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Shaping Mental Health Policy in Australia, 1988-2008

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ABSTRACT

This thesis uses the theoretical framework developed by John Kingdon to analyse, from the perspective of the Commonwealth government, the problems, policy solutions and political context that led to the opening of three mental health policy windows in Australia: the adoption of Australia’s National Mental Health Policy and first National Mental Health Plan in 1992, the adoption of the Second National Mental Health Plan in 1998 and the adoption of the Council of Australian Governments’ National Mental Health Action Plan in 2006.

Data was assembled from four sources: firstly political party documents, ministerial speeches, Parliamentary debates and government documents; secondly a systematic review of literature published in academic journals; thirdly interviews with key informants; and fourthly my own observations as an expert key participant in mental health reform. From a thematic analysis of data from the first three sources five themes emerged that describe the issues shaping the mental health policy debates over the twenty year period covered by the thesis. These themes are human rights and community attitudes, community need, service structures, service quality and effectiveness, and resources.

For each of the periods that led up to the opening of the policy windows in 1992, 1998 and 2006, the problems confronting the Commonwealth government and the policy solutions proposed were identified in each of the five thematic areas. The political response that occurred at each time is also discussed. For each policy window a set of defined problems and policy solutions, specific to that window, were identified. While taking action suited the political agenda of the government, each occasion was also associated with a highly publicised mental health issue that had dominated the media and demanded a policy response.

While mental health waxed and waned as a policy priority over
the twenty years covered by the thesis, it became progressively more important during this period with increasing engagement by government, civil society and policy entrepreneurs. This increasing focus has been influenced by high profile events given wide media coverage. The initial focus on improving services for people with severe mental illness broadened to include increased access to treatment for those with more common mental disorders and the need for population wide interventions including a focus on prevention and health promotion. The policy space in mental health became much more contested with multiple agendas within mental health competing for government attention.

Because the Kingdon model was used to organise the information collected it could not be used to also validate the model. However it was not difficult to find, for each policy window, clear problems, policy solutions and a political context within which the opening of the window occurred. The events shaping the political stream were largely independent of those shaping the problem and policy streams, which themselves were not independent of each other. In most cases, the individuals who had identified the problems were also promoting and advocating policy solutions to those problems. While the Kingdon model establishes a preconfigured cyclical dynamic and does not predict when a policy window might open, it did provide a useful framework for identifying and explaining factors important in mental health policy development and adoption.
ACKNOWLEDGEMENTS

At the end of 1986 I returned to Australia from Stanford University, California having completed a Research Fellowship in Psychopharmacology made possible by a Queensland government scholarship. My goal was to establish an academic research career in neuroscience but first I returned to my government job in the head office of the Division of Psychiatric Services in Brisbane. The work I started in that position from 1987 was the genesis for this PhD.

My experience over the next twenty-five years working in mental health policy and services with the Queensland and Commonwealth governments in Australia and internationally shaped the views which are expressed throughout the thesis.

It is impossible to name all the people who influenced me over the next quarter of a century, many of whom are rarely acknowledged for their expertise and commitment to improving the health system. My public service colleagues in Brisbane and Canberra have been a source of enduring support and it was largely from them I learned about public administration, something in which I had never been formally trained.

While I am fortunate to have made many friends and colleagues throughout my career, I particularly acknowledge Bill Buckingham with whom I have had the privilege to work on the issues covered in this thesis for the last twenty years. He critically reviewed earlier drafts of the thesis, as did Professor Brian Head from the University of Queensland.

I am grateful to the many clinicians, in the public and private sectors, and in the not-for-profit community sector in Australia and in countries throughout the world, who have helped me understand the breadth and nuances of service delivery.

Throughout my career I have maintained a clinical practice in psychiatry and this has reinforced for me that health policy and services exist only to improve the lives of individuals with mental disorder and to promote
the mental health of the population.
I must acknowledge my colleagues at the Queensland Centre for Mental Health Research. Their rich collegiality and desire for research excellence is second to none. Gemma McKeon and Roman Scheurer in particular provided assistance in data searching and in the thematic analysis.
I would like to thank Wayne Kratzmann and Christine Gee. The endowment from Toowong Private Hospital in Brisbane to the University of Queensland has supported my academic work since 2000.
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Special thanks must go to Karyn White who had the unenviable task of balancing the very many competing demands on my clinical and academic schedules whilst I was also completing this thesis. Lisa Badrick and Sarah Yeates showed amazing patience and expertise in ensuring the content of the thesis was presented in a form which not only met the University requirements but which also made it an eminently more readable document.
Final thanks go to my family, especially my wife Marianna Serghi. She has provided unfailing personal and intellectual support. Without her this thesis could never have been produced.
STATEMENT OF ORIGINALITY

This is to certify that to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any other degree or used for other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and the sources used have been acknowledged.

