overall understanding of the performance of Australia's mental health system and inform associated policy development.

The Strategy has evolved based on evaluation findings of the respective plans and has included KPIs, but a notable gap is the specification of targets that would facilitate measurement of whether objectives have been met. An analysis of policy success and failure in formal evaluations of the Strategy from 1992–2012 reported an overall improvement in the development and application of policy levers (e.g., organisation, regulation, finance, community education, payment) but highlighted variations in evaluation depth over time and difficulties matching indicators to specific reform objectives due to lack of correspondence between individual initiative and population level outcomes (Grace et al., 2017). Other analyses of Australia's approach to performance monitoring of mental health suggested there were gaps and problems, including the difficulty in establishing a link between outcome data and processes of quality improvement (Rosenberg et al., 2015; Rosenberg & Salvador-Carulla, 2017).

There have also been systematic attempts to identify policy-relevant gaps in mental health research including the extent of alignment of funding (and publications) with epidemiological evidence and stakeholder priorities, comorbid physical illness, digital mental health care and suicide prevention. Findings suggest that research publications and funding are not necessarily aligned with burden of disease and stakeholder priorities; for example, a study of these indicators in Australia in 2008 revealed that the areas of suicide and self-harm, personality disorders, anxiety disorders, childhood conditions and dementia were all insufficiently funded (Christensen, Batterham, Griffiths, Gosling, & Hehir, 2013). Using the World Health Organization Mental Health Action Plan 2013–2020 as a framework, an analysis of state and federal policies on mental and physical illness found that related policy attention had grown but policies and their implementation were inconsistent and insufficiently interconnected, therefore calling for a coherent national framework to guide system reform and address this shortcoming (Happell et al.,

2015). Digital mental health interventions have rapidly proliferated over the past decade, accordingly, research focusing on policy development and implementation planning including issues such as financing and governance is needed (Meurk, Leung, Hall, Head, & Whiteford, 2016). A review of current and future priorities in Australian suicide prevention research from 2010–17, based on journal articles and funding, reported that epidemiological studies seemed to be a focus, but intervention studies had declined even though stakeholders had consistently deemed intervention studies to be the highest future research priority for real advancement (Reifels et al., 2017). These gaps have been addressed in the priority areas of the Fifth Plan to varying extents.

CONCLUSION

Monitoring and evaluation of mental health policy is vital to determine the nature of, and reasons for, its achievements as well as areas requiring improvement. Australia's National Mental Health Strategy has evolved in response to evaluations and reviews. Although KPIs have been a component of the Strategy, specific targets that could inform evaluation have been lacking. Under the Strategy, Australia has been a pioneer in establishing systems for the routine monitoring and evaluation of major mental health programs but processes of systemic service quality improvement are yet to emerge.

1.4.12 EVIDENCE-BASED PRACTICE

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DEFINITION AND ORIGINS OF EVIDENCE-BASED PRACTICE

The terms evidence-based practice (EBP) and evidence-based medicine (EBM) are often used interchangeably, but for allied health and non-medical professional groups, the term evidence-based practice is more commonly used. Guyatt and colleagues