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Australian *National Standards for Mental Health Services*: a blueprint for improvement

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Abstract
The *Australian National Standards for Mental Health Services* (Commonwealth Department of Health and Family Services, 1996) were developed as a plank of the first *National Mental Health Plan* (Commonwealth Department of Human Services and Health, 1992). Over the two subsequent national five-year plans, they have become the basis for accreditation surveys for all Australian mental health services, both hospital and community components, whether acute or rehabilitation oriented, throughout the psychiatric career of all mental health service users and their families. The development and implementation of these standards are described. Innovations in this set of standards are detailed, specifying requirements of each phase of care, including access, entry, exit and re-entry, and the parallel development and training of paid consumer and family carer surveyors. Largely due to the brevity and clarity of these innovations, because of a broad consultation process, and incorporation of interventions and service delivery systems that are both evidence-based and congenial to service users, they have achieved a wide acceptance among, and championing by, service user and family carer networks. A recent review of the national standards was timely and welcomed, but is still incomplete, contentious in its protracted process, has a lack of consistent consultation and contains diluted and disorganised results. Implementation guides will now be developed to be superimposed on this revision in an attempt to improve and navigate it.

Key words
Australian *National Standards for Mental Health Services*; national; service improvement; leadership; accreditation.

Creating the national agenda for change

Mental health services in Australia have changed and evolved greatly over the past few decades. Deinstitutionalisation, which began in the 1950s and 1960s in Australia, changed the locus of psychiatric care from the hospital to the community. Mental health service funding has increasingly followed the consumer (ie. the service user) into the community.

Australia's *National Mental Health Policy* (Commonwealth Department of Health, Housing and Community Services, 1992) was launched by the then federal Minister of Health, Mr Brian Howe. Mental illness was identified in this document as the fifth most prevalent disabling condition in Australia. Consequently, mental health became a major part of the overall national health policy. Under this national health policy Australia, for the first time, developed a national mental health strategy that has since been supported by successive national and state/territory governments on a bipartisan basis.

In 1991, the *Statement of Rights and Responsibilities* for people with mental illness was published (Commonwealth Department of Human Services and Health), followed in 1992 by the *National Mental Health Policy* (Commonwealth Department of Human Services and Health). Both have been major catalysts for change towards improving services and outcomes for people with mental illness, though some would argue that this has still not happened quickly or fully enough.

Some of the major elements of the first *National Mental Health Strategy* (Commonwealth Department of Human Services, 1994) include: participation of service users and family carers, mainstreaming psychiatric services within general health services, downsizing or closing stand-alone psychiatric facilities, changing the service mix of the psychiatric system, enhancing multidisciplinary teamwork, and increasing research/evaluation/quality activities, see ***Table 1***, opposite. The *National Mental Health Strategy* document (Commonwealth Department of Human Services and Health, 1994) set out the ambitious, yet achievable framework for reform. ***Table 1*** highlights the breadth and depth of the national objectives.

Three years later, the second *National Mental Health Plan,* gave greater emphasis to three major aspects: prevention of mental illness and promotion of mental health; partnerships (eg. between health and welfare, housing, general practice); quality and effectiveness (including implementing national standards). Annual reports of the progress towards service improvement continue to be published by the Commonwealth Government (Commonwealth Department of Health and Ageing, 2002). Further information is available from the Department and on their website: www.mentalhealth.gov.au.

The movement for change and innovation – origins of the standards

Australia's *National Mental Health Strategy* not only set out the agenda (see ***Table 1***, point 9), but also provided additional transitional funding to ease the financial burden on services as they adopted new systems of care. Grants were given for innovative projects, transitional programmes, evaluation of services and for many other purposes in order to ensure that services made progress in adopting the tenets of the national strategy.

We know that '*innovations are usually developed in response to the incentive system of the society*' (Fullan, 1982: 42). There were a number of incentives and pressures for Australian psychiatric services to change, and these were not only financial. The time was right – there was new research evidence that consumer outcomes were improved by community-based, integrated service systems (Hoult *et al*, 1984); there was a growing ground-swell of consumer and family support for change; there were local models of community-based services; there was government will and support at a national level. Increased national funding for mental health services and targeted transitional programmes assisted state/territory and local services to shift their emphasis of care in line with national directions.