[Signature]

[Date]
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**ABBREVIATIONS**

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<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACHS</td>
<td>Australian Council on Healthcare Standards</td>
</tr>
<tr>
<td>ADGP</td>
<td>Australian Divisions of General Practice</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>AICAFMHA</td>
<td>Australian Infant, Child, Adolescent and Family Mental Health Association</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AIMHS</td>
<td>Area Integrated Mental Health Service Standards</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>ANAMH</td>
<td>Australian National Association for Mental Health</td>
</tr>
<tr>
<td>AOTs</td>
<td>Assertive Outreach Teams</td>
</tr>
<tr>
<td>BMRI</td>
<td>Brain and Mind Research Institute</td>
</tr>
<tr>
<td>CHASP</td>
<td>Community Health Accreditation Standards Program</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>DSA</td>
<td>Disability Services Act</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HREOC</td>
<td>Human Rights and Equal Opportunity Commission</td>
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<tr>
<td>MHCA</td>
<td>Mental Health Council of Australia</td>
</tr>
<tr>
<td>NATSIHC</td>
<td>National Aboriginal and Torres Strait Islander Health Council</td>
</tr>
<tr>
<td>NCAG</td>
<td>National Consumers Advisory Group</td>
</tr>
<tr>
<td>NMHETAG</td>
<td>National Mental Health Education and Training Advisory Group</td>
</tr>
<tr>
<td>NMHWG</td>
<td>National Mental Health Working Group</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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CHAPTER 1 - introduction

This thesis is about national mental health policy in Australia during the twenty years from 1988 to 2008. Specifically it is about the adoption of new policy directions by the Commonwealth government during this period. During those twenty years I worked in the mental health field as a clinician, as a director of mental health for a State government and for the Commonwealth government in Australia, for an international development bank and as an academic. Throughout this twenty year period I was involved in mental health policy development and implementation. At first I focused on the content of policy and how I thought service direction should be reformed to achieve better outcomes for patients. The perspectives I gained in these multiple roles have afforded me many opportunities to observe that the content of policy adopted by governments, and the timing of its adoption, often appears disconnected from the problems being experienced by patients and the community and from possible technical solutions. I therefore became increasingly interested in understanding why governments adopted certain policies and not others and this interest formed the basis for undertaking the research contained in this thesis.

Each wave of mental health policy development in Australia over the twenty years being studied was both applauded and criticised by different stakeholders, with escalating public scrutiny and political attention being paid to the area of mental health. The public debate preceding each major policy initiative was one of mental health care being in crisis due to failures of policy direction and/or implementation. This thesis analyses the three main waves of mental health policy development during the period, provides an explanation of how and why the Commonwealth government adopted the policy directions it did at the time and draws implications for policy development from an understanding of the actions of government in this sector.

Mental health policy aims to improve the mental health of the
population and reduce the impact of mental illness on individuals in the community. Mental illness is a leading cause of health related disability (Begg et al. 2008) and a global health challenge (Collins et al. 2011). The Australian Bureau of Statistics (ABS) has estimated that around 20% of Australians experience a mental illness in a given year and many Australians with a mental illness do not receive treatment (ABS 2008). Mental illness has a significant effect on the family of those with mental illness and a substantial impact on the wider community and the economy through costs attributed to the health and social welfare system and loss of productivity in the workplace (Hilton et al. 2010).

There have been international as well as national calls to enhance services for people with mental illness (Chisholm et al. 2007, Rosenberg, Hickie and Mendoza 2009) and agencies such as the World Health Organization (WHO) have recommended improved policy and planning in the delivery of mental health services (WHO 2005b). Most of the mental health policy and planning literature, both in Australia and internationally, has focused on the content of policy and policy implementation. Much less attention has been paid to understanding the factors that determine how and why policy is formulated and adopted by governments, the focus of the thesis applied to the Australian federal context.

For the purposes of the thesis, mental health services are defined as those services which aim to prevent or treat mental illness as defined in internationally accepted medical classification systems (for example, the American Psychiatric Association Diagnostic and Statistical Manual or the WHO International Classification of Diseases). The terms mental illness and mental disorders are used synonymously and, for the purposes of this thesis, exclude alcohol and drug use disorders and intellectual disability, both of which followed different policy trajectories. Services for the latter are mostly provided separately from mental health services in Australia. In addition the boundary between mental health services and aged care services is often blurred. This thesis does not specifically address aged care policy or services. The provision of
care to people with dementia is predominantly within aged care services. It also does not address in detail, policy areas that are specific to a section of the population who may have special needs (for example Indigenous Australians).

Mental health services have been changing in Australia since the establishment of the first psychiatric hospital at Castle Hill in Sydney in 1811. Patients with mental illness were, for the most part, treated in hospitals separate from general hospitals that treated other medical conditions. In the public sector, both the general and the psychiatric hospitals were the responsibility of State governments and, to the extent that it was actually articulated, mental health policy was the responsibility of individual State and Territory governments.

Prior to 1946 the Commonwealth government had no involvement in the provision of mental health services. From 1946 onwards Commonwealth legislation allowed benefits to be paid to the State governments for patients in public hospitals. This could have included psychiatric patients if they had been admitted to those hospitals. In 1948 Commonwealth legislation was extended to provide for Commonwealth benefits to be paid for patients in stand-alone psychiatric hospitals. In 1955 the Commonwealth government stopped paying per diem patient benefits and instead provided funding to the State governments for capital works programs to establish additional bed capacity in State psychiatric hospitals. This funding continued until the introduction of the Medibank Scheme, Australia’s first universal health insurance scheme, in 1975. The Medibank Scheme provided for funding from the Commonwealth government to the State and Territory governments to assist in the provision of services in general hospitals but separate psychiatric hospitals were excluded from this arrangement. Commonwealth funding was also provided for community health services which in many States, especially Victoria, included mental health service provision. These forerunners of community based mental health service delivery started to build a critical mass of clinical expertise and demonstrated the viability of community-based care.
In the 1980s the Commonwealth government began to reconsider its involvement in mental health services delivered by the State and Territory governments. In 1984 the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian National Mental Health Association (ANAMH) petitioned the Commonwealth government to develop a national mental health policy. In March 1991 Australian Health Ministers released the report *Mental Health: Statement of Rights and Responsibilities* (Australian Health Ministers 1991) and in April 1992 Australia’s first *National Mental Health Policy: Joint Statement by the Health Ministers of the Commonwealth, States and Territories of Australia* (1992b) and the first five-year *National Mental Health Plan Endorsed by Health Ministers Subject to Commonwealth Financial Contribution* (1992a) were adopted by the Commonwealth, State and Territory governments. These three documents, together with Schedule F of the 1993-98 Medicare Agreements, comprised the National Mental Health Strategy (Department of Health and Ageing n.d.). In 1996 mental health was made a national health priority area along with cardiovascular health, cancer and injury prevention. Since then mental health has been a prominent health and social policy issue for governments.

From the adoption of the National Mental Health Policy in 1992 onward there were periodic changes in policy direction and these dictated cycles of service reform. Each cycle lasted for five years, with the policy directions detailed in a national mental health plan signed by Commonwealth, State and Territory health ministers. Each national mental health plan corresponded, and ran concurrently, with Commonwealth/State Health Care Agreements; 1993-98 (the first plan), 1998-2003 (the second plan) and 2003-08 (the third plan). The focus of the first plan was on reform of services for people with severe mental illness, primarily specialist hospital and community treatment services. In the second plan, Commonwealth attention shifted to mental health promotion, illness prevention and early intervention in primary health care. An ambitious attempt to encompass the policy priorities of the first
two plans in the third plan illustrated the inherent danger of attempting to be all things to all stakeholders, as available resources were diluted and the implementation of plan struggled to gain traction. In part as a result of this, there was widespread disillusionment among stakeholders, and in response the Council of Australian Governments (COAG) in 2006 endorsed a whole of government National Action Plan on Mental Health 2006-2011 (COAG 2006b) which superseded the third National Mental Health Plan 2003-08 (Australian Health Ministers 2003), making it less relevant from a Commonwealth perspective (Rosenberg 2011). However the COAG National Action Plan on Mental Health was basically a list of areas in which each jurisdiction would independently commit funding, compared to the three preceding national mental health plans which were set agendas for collaborative action in areas where combined effort was required as well as priorities that could be pursued by each jurisdiction independently.

This thesis explores the twenty years of mental health policy and service reform in Australia, from 1998 when the Commonwealth government actively began to consider having a policy position on mental health to 2008, the year when the third national plan ended. This twenty year period is considered in three parts: 1988 to 1996, the years of the Hawke-Keating governments (1983-96) up to 1996, the year when the Howard Coalition government was elected; 1996 to 2003, the year when the Second National Mental Health Plan ended; and 2003 to 2008, two years after the adoption of the COAG National Action Plan on Mental Health and the year when the third National Mental Health Plan ended. Each of these time periods saw escalating stakeholder activity accompanied by public and media attention leading to the opening of a policy window with governments adopting a national mental health plan, reflected in the corresponding Commonwealth/State and Territory Health Care Agreements.

My analysis concentrates on the perspective of one jurisdiction; the Commonwealth government. This is not to suggest that other stakeholders, such as State and Territory governments, professional
organisations, private providers and consumer and carer groups were not important in advancing the policy agendas. However my aim is to explore why the Commonwealth government became involved in national mental health policy development and service reform and how and why the Commonwealth government’s policy direction changed over time. The twenty year time-frame allows consideration of policy development and adoption under governments of different political philosophies. In this thesis, I describe many of the areas of reform undertaken during this period but it is not my intention to provide a comprehensive account of all areas of reform.

In that twenty year period there were three major changes in mental health policy referred to in the thesis as ‘policy windows’, borrowing the term from John Kingdon as discussed below. The first was when the Commonwealth Labor government became involved in and adopted a national mental health policy for the first time. The second was the change in policy direction by a newly elected Liberal-National Coalition government with the adoption of the second plan. The third was when mental health policy reached a political threshold for it to be considered by COAG in 2006. The latter was widely perceived to be a more decisive political development than the adoption of the third plan in 2003 which was, as noted earlier, essentially a continuation of the directions in the first and second plans and not seen to be groundbreaking. To analyse this trajectory, three specific research questions are posed. These are:

1. What led the Commonwealth Labor government to adopt Australia’s first *National Mental Health Policy* and first plan in 1992?
2. What led the Commonwealth Coalition government to adopt the second plan in 1998?
3. What led the Commonwealth Coalition government to adopt the COAG *National Action Plan on Mental Health* in 2006?