Concurrently a new multidisciplinary, consumer and family inclusive conference began. The Mental Health Services (TheMHS) Conference Inc was one of the first independent forums where all the mental health stakeholder groups could showcase their work and learn from each other. TheMHS Conference has become a conduit for networking between services, and between

Table 1: First *National Mental Health Report* (1993)

Progress towards national policy objectives was reported as follows

1. Approach to monitoring	Information collected; consistency of data.
2. Service mix	Reducing and replacing psychiatric hospitals; size of separate psychiatric hospitals; 1992–93 investment in community services; targets and timetables for moving resources; upgrading the remaining institutions; community accommodation; decentralising resources; planning the framework for change.
3. Relationship between mental health services and the general health sector	Co-location of acute inpatient services with general hospitals; design of acute units; financing and organising mental health services to reflect mainstreaming and integration principles (including programme budgets and budget protection); case management and continuity of care.
4. Consumer rights and legislation	Mental health legislation; state initiatives towards legislative reform to protect consumer rights; establishment of consumer advisory committees.
5. Linking mental health services with other sectors	Anti-discrimination legislation; Commonwealth Government and national developments (disability reform, housing, Better Cities Programme, employment-related services, social security); state/territory government agency guidelines and formal interagency mechanisms.
6. Mental health workforce and impact of financing arrangements	Medical workforce; other issues.
7. Primary care services	Enhancing general practitioner roles; rural health workers; health professional training; Commonwealth-state review of primary care.
8. Carers (families) and non-government organisations	Non-government organisations; carers.
9. Standards	Develop national mental health standards.
10. Promotion and prevention	Mental health promotion; prevention programmes; research and primary prevention.
11. Research and evaluation	Mental health research; agency evaluation; national minimum dataset.

clinicians, consumers, families, managers, policy-makers, educators and researchers, in the public, private and non-government sectors. This has assisted in the dissemination of new ideas, the adoption of the principles of the national strategy, and benchmarking between services. TheMHS website is: www.themhs.org.

Like any innovation or change, the adoption and implementation of new systems of mental health care takes time. The process of developing national standards began in 1986, with the *Area Integrated Mental Health Service (AIMHS) Standards* (Rosen *et al*, 1989; Rosen & Miller, 1990; Rosen *et al*, 1991a; 1991b; Miller *et al*, 1991; Rosen *et al*, 1993). The AIMHS Standards are a detailed framework that encompass the phases of mental health care: initial contact/assessment; acute and short-term management; ongoing management/rehabilitation; long-term follow-up; and standards applicable across every phase of care. They were accompanied by *A Guide to Standards of Care and Quality Assurance for Area Integrated Mental Health Services* (Miller *et al*, 1991). This was a practical set of guidelines for mental health services which, at the time, were only beginning to integrate a quality agenda into their everyday practice. A distinct role for consumers and their families in evaluating services using these standards was mapped out (Miller, 1993), and was a precursor for the later development of the role of service users as accreditation surveyors in conjunction with the national standards.

Development of Australia's *National Standards for Mental Health Services*

The development of *National Standards* was a key element of the *National Mental Health Policy* (1992) for reforming Australia's mental health services. Australia developed *National Standards for Mental Health Services* over a 12-month period during 1996/97. They were to be applicable to all public and private mental health services across the country regardless of model, size or degree of specialty. The model of integrated public mental health services (integrating acute and long-term care, rehabilitation, inpatient and community services) was already well accepted and promoted by the *National Mental Health Strategy*. The emphasis on integrated services was the core of the development of standards, and was modelled upon the *AIMHS Standards*. Australia was one of the first countries to develop such overall standards.

The project to develop the *National Standards for Mental Health Services* was undertaken by a consortium composed of the Australian Council on Healthcare Standards (ACHS), the Community Health Accreditation and Standards programme (CHASP – now called the Quality Improvement Council – QIC) as well as the co-authors of the *AIMHS Standards*. The involvement of the two leading national health accrediting bodies, ACHS and CHASP, reflected the fact that the standards needed to be compatible with the existing standards for general health care provision in Australia. The degree of compatibility would later become critical as various systems of implementation and review were explored.

Australia's commitment to the United Nations General Assembly *Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1992) and to the Report of the National Inquiry into the Human Rights of People with Mental Illness (1993), ensured that the standards would be firmly based on the human rights of people using mental health services. This principle was a driving factor throughout the development of the standards.

Other factors shaping the *National Standards for Mental Health Services* were a strong commitment to the involvement of consumers at all levels of service provision (and, very importantly, in any review process attached to the standards), an emphasis on outcome rather than process in terms of service quality, and strong recognition that mental health services in Australia, although encompassing great variety, were increasingly becoming mainstreamed with general health care provision.

Additionally, the standards were to be relevant to every public and private mental health service in Australia and encompass a range of populations, specialties and geographical differences. Finally, the standards had to 'fit' the existing national approaches to general healthcare accreditation. This was to prove the most critical factor in determining successful national implementation.

The methodology used in the development of the standards strongly emphasised the involvement of stakeholders. A reference panel was established with representation of consumers, professional bodies, the states/territories, major service providers, academics and experts in the provision of mental health care. Through consultation with this group, an exhaustive consultation strategy was developed that involved 48 consultation events in 21 locations across Australia and over 2,000 written comments from individuals and organisations over a six-month period between the first and final draft of the standards.