These questions focus attention on the initiating and authorising role of Commonwealth government. To answer these questions, I
analysed information from four sources.

First, I reviewed primary data sources including political party documents, ministerial speeches, information from Parliamentary debates (House of Representatives and Senate Hansard) and government documents (e.g. policy documents, evaluation reports of the national mental health plans and documents held by the Commonwealth Department of Health and Ageing).

Second, I conducted a systematic review of secondary sources, mainly literature published in academic journals, using a standard methodology for systematic literature review.

Third, I conducted interviews with key informants representing three groups: politicians and their advisors, government officials, and mental health stakeholders from the community (technical experts and advocates).

The fourth source of information is my own observations as an expert key participant in mental health reform.

To understand the factors which influenced the Commonwealth government's consideration of mental health policy at these three time points I apply the theoretical framework developed by John Kingdon (1984, [1995] 2003). Kingdon described three major streams, problem recognition, policy formulation and politics, operating independently in any area of interest to the public and government. Using this framework, he describes how various problems are identified and come to the attention of government. He further describes how a community of policy specialists generate proposals which, when coupled with the identification of problems, identify a range of solutions. Thirdly Kingdon employs the model to describe a political stream in which events and concepts such as national mood, electoral changes and political opportunism connect with an emergent policy solution which is attached to an identified problem, opening a window for action by a government.

In applying the Kingdon framework to the thesis topic, I identify the extent to which the model adequately explains the data and also identify the areas where the model is inadequate; i.e. where the data is
inconsistent with and does not fit the model.

The limitations of the thesis relate primarily to the limitations of the data sources. Specifically, there are two areas where the data sources are most problematic. Political decisions about adopting certain policy positions are often made in confidential meetings (for example, Cabinet meetings). As of 2013, access to Cabinet records is available up to and including 1985, three years before the start of period under study. Secondly, while I have chosen key informants so as to provide representation across the major stakeholders of the policy area, I cannot guarantee that the key informants interviewed held positions and views that are representative of that stakeholder sector.

Another limitation relates to my own potential bias. I am not an independent observer of the national mental health policy and reform process, but rather have been involved at senior government official and advisory levels, as discussed in Chapter 3. The influence of my perceptions on areas such as the thematic analysis is therefore a source of potential bias, although efforts were made to overcome this by having the coding of the themes independently confirmed by a research assistant.

The structure of the thesis is as follows:

In Chapter 2 I define how the term public policy is used and provide a brief overview of a number of different models of policymaking with a focus on the policy cycle model, specifically where problem identification and political decision sit within the cycle as these are the most relevant to the thesis. To address in more detail how and why a particular policy is developed and adopted I discuss the Kingdon model of problem, policy and politics streams and policy windows.

In Chapter 3 I provide a brief review of the mental health policy literature and a summary of the mental health policy situation in key OECD countries and in developing countries.

In Chapter 4 I describe in detail the methodology used in the thesis. Four data sources were used to collate information necessary to address the research question. The first was a review of primary source
documents including Parliamentary proceedings as recorded in Hansard; the second a review of secondary source documents, for example published academic literature; and third, interviews with key informants and fourth, information I have obtained as an expert key participant. The data retrieved from the first three sources was subjected to thematic analysis from which five themes emerged that describe the issues that shaped the mental health policy debates over the twenty year period covered by the thesis. These themes are human rights and community attitudes, community need, service structures, service quality and effectiveness and resources.

In Chapter 5 I describe the mental health service context within which the twenty year period of analysis takes place. This includes the historical context summarising the development of mental health services internationally and a more detailed overview of mental health services in Australia before 1988.

In the next three chapters I describe, for each of the three periods of major policy change (1988-96; 1996-2003; and 2003-08), the problems identified as confronting the Commonwealth government, the policy solutions proposed in each of the five thematic areas and the political response that occurred at that time.

In Chapter 6 I focus on the years 1988 to 1996. I describe, for each of the five thematic areas, the problems that were identified in the data sources as confronting the Labor government, the policy solutions being proposed and the political response by the government with specific attention to the factors which influenced the decision to adopt a national mental health policy and plan in 1992. In this chapter I conclude with a discussion of mental health reform undertaken from 1993 to 1996.

In Chapter 7 I focus on the years 1996 to 2003. I describe, for each of the five thematic areas, the problems that were identified in the data sources as confronting the new Coalition government, the policy solutions being proposed and the political response by the government with specific attention to the factors which influenced the decision to

In Chapter 8 I focus on the years 2003 to 2008. I describe, for each of the five thematic areas, the problems that were identified in the data sources as confronting the Coalition government, the policy solutions being proposed and the political response by the government with specific attention to the factors which influenced the decision to adopt the COAG National Action Plan on Mental Health in 2006. In this chapter I conclude with a discussion of mental health reform undertaken from 2006 to 2008.

In Chapter 9 I summarise the problems in the mental health sector confronting governments in Australia over the twenty year period and what policy solutions were proposed to respond to those problems. I then discuss the reasons why the Commonwealth government chose a particular policy direction on the three occasions of major mental health reform during this twenty year period. I describe the similarities and differences in the dynamics of each policy window. I examine the extent to which the Kingdon model was able to provide a framework for understanding policy development and adoption, and identify any weakness in the robustness of the model in explaining mental health policy changes during these 20 years. Finally I conclude with comments about future directions for mental health policy and services.
CHAPTER 2 - Policy LITERATURE REVIEW

This thesis is a study of policy change and policy reform. This chapter will therefore focus on literature that helps to construct an understanding of the challenges of explaining these processes. The term 'policy', when used in the sense of 'public policy', describes government actions, government programs, specific decisions taken, and/or the political process by which policy is shaped. As its use in non-academic discourses has become more frequent, its precise meaning in some public discussions has become less clear. A working definition (Dimock, Dimock and Fox 1983) for the purposes of this thesis is:

Public policy is deciding at any time and place what objectives and substantive measures should be chosen in order to deal with a particular problem, issue or innovation.

This review of the public policy and health policy literature identifies the contextual issues within which policy development takes place, as well as the factors that shape its content and impede or facilitate implementation (Althaus, Bridgman and Davis 2007, Baker 1996, Cochrane and Malone 1999, Gardner 1995, Palmer and Short 2000, Walt 1994). Many different models of policy-making have been proposed and I briefly survey these below.

Ostrom (1986) argued that individuals and organisations are like actors in 'action arenas'. She proposed that the focus of institutional analysis should be on variables such as participants, positions, outcomes, action-outcome linkages, control exercised by the participants, and (perceived) costs and benefits to the actors. Ingram et al. (1984) described four tasks of institutional analysis: identifying actors and their stakes, the resources actors can use to advance their interests, the orientations of different decision arenas; and the means necessary to overcome institutional impediments. Many policy scholars have contributed similar perspectives, essentially taking a systems approach (ed. Colebatch 2006), in which policy-making is a process characterised by interactions between diverse agendas from which a
policy direction ultimately emerges.

The punctuated equilibrium model (Baumgartner and Jones 1993) states that policy change generally occurs only incrementally due to constraints imposed by the ‘stickiness’ of institutional cultures, opposition from vested interests, and the bounded rationality of individual decision-makers (limited by the information they have, the cognitive limitations of their minds, and the finite amount of time they have to make a decision). According to this model, policy is characterised by long periods of stability, punctuated by large but infrequent changes brought about by the election of a new government or a marked shift in societal opinion.

Other theories of policy change, referred to collectively as policy diffusion (or policy transfer) have focused on how innovations that exist in one institution are adopted by another institution (Berry and Berry 2007). These theories have evolved from an initial focus on variations over time to a more recent study of mechanisms in channels of diffusion such as emulation, learning or coercion (Gilardi 2010, Jordana, Levi-Faur and Fernández-i-Marín 2011).

Moore (1995) advocated a value-adding approach to understanding policy-making in which the policy world is organised by incorporating new ideas that enhance public value, analogous to the growth of shareholder value in public companies (but acknowledging that public policy value has characteristics that distinguish it from private sector concepts of value).

Another approach is that of risk uncertainty management (Boin et al. 2005, Perrow 1984) which views policy-making as the management of risk and crisis. This model acknowledges that policy development often takes place with insufficient information and within serious time constraints. In attempting to achieve their objectives, policy-makers try to establish order in an environment which is unpredictable, high-risk and crisis-driven.

Cohen, March and Olsen (1972) described a ‘garbage can approach’ to policy-making that suggests:
Organisations can be viewed for some purposes as collections of choices looking for problems, issues and feelings looking for decision situations in which they might be aired, solutions looking for issues to which they might be an answer, and decision-makers looking for work.

Burch and Wood (1989) proposed a model in which government works like a firm, taking private and public resources and producing goods and services, rules and regulations and transfer payments as policy outputs. Simeon (1976) proposed a model in which policy development is a 'funnel of causality'. At the wide end or mouth of the funnel, policy options seem more amenable to social and economic imperatives. As the funnel narrows, remaining options are those that promise to address issues perceived as immediate and urgent. At the narrowest end of the funnel, those issues of immediate relevance to the policy being considered are all that matter.

Sabatier and Jenkins-Smith (1993) propose an 'advocacy coalition framework', which describes policy-making as arising from the negotiation between government and interest groups. In this model, the interaction between a coalition of interested stakeholders, policy-makers and political institutions (working together as a policy community) develop an agreed solution to a particular problem. Initially, a shared understanding or conceptualisation of the problem is necessary and compromise is required to arrive at the solution.

All models are imperfect and each has its limitations. For the purposes of this thesis I have assumed that while policy change tends to be cyclical, identifiable events can be described in the process. Despite the contextual complexities, it is useful to describe policy development via a sequence of tasks which are deliberate and explicit. This understanding attempts to overcome the 'irrationality' of politics.