Considerable effort was made to involve consumers with a range of experiences of mental health care in Australia. Small consultations were conducted in long-stay wards: there was formal consultation with the National Community Advisory Group (which represented a network of consumer and carer groups), specific meetings with carer groups, independent consumer groups and, on many occasions, individual consumers. Specific consultations were held with Aboriginal people with experience of the mental health care system. One important and very deliberate feature of the consultation methodology was that in every site there was a meeting of mixed stakeholders (consumers, carers and staff), and it was often the interaction at these events that yielded the most useful information and guidance. This consultation process has been a key factor in the general acceptance of the standards in the years that followed. Exposure drafts were sent out for comment to the large distribution list of people who were consulted at three separate stages of the development of the standards.

Then, the standards were pilot tested for relevance, usefulness and clarity in a number of mental health service settings. Twelve months after the project started, and with considerable national interest in the project and substantial momentum from consumers for the promise of the standards to be a reality, the standards were submitted to the Australian Commonwealth Government and endorsed by the Australian Health Ministers Advisory Committee (AHMAC). The final set consisted of 11 overall standards (see ***Table 2***) with indicators and examples, published in a concise and accessible form.

The Commonwealth Government wholeheartedly committed itself to the public dissemination of the standards, with some 10,000 free copies distributed to mental health services, service users, carers and other stakeholders. This early and massive distribution of the standards was designed

Table 2: Overview of *National Standards for Mental Health Services* (1996)

Number	National Standards for Mental Health	
1	Rights	The rights of people affected by mental disorders and/or mental health problems are upheld by the mental health service (MHS).
2	Safety	The activities and environment of the MHS are safe for consumers, carers, families, staff and the community.
3	Consumer and carer participation	Consumers and carers are involved in the planning, implementation and evaluation of the MHS.
4	Promoting community acceptance	The MHS promotes community acceptance and the reduction of stigma for people affected by mental disorders and/or mental health problems.

Continued...

Table 2: Overview of National Standards for Mental Health Services (1996) (...continued)

Number	National Standards for Mental Health	
5	Privacy and confidentiality	The MHS ensures the privacy and confidentiality of consumers and carers.
6	Prevention and mental health promotion	The MHS works with the defined community in prevention, early detection, early intervention and mental health promotion.
7	Cultural awareness	The MHS delivers non-discriminatory treatment and support which are sensitive to the social and cultural values of the consumer and the consumer's family and community.
8	Integration	
8.1	Service integration	The MHS is integrated and co-ordinated to provide a balanced mix of services which ensure continuity of care for the consumer.
8.2	Integration within the health system	The MHS develops and maintains links with other health service providers at local, state and national levels to ensure specialised co-ordinated care and promote community integration for people with mental disorders and/or mental health problems.
8.3	Integration with other sectors	The MHS develops and maintains links with other sectors at local, state and national levels to ensure specialised co-ordinated care and promote community integration for people with mental disorders and/or mental health problems.
9	Service development	The MHS is managed effectively and efficiently to facilitate the delivery of co-ordinated and integrated services (this standard includes criteria on organisational structure, planning, funding, resource allocation, staff training and development, information systems, service evaluation, outcome measurement, research and quality improvement).
10	Documentation	Clinical activities and service development activities are documented to assist in the delivery of care and in the management of services.
11	Delivery of care	The care, treatment and support delivered by the MHS is guided by the principles of: choice, social, cultural and developmental context; continuous and co-ordinated care; individual care; least restriction.

Continued...

Table 2: Overview of National Standards for Mental Health Services (1996) (...continued)

Number	National Standards for Mental Health	
11.1	Access	The MHS is accessible to the defined community.
11.2	Entry	The process of entry to the MHS meets the needs of the defined community and facilitates timely and ongoing assessment.
11.3	Assessment and review	Consumers and their carers receive a comprehensive, timely and accurate assessment and a regular review of progress.
11.4	Treatment and support	The defined community has access to a range of high-quality mental health treatment and support services.
11.4a	Community living	The MHS provides consumers with access to a range of treatment and support programmes which maximise the consumer's quality of community living (in self-care, leisure, recreation, education, training, work and employment; family, relationships, social and cultural system).
11.4b	Supported accommodation	Supported accommodation is provided and/or supported in a manner that promotes choice, safety and maximum possible quality of life for the consumers (supported accommodation provided by the MHS; accommodation provided by agencies other than the MHS).
11.4c	Medication and other medical technologies	Medication and other medical technologies are provided in a manner that promotes choice, safety and maximum possible quality of life for the consumer.
11.4d	Therapies	The consumer and the consumer's family/carer have access to a range of safe and effective therapies.
11.4e	Inpatient care	The MHS ensures access to high quality, safe and comfortable inpatient care for consumers.
11.5	Planning for exit	Consumers are assisted to plan for their exit from the MHS to ensure that ongoing follow-up is available if required.
11.6	Exit and re-entry	The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Note: The term consumer is the most commonly accepted term used in Australia to refer to a person with a mental health problem or disorder. The term carer is the most commonly accepted term used to refer to the person's family and/or significant other people in their life.

to enable consumers and carers to express their need for service improvements. There are many examples of frustrated and angry consumers literally waving the standards boldly at directors of services, as evidence of the new legitimacy of their voice in the movement to reform mental health service delivery. It is this force, more than any other, that has contributed to the successful implementation of the standards.