Althaus, Bridgman and Davis (2007) use the policy cycle as an explanatory tool. They note that as early as 1951 Harold Lasswell characterised policy-making as a sequence of steps, an approach later writers modified (for example Anderson 2005). They acknowledge the
risk that an over-reliance on a cyclical view to explain policy outcomes may impose (Althaus, Bridgman and Davis 2007, 36):

... too great a neatness on policy-making, renowned for complexity and discontinuity rather than the relentlessly logical unfolding implied ....

1. Problem Identification in the Policy Cycle

Althaus, Bridgman and Davis (2007) have identified eight steps in the policy cycle (see Error! Reference source not found.), beginning with issue identification, then proceeding through policy analysis using policy instruments and consultation to coordinate decision-making, implementation and evaluation.

Figure 1: The Australian Policy Cycle
The public policy cycle has been well documented and health policy analysis is becoming an important area of academic research (Walt et al. 2008). Within the health policy literature a similar five-part policy cycle has been described (Roberts et al. 2003). This policy cycle collapses some of the steps described by Althaus et al. The next part of this chapter briefly discusses the five steps of the policy cycle as described by Reich (1996): problem identification; option development; political decision; implementation; and evaluation. The stages of problem identification and political decision as described by Roberts and colleagues (2003) are the focus of this thesis and are considered in more detail, below. Examples applicable to mental health policy are provided.

1.1 Problem Identification

As a starting point for an understanding of what shapes policy, it is important to clearly identify the real or perceived problems that the policy response is intended to address. All governments have some kind of policy agenda which ‘represents the narrowing of an infinite array of possible policy problems to those few that command government interest’ (Althaus, Bridgman and Davis 2007, 43). The identification of any particular problem as needing policy attention occurs within the wider social, economic, historical and political environment. My interest in this thesis is to understand how the particular issue of mental health becomes significant enough to reach the threshold for policy attention.

To understand the factors that create the momentum for an issue to reach the threshold for attention requires an understanding of the nature of the policy problem and what drivers are behind the agenda. ‘Issue drivers’, whether they are external to government or internal to political parties in government, constantly produce topics to be suggested for policy attention. Althaus et al. (2007) have identified examples of external drivers as economic forces, media attention, opinion polls, legal decisions (for example, High Court judgments), international relations (for example, refugee arrivals), technological
advances (for example, the internet and GST) and demographic shifts (for example, population growth).

They described factors within government that also contribute to the identification of issues by policy specialists, such as monitoring responses to similar policy issues in other jurisdictions, monitoring local ‘wicked’ problems and intractable issues of perennial government concern, and coordination of responses to policy issues across governments and between government institutions.

Althaus et al. (2007) have suggested that, for an issue to attract policy attention, four conditions need to be met:

1. There needs to be agreement on the existence of a problem by significant interest groups and individuals. They must agree that the current situation is unacceptable and that something different is needed;

2. A prospect of a solution is necessary. Some intractable problems always need to be responded to, but those with a plausible resolution are more likely to attract political support;

3. The problem needs to be appropriate and worthy of support. The opportunity cost of investment in the response to the problem needs to be weighed in the political process. Consideration needs to be given as to whether there would be a better (or more politically rewarding) response if resources were allocated to a different area; and

4. The problem needs to be acceptable within the ideological framework of the government in power. Some problems would not be ones which governments of a particular political persuasion would wish to deal with.

Perspective matters here, as what is thought of as a problem by one group may not perceived that way by another. A problem that those working in health services think is deserving of government attention may not necessarily appear prominent from a government perspective. For example, the fact that the majority of Australians with depression do
not receive treatment (Andrews, Henderson and Hall 2000) might not be a priority for busy health providers who already have enough patients wanting to see them, but the general population is likely to take a different view. Governments therefore may see improving access to care as a priority needing policy attention.

Given the many issues competing for policy attention by government, the question becomes how particular issues are selected for policy attention. In their review of the health policy literature, Roberts and colleagues highlighted mechanisms that determine which issues receive selective attention (Roberts et al. 2003). First, cultural and social attitudes act as filters that selectively focus on or divert public and government attention from issues. If a particular problem does not evoke public sympathy or is seen as less worthy, attention is diverted to other, more 'meaningful' problems. In mental health this was the case with the issues of poor physical conditions, poor quality of care, and abuses inflicted on patients in psychiatric hospitals during much of the last century. For decades these circumstances were not seen as warranting intervention (Lipton 1983). A change in societal attitudes saw a human rights perspective expanded to include individuals with mental illness. This legitimised a change in the political perception of the problem and contributed to government action in the form of a major policy shift towards de-institutionalisation, leading to the closure of many wards and hospitals and an impetus to improve conditions in those that remained.

As societal attitudes shifted again, de-institutionalisation came to be seen as a problem to do with the welfare of people with mental illness living in the community. The focus for societal attention had changed from concerns about patient abuse and neglect in institutions to community safety and the 'right' to treatment for people with mental illness living in the community (Whiteford 2001). A similar change in societal norms and attitudes has underpinned fluctuations in the threshold for involuntary detention seen in mental health legislation (Salize and Dressing 2004). When societal focus is on individual liberty,
the threshold for involuntary detention and treatment is higher. When the focus is on the 'right to treatment' and public safety, the threshold for involuntary detention and treatment is lower.

The second mechanism relates to the role of 'issue entrepreneurs'. Roberts et al. (2003) describe these individuals or groups as activists who take up particular issues, and promote them as problems needing attention, following the filtration process described above which has confirmed them as worthy and meaningful issues. These entrepreneurs may be politicians, public servants, professional bodies or interest groups within the community. Their motives vary. Some act on the basis of a personal conviction about the need to improve a particular area. These individuals or groups often have a stake in that area. As will be discussed in Chapter 5, a coalition whose member groups hold values-based convictions regarding public advocacy, including the ANAMH and the RANZCP, acted as issue entrepreneurs between 1984 and 1989 to build the momentum for the National Mental Health Strategy.

The interaction between the social filtering process and the efforts of issue entrepreneurs produces fluctuating patterns in the process of problem definition and in this the media play an important role (Miller 2007). Cobb and Elder (1972) suggested that issues most likely to reach the threshold for policy attention are those which have mass public appeal and this is often expressed through the media. The reporting of issues by the media can highlight problems needing attention or create the perception of a problem where none really exists. The media focus can be captured by scandal and/or personalities. There can be a herd mentality when it comes to reporting in the media. Competitive media outlets feel compelled to cover a story simply because other outlets are doing so. However media interest in an issue can quickly fade following a loss of interest by the public and government. There are usually only brief windows of opportunity to target policy decision makers. A finite issue attention cycle (Downs 1972) exists, especially given the susceptibility of governments to the influence of the media.
Issue entrepreneurs attempt to influence those whom they believe can have an impact on the decisions they want made. These are usually politicians and their advisers. However, Parliamentarians and political appointees must have regard to the realities of partisan interests, competing factions, public perceptions and power politics in their dealings with those acting on conviction. Although they may be moved by the convictions of advocates, their interest in the problem is affected by their concerns over the attractiveness of proposed solutions, party positions, and electoral politics. The balance between these motives is often not clear to the advocacy groups, and the willingness of politicians to become involved in particular issues can be influenced by the electoral cycle, given the ultimate priority for the politician is to be re-elected.

It is generally expected that public servants will implement the policies of the government of the day. However, most governments do not come to power with a detailed action plan for how they will deal with every area within each portfolio. Many areas, such as mental health, may not be mentioned at all in the party political platform and even when they are, detail is usually lacking and there is much room for interpretation. Public servants in health departments and related government agencies (such as those with responsibility for social services, justice, housing, and education programs) undertake most of this interpretation. These officials hold the corporate history about government programs and prepare submissions with options (and often costings of those options) for ministers and governments to consider. They can facilitate or impede problem identification (and policy adoption and implementation). Given they generally hold the keys to making the machinery of government work it is important to understand the role they play in having policy considered by the government.

For a national policy to be adopted in a federated system of government such as Australia there are added complexities. Agreement on a national policy requires its endorsement by the Commonwealth government and all State and Territory governments. All (or at least
most) jurisdictions need to accept that the problem is important enough for national policy attention, even before policy solutions start to be considered. Issues can become caught in competition between the Commonwealth government and the State/Territory governments, which may have nothing to do with the problem but which may reflect political rivalry, especially when different political parties hold government in different jurisdictions.

In health policy there is a long-standing Commonwealth/State power struggle for influence. Section 51 of the Australian Constitution allocates a very small role for the Commonwealth government in health, essentially assigning only quarantine powers to prevent disease entering the country. However, the Commonwealth government has gradually assumed a more prominent role following the centralisation of income tax collection which occurred during World War II. The Commonwealth government now raises more revenue than it spends in directly delivering services, with the State and Territory governments spending more on the services they provide than they can raise through State taxes. This so-called vertical fiscal imbalance requires the Commonwealth government to transfer money to the State and Territory governments for areas such as health. Conditions tied to the transfer of these funds allow the Commonwealth government to influence or even dictate the direction of health reforms. This state of affairs has also allowed the Commonwealth government to subsidise major parts of the health system, including primary care, private specialist medical services and pharmaceuticals.

1.2 Policy Analysis and the Development of a Policy Option

Once government has agreed that a problem exists and needs to be addressed, policy solutions need to be identified and considered. Occasionally, the solution to be adopted is largely prescribed. This occurs when a political party has made a commitment to take certain actions during an election campaign and will not change from this. However, this is rare and, when a new government has been elected,
solutions to various problems need to be found. How a particular solution is chosen among a range of potential options is conceived as policy development.