In mid-1997, the consortium was once again funded to examine methods for the integration of the standards into existing national general health care accreditation/quality improvement mechanisms. At this time the largest national provider of health accreditation was the ACHS, which had recently launched a new process for monitoring standards and promoting quality improvement called EQuIP (Australian Council on Health Care Standards, 1996). The standards project team sought to test the appropriateness and effectiveness of the EQuIP methodology and the existing CHASP (Community Health Accreditation & Standards Project, 1993) methodology as a mechanism for reviewing services against the *National Standards for Mental Health Services*. What became immediately clear was that each of the existing methodologies was incompatible with the values and emphasis required by the standards. A third methodology, *Tools for Reviewing Australian Mental Health Services* (TRAMHS) was developed as a benchmark against which the other methodologies could be compared (Commonwealth Government, 1997).

A series of detailed pilot testing was conducted in a range of mental health services that reflected public, private, urban, remote, mainstream and institutional settings. Each pilot site involved reviewing the service over four to five days using one of the three methodologies. In one site, the TRAMHS was conducted by a hybrid ACHS/CHASP review team to explore the possibility of the two organisations delivering a collaborative review methodology.

The results of the pilot testing suggested that both the ACHS and CHASP methodologies had merit and that they could be used to review mental health services against the standards provided that there was some additional development of their own review tools and, in the case of the ACHS, changes in their selection of reviewers to ensure the involvement of consumers, carers and non-medical or nursing mental health professionals. Although TRAMHS was a long and detailed methodology, it was considered to be rigorous, and strongly consistent with the intent and values of the standards. It was recommended that the tools be distributed to mental health services in each state for the purpose of self-assessment and/or preparation for an ACHS or CAHSP review.

Implementation

Australia's federal/state/territory system of government produced considerable variation in implementation of the standards between the states and territories. Despite having *National Standards for Mental Health Services* and strong Commonwealth leadership for the development of the standards, it was left to the states and territories as to how they would implement the standards at a service level. A majority of services opted for ACHS to conduct reviews of mental health services using the *National Standards for Mental Health Services* within a modified EQuIP methodology. Nevertheless, some services conducted their monitoring through the CHASP (now QIC), and some opted for other generic auditing through, for example, the Australian Quality Council's system.

Overall, there has been progress in implementing the *National Standards* across Australia in the years since the consortium concluded its work. In particular, considerable innovation has come from consumer groups in marketing the key messages of the standards to other consumers (there have been fridge magnets, bookmarks, posters, standards festivals) and collectively maintaining the pressure on services locally and on government generally to continue their commitment to raising the quality of mental health care provision in Australia. The goal of the *National Mental Health Strategy* was to have all Australian mental health services accredited by June 2003. A funding agreement was signed by Commonwealth, State and Territory Governments to ensure that this would come to fruition. In fact, by June 2003, not all services were accredited, although most had booked their accreditation date.

Accrediting and monitoring the *National Standards for Mental Health Services*

The *National Standards for Mental Health Services* were built upon the United Nations *Principles on Human Rights*, and were designed to be mainstreamed into existing (and possible future) general health care accreditation systems. Hence the set of standards subsequently developed, focused on those issues specific to mental health services. Infrastructure standards such as fire, occupational health and safety, and governance, were not included in the *National Standards for Mental Health Services*, as the existing generic health care accreditation systems quite adequately covered these issues.

Accreditation is one major means of demonstrating that services have met the standards. From the outset, the Commonwealth Government stipulated that the monitoring (accrediting) of mental health services would be mainstreamed, ie. the same independent body accredits both general health and mental health. The two major accreditation organisations in Australian mental health services are: the Australian Council on Healthcare Standards (ACHS) and the Quality Improvement Council (QIC, formerly CHASP).

Applications of the standards

Accreditation is the summative evaluation of a mental health service. It is like the exam at the end of the school year, which is simply one measure of what the student knows. Continuous quality improvement (for example, using the TRAMHS tool) is like formative evaluation – it is continuous self-monitoring. There are numerous formative types of evaluation activities for which the standards may be used. For example as below.

1. State and territory governments may incorporate the standards into service and funding agreements and regularly monitor the achievement of the standards.
2. The standards can be used as a blueprint for the development of a mental health service.
3. Local services can use the standards as an agenda and/or a guide to service improvement, using the rating sheets.
4. Consumers and families/carers will know what to expect from their local mental health service and can use the standards to feedback into a service's planning, development and evaluation processes.
(Commonwealth Department of Health and Family Services, 1996: 4)

How should mental health authorities approach the whole question of improving services – by the carrot or the stick? In Australia, funding has been used as an incentive for services to monitor and improve their service. In the future, it could be possible for governments to link funding of mental health services to the attainment of certain standards, ie. the 'stick' approach. So far, governments have favoured the incentive approach. The *Standards* were designed to be able to be applied at different levels according to the development of the particular service. They can apply as minimal or operational standards for the more developed services, but can also apply as optimal standards for patchy or relatively under-developed services.

It is now more than 12 years since the initial development of the *Standards* and while some services are still striving to meet their requirements, there are now many services who are finding that the *Standards* need revision in order to be able to be applied as optimal standards (ie. something to aim towards). The first revision of the *Standards* in 10 years commenced in 2006 and at the time of writing this they have not yet been released publically. Although the Consortium that developed the *Standards* strongly recommended a standing reference group to monitor their application and to instigate regular reviews and updates, the National MHS Standards Implementation Committee was disbanded by the Commonwealth Government in 2003, and no review was instigated until late 2006.

Consumer confidence in standards

Standards are a common language by which we can communicate just what can be expected of an organisation in terms of the service it offers. What of consumer confidence in mental health services? Can the *National Standards for Mental Health Services* offer consumers any confidence that they will receive quality mental health services? Most organisations (not only

mental health organisations) today provide some form of guarantee of service, for instance, the electricity company, the railways, food manufacturers. National service standards should move towards providing the basis for a guarantee to consumers, of a certain level of mental health care. Consumers themselves have begun to develop their own systems for monitoring service standards. These have not yet reached the stage of a national auditing/monitoring system, but may well do so in the future.

Consumer participation

Mental health consumer participation in the early 1990s began with a National Consumer Advisory Group (NCAG) and State-Wide Consumer Advisory Groups (CAGs). During the 1990s, some mental health services employed and supported consumers to participate in a number of roles within the mental health services. By 2009, a range of consumer-run programmes and services exist across Australia, some are independent and others in partnership with government and non-government mental health services. These provide peer support, individual and systemic advocacy and consultation services. Fifteen years on, however, true partnerships in consumer participation remain patchy, insufficiently funded and supported, unco-ordinated at all levels of the organisation and there is a lack of peak leadership at state and national levels. Inconsistent practices, numerous awards, differing conditions of employment, poor professional development and unreasonable demands on consumer employees is common across Australia.

Consumer surveyors

The ACHS, the largest independent health care accreditation agency in Australia, now routinely includes trained consumer surveyors for the surveys of the larger mental health services. This had never been done before the *National Standards* project. In November 1999, eight consumers and two carers from across Australia attended the first training of consumer surveyors. In 2008, there were 13 consumer surveyors and the intention for this process to extend to general hospital and community health surveys.

Consumer surveyors have a unique role within the accreditation team according to their skills and knowledge, training, experiences and personal resilience. Mental health surveyors were more at ease with the transition towards including consumers on the survey team. However, a number of consumer surveyors reported experiencing poor acceptance and understanding of their role, professionalism and expertise. General health surveyors were less comfortable at first, but over the years many have adapted and have become more accepting. The stigma of mental illness is faced not only by the consumer surveyors but also at times by the whole mental health team.

Consumer surveyors participate in all aspects of the survey, attending presentations, interviewing senior management, staff, reviewing policies and other documents (except consumers' files), report writing and summation presentations. In addition, an important function of the consumer surveyor is to conduct focus groups with consumers, carers, staff (not held consistently) and community organisations.

Surveying provides an opportunity to observe practices, provide a conduit for the voice of local consumers and carers, participate in service development and appreciate the vast differences of service structures across city, regional, rural and remote service settings.

Consumer surveyors who have experience, skills, knowledge and confidence as consumer workers, representatives, advocates and/or consultants adapt to the role with ease, the functions being an extension of their current roles. Consumer surveyors are required to attend annual surveyor training and update days, encouraged to participate in ACHS training, web-based surveys and consultation on *Standards* reviews. Consumer surveyors are included on working parties, such as the review and development of *National Standards for Mental Health Services* and clinical/performance indicators. A peer support and consultation process has been established by the ACHS, with quarterly teleconferences for consumer surveyors with key ACHS staff.

Issues for accreditation of standards

Despite the overall optimism, there are a number of issues that create concern about the efficiency and efficacy of the accreditation process. In the past, surveyors had been

drawn from the ranks of senior managers and clinicians who were employed by mental health services and hence were not paid for their time. However, consumers and retired health professionals are paid by the accreditation bodies and so surveys have become more expensive for the local mental health service. Due to the high cost, mental health surveys are booked for fewer days than general health, with the mental health team arriving mid-survey. This has negative effects for team acceptance and bonding and the development of valid timetables to enable sufficient review of service structures, meeting with staff, consumers, carers and community partners, reviewing files, policies and procedures. There is a pressure to review services across numerous hospital and community sites, spend time with key managers and staff, review policies and procedures, and conduct sufficient file audits to be satisfied that services are being monitored in a safe and efficient manner. This can lead to incomplete reviews and ineffective reporting. It would be more effective if mental health accreditation were to be funded as a separate allocation from general health.

Some observers of the accreditation process express concern that services can be accredited without sufficient evidence of quality programmes, often due to lack of resources and poor leadership. Consumers, carers and the general public will continue to question the competency of the accreditation process unless services can clearly meet the *National Standards*, including adequate resources and good leadership.

Accountability at national and state government levels must be established, monitored and publicly reported to ensure that accreditation funding is quarantined and used proficiently.

Research and evaluation basis of the *National Standards*

The *National Standards for Mental Health Services* were developed from the current (at that time) evidence-based literature of mental health service systems, which had been demonstrated to produce desirable outcomes, from consumer, carer and service provider viewpoints.

The *National Standards* assist in producing better outcomes. They are outcome-oriented, encouraging services to systematically monitor outcomes, and to produce more desirable outcomes for consumers and their families. However, outcomes aren't everything. In Australia now there is a nationally mandated suite of outcome measures. These are integrated into the state/territory's information and assessment strategy thus constituting a process strategy (see: National Standard 11.3, on assessment; Standard 9.29 and 9.30, on service evaluation). This is implemented on the as-yet insufficiently tested assumption that such processes are intervening variables to improving service outcomes.

There have been significant empirical studies of quality improvement mechanisms, as well as quantitative applications of the *AIMHS Standards* and the *National Standards*. Quantitative research of the quality improvement arena has demonstrated encouraging trends, as reviewed by Norman Vogel, CEO of the Australian Quality Council.

> '*A rigorous, independent university study* (Hausner, 1999) *found a strong positive correlation between performance in the Australian Business Excellence Awards and improvements in organisations' key performance indicators* (KPIs), *including bottom-line results. The study shows that an increase in the Award's evaluation score is strongly associated with an improvement in KPIs. It proves that the application of* [... a quality framework...] *creates an organisation that learns, adapts and improves faster in all important areas. The framework creates innovative organisations by fostering those that have the ability to intentionally change to create or meet new opportunities.*' (Vogel, 2000)

The *AIMHS Standards Project* (the precursor to the *National Standards*) envisaged that there should be both quantitative and qualitative evaluation tools developed in plain language, for the use of practitioners and other stakeholders, without assuming any access to expert research staff. A central example of a quantitative strategy was the parallel development of the *Life Skills Profile* functional outcome measure (Rosen *et al*, 1989), which is now part of the nationally mandated suite of outcome measures for all Australian mental health services. At the same time, the *AIMHS Standards* were developed and became the core of the qualitative strategy.

In the Far West Health Service (of NSW, Australia), Hemming and Yellowlees (1996) qualitatively and statistically compared the ratings and responses of consumers and their case managers against the indicators of the AIMHS case management standard. A fairly strong correlation was found between consumers' and case managers' perceptions of case management services delivered by staff and received by consumers, eg. a negotiated, agreed plan, stating what both consumer and case manager will do, constituting a formal statement of reciprocal obligations.

The Consumer Outcome Assessment Tool (COAT) (Holmes, 2001) demonstrates an elegant consumer co-ordinated method of statistically trending the degree of attainment of *National Standards*, while demonstrating their linkage to management and key performance indicators.

Applications of the *National Standards*, eg. in clinical record audits, can be used as one arm of triangulated studies, which demonstrate that qualitative and quantitative methods can be used to mutually enrich and cross-validate each other, without assuming the prior value of one over the other. A study to develop evaluation strategies for the Richmond Implementation, a groundbreaking state mental health service reform agenda, developed a triangulated set of quantitative and qualitative tools including integrated hospital and community mental health service standards (Rosen *et al*, 1987). Subsequently the Factors Affecting Community Tenure (FACTS) study (Hobbs *et al*, 2000; Newton *et al*, 2000; Hobbs *et al*, 2002) monitored the effects of community resettlement on individuals who had been institutionalised from 2–40 years, by triangulating three very different methodologies and replicating a larger scale study (TAPS) in the UK. The quantitative method involved one research officer applying outcome measurement tools, the qualitative method involved a social anthropologist following each patient over the same period pre- and post-discharge and a health economics study was run in parallel. That the three different methodologies all resulted in positive findings for the intervention increased confidence in the results of this otherwise only quasi-experimental study. Another four-and-a-half year study of implementing early intervention in psychosis triangulated outcome measurements, clinical record audits and clinician attitudes using qualitative stages of concern methodology (Rosen *et al*, 2009).

Relating inputs, processes and outcomes of quality improvement at the macro (national/state) meso (local) and micro (individual service user) levels of service, is an application of the *Mental Health Matrix Model* (Thornicroft & Tansella, 1999), see ***Table 3***, opposite.

The heuristic value of this matrix organisation lies in its allowance for qualitative as well as quantitative inputs, processes and outcomes. Consistent with contemporary quality improvement methodologies, it emphasises the following.

- The importance of variables at the structural and process levels, while monitoring outcome variables, ie. an outcome focus is important but cannot purely be preoccupied with 'the bottom line', without concern for how the end does not always justify the means.
- There is a need to focus on systemic errors rather than blaming the individual clinician, and to use the former as an opportunity for constructive change.

An application of the matrix may help us to understand the systemic relations and impact of quality improvement processes, and the increasing involvement of consumer and family groups in the management of our services.

In response to ongoing community criticism of experiences of care, in 2004, the Mental Health Council of Australia (MHCA) and the Brain and Mind Research Institute (BMRI), University of Sydney, in association with the Australian Human Rights and Equal Opportunity Commission (HREOC) initiated a new national review – the report of which was entitled *Not For Service: Experiences of injustices and despair in mental health care in Australia* (2005). The goal of this review was to capture the current critical themes in mental health care from the perspective of those who use and deliver its services on a daily basis.

It was agreed by the MHCA, BMRI and HREOC that the most useful framework for organising the vast amount of written and verbal data collected through the consultation process was the *National Standards for Mental Health Services*.

Table 3: Relating inputs processes and outcomes of quality improvement methods at the macro, meso and micro levels of service (adapted from Rosen, 1999; in Thornicroft & Tansella, 1999)

	Input	Process	Outcome
MACRO: National/state	National accreditation mechanisms for all hospitals and community health organisations. State laws providing qualified privilege for quality assurance mechanisms involving clinicians. Statutory watchdogs: eg. Health Complaints Commission, Official Visitors.	*National Mental Health Service Standards* generated following nation-wide consultations with all stakeholders.	All states mental health services complete accreditation with *National Mental Health Standards* indicators.
MESO: Local service	Resources and infrastructure provided by management for professional peer review mechanisms. Consumer and family management advisory boards. Consumer monitoring and evaluation mechanisms.	Eg. QARNS (Quality Assurance Royal North Shore Hospital, Sydney). Eg. SUNS (Service Users North Shore – a consumer and family advisory board to management) community team or facility surveyors. Eg. Consumer network. Eg. Consumer consultants.	Corrective response by service to: • collated adverse events and trended data rates • consumers and family feedback to management • community visitors' survey reports • consumer satisfactory studies.
MICRO: Individual service user/consumer	Explicit and openly advertised complaints and comments mechanism strongly supported by consumer and family networks.	Monitoring of: a) Ease of access for both service user and family b) Quality of contact c) Information provided d) Nationally mandated suite of routine outcome measures.	Monitoring and adjust service in response to consumer's, family's or clinicians' perception of: • adverse outcome • good practice outcome • satisfaction with service.

Despite the fact that evidence was not specifically sought in order to prove or disprove the successful implementation of the *Standards*, the volume and consistency of the information demonstrates the gaps and the difficulties that governments have had in meeting these *Standards*. This report was careful to present the data as a cumulation of personal experiences rather than definitive proof of neglect of the *Standards*.

National Review of *National Standards for Mental Health Services*

In 2009 the *National Standards for Mental Health Services* are currently being revised. However, after a protracted and buffeting three-year process so far, the revised standards have not yet been released. This compares to a two-year process to publication and application for the original version, complete with extensive consultations and wide circulation of several exposure drafts. The current review process has been contentious, and has resulted in their potential compromising as credible accreditation standards. This federally commissioned and directed review of the *National Standards for Mental Health Services*, conducted by the Australian Council for Healthcare Standards, has resulted in their dilution, disorganisation and deletion of clear criteria ensuring that services should provide convenient community access, and deliver evidence-based technologies and specific recovery-oriented practices. The consultation process so far has been overly selective, sparse and patchy. This review has occurred in the context of the gradual downgrading of the national mental health reform strategy, from the second to the proposed fourth *National Five Year Plan*. In a rearguard attempt to improve the application of the revised standards, implementation guides are being developed to simplify their application for accreditation purposes, and to provide a matrix or map of different pathways for public, private, and non-government service providers to navigate their way through a convoluted maze of standards, criteria, guidelines and notes for implementation (Rosen, 2009).

One of the difficulties with the current type of review process is that the co-ordination and leadership roles have changed several times during the three-year period. This has lead to changes in direction, duplication of effort and a lack of historical knowledge of national standards. This sort of discontinuity of leadership at several levels means that each generation of leadership must start over again. It could be argued that fresh ideas can be brought to bear on the process with each new generation (a generation may last only a few months), however it is more likely that without specific expertise, a sense of history and an understanding of context, leadership is doomed to repetition and redundancy. Once the process and product of this current type of review begins to haemorrhage it is difficult for any leader to stem the flow and limit the damage.

A conundrum for those who commission the development and review of the *National Standards for Mental Health Services* is 'who should undertake this work?' Should it be the accrediting body that audits mental health services? The weakness of the current review process is that it was the accrediting body that was awarded the contract. They proceeded without mental health expertise within their own ranks to develop standards that neatly match their own accreditation system but which do not provide a blueprint for a good national system of mental health services. The strength of the consortium of 'bodies' who developed the 1996 set of *Standards* is that it not only included the expertise of the accrediting organisations, but it also included a mental health group with standards expertise. Additionally, the consortium's project leader was an experienced mental health clinician.

Conclusions

The *National Standards for Mental Health Services* have stood the test of time, but they were not meant to be permanently fixed at 1996 levels. They are not written in stone – but on paper and now electronically, so they can be revised – ever upwards. As one ceiling is reached, it becomes the floor for the next level of endeavour (Rosen *et al*, 1989). No service should become complacent. It is imperative that standards be revised at least every three to five years. The ultimate test of the *Standards* is that they must be shown to facilitate change towards better services for mental health consumers. As reported by Taylor and colleagues (2000) the implementation of the National Standards in the Northern Sydney Area Health Service, in Sydney, has led to increased consumer and carer participation in local services, an increased focus on improving outcomes, increased standardising of service delivery, an improving work culture, and fostering creativity to produce a quality improvement focused culture.

The National Standards for Mental Health Services (1996) have proved to be of great

value where they have been implemented systematically. However, in the few instances where they have been seen of questionable value, we must question whether local service providers and consumers have taken the time to become fully familiar with them, and their commitment to the participatory process of implementing them.

The mental health consumer movement has been the strongest advocate, most supportive custodian, guardian and champion of the *National Standards for Mental Health Services*. Unless the quality of the revised product can be restored and enhanced, it will now be up to services themselves to continue the path towards quality and effective mental health services.

Can the revised set of Standards (as yet unreleased) be salvaged and improved? However well-intentioned, it is doubtful that the implementation guides, currently being built, will be able to be more than a cosmetic papering-over of the flawed construction of the recent revision. These guides are being built over a shaky foundation and framework, which may well become clear to those who try to open the door and enter the set of Standards for detailed guidance.

To ensure real utility, a longer use-by date, and acceptability as a living document promising real service improvement to all stakeholder groups of the revised Australian Mental Health Service Standards, the Australian Government should intervene to restore and improve the requirements for:

a) specificity to mental health services
b) broad consultation with all constituencies in the Australian mental health community, including opportunities to comment on latest drafts of the standards before formal endorsement by the Federal Health Minister and publication
c) clarity and brevity of the standards and criteria, with concise concrete examples
d) criteria that can demonstrate real improvements over time of the services, in terms of actual implementation of mental health practices and service delivery systems, in line with recent advances in both quantitative and qualitative evidence
e) providing evidence of active co-ordination and holistic integration of clinical mental health, rehabilitation, recovery orientation, substance use, general health, and social services, leisure, social inclusion, housing and vocational services, and reciprocal working partnerships between public, private and non-government service sectors
f) universal applicability to all potential accreditation agencies, rather than being tailored to the generic needs and convenience of the agency that conducted the review.

Implications for leadership in practice

- All levels of leadership need to be consistent, persistent and guided by standards that provide a clear blueprint for service development, implementation and evaluation, based on current and emerging evidence.
- Mental health leaders need mental health expertise, therefore standards and policy development must be guided by people from all relevant disciplines with such expertise.
- Leadership needs to be shown by service director/managers, clinicians, consumers (people living with mental illness) and families/carers, for services to move forward with vision and practicality.
- The development, implementation and revision of the standards should be guided by a consistent standing expert steering group on a continuous basis.
- To enable leaders to move services to the next level of reform, standards must evolve, raising the bar for leading services, while encouraging lagging services to creatively lift their game within and despite their resources.
- Standards can be effective levers to achieve service quality improvement. They enable leaders to be goal-focused, translating standards into clear objectives and threshold values, which can easily be recognised by service providers, consumers, families and accreditation surveyors.

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Glossary of acronyms

ACHS – Australian Council on Health Care Standards
AHMAC – Australian Health Ministers Advisory Committee
AIMHS – Area Integrated Mental Health Services (Project)
CHASP – Community Health Accreditation and Standards Project
EQuIP – Evaluation, Quality Improvement Program
QIC – Quality Improvement Council
QSA – Quality Society of Australia
TRAMHS – Tools for Reviewing Australian Mental Health Services

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