Experts, both within and outside government, in any particular policy area will usually propose potential solutions. These solutions can be adapted from a consideration of what other jurisdictions or countries have chosen to do in response to similar problems. In health where rationing of client services is widespread, the need for solutions promoting efficiency is a recurrent policy challenge. Industry solutions have, for example, been imported by considering health services as a production of outputs (for example, a given number of patients treated) with a need to improve capacity, quality and equity. In mental health this has seen the introduction of routine outcome measures and the development of methodologies for cost-effectiveness of mental health interventions (Chisholm 2005, Thornicroft et al. 2006).

Whether a policy solution is being imported from another jurisdiction, from industry or developed generically, it is necessary for government to agree upon and select a proposed solution. Achieving a consensus requires the government to consider the possible options and choose from among them. Stakeholder consultation allows government to determine the position of relevant groups and individuals both inside and outside government who are likely to influence the policy choice and the success of its implementation (Sturm 1999). Stakeholder analysis includes interest group analysis and bureaucratic analysis and has been refined to the extent that software now exists to undertake the analysis (Reich 1996). Choosing which stakeholders to consult is important, because excluding any major group from the process is likely to generate resentment and opposition to the policy. It is nearly always better to have all stakeholders involved in the consultation process, even if it is time-consuming, to build the greatest possible support for the policy position.

Broad stakeholder consultation can also assist in determining the extent to which a policy solution is politically feasible. The options
proposed by policy experts and stakeholder consultation with the broader community can demonstrate irreconcilable differences and impact on the political feasibility of a policy solution. In health, the debate about needle exchange programmes is an example (Collins and Coates 2000). The scientific data supported the use of such programmes but the political view for a long time was that this would be unpopular with the electorate. Examples like these demonstrate that the final decision to adopt a policy is often a political decision rather than a technical or bureaucratic one.

1.3 Reaching a Political Decision

The environment of political decision-making is complex. Factors such as the relative power of different people and groupings in the political landscape, the views of the constituencies they represent and negotiations that need to be made, all impact on the final decision. Successfully negotiating a coalition of support from among the various players usually involves bargaining and trade-offs. Throughout the process of negotiation, the content of a policy solution will usually be modified, because compromise is usually necessary to achieve consensus.

In trying to arrive at a decision about adopting a policy, politicians and their advisors consider the reaction from their constituencies, policy experts and the broader community to assess the degree of support the policy will have. Estimating the degree of support or otherwise is often difficult, especially in the complex environment of health and mental health. A policy solution can affect different parts of the system differently. It may be necessary to make multiple policy changes at the same time in order to achieve the desirable outcome. Failure to do this can undermine the success of good policy decisions. For example, the policy of closing more long-stay hospital beds during the 1980s and 1990s was undermined by the lack of accommodation for patients discharged from the hospitals into the community. The health policy was not accompanied by a policy of expanding the availability of community
housing, the responsibility of a separate government department (e.g. the Housing Department) (Whiteford 1994b).

Another component of this complexity is the concentrated costs, and power, of certain stakeholder groups such as the medical and nursing professions. The potential beneficiaries of a policy, for example people with mental disorders, are generally less well-organised and influential. The closure of a ward in a psychiatric hospital with the savings going to community-based services might generate vocal opposition from the staff who are to be affected in the hospital. The potential beneficiaries of the community services are less likely to coalesce into a strong advocacy group. This imbalance can create significant obstacles to having a policy adopted. The formation of a stakeholder network attempting to encompass those potentially benefiting from policy changes has been used in Australia (via the creation of national and State consumer advisory groups) to help address this imbalance (Whiteford, Buckingham and Manderscheid 2002).

To create the necessary support for a policy to be adopted, it can be useful to align it with symbols that have strong ideological appeal. For example, the policy of de-institutionalisation was accompanied by the promotion of treatment in the community, rather than hospital, as aligned with 'least restrictive care'. The more recent backlash against de-institutionalisation has been accompanied by the increased attention to accessing hospital care and a promotion of the 'right to treatment'.

Reframing the explanation around a policy can help ensure political adoption. For example the policy position of allowing patients to be involuntarily treated under mental health legislation in private hospitals as well as public hospitals was initially seen as unsupportable because the private sector would receive payment as a result of patients being admitted and detained in hospital against their will. With statutory safeguards in place, including independent review, the policy explanation was reframed to emphasise that a person with mental illness, who had chosen and paid for private health insurance, should be
allowed to remain with the psychiatrist (and hospital) of their choice even if their illness deteriorated to the point where involuntary treatment was needed. With this reframing, the policy became politically acceptable and was adopted in several jurisdictions. Political decision-making is influenced by the way the policy solution is portrayed (Whiteford 2001).

1.4 Policy Implementation

Policies can be successfully developed and adopted but implementation can still fail. Government options for implementation are limited with five main levers available (Lee, Buse and Fustukian 2002, Musgrove 1996, Palmer and Short 2000, Roberts et al. 2003). These are: information; financing; payment; service organisation; and regulation. The information system collects and publishes data. The financing system determines what resources are available, where these resources come from and who has access to them. The payment system determines on what terms these resources are made available to individuals and organisations. The organisation of the service system shapes the distribution of services and how they respond to consumer demands. The regulatory system determines the constraints on services, for example how providers are trained and registered.

The Commonwealth government used financing and payment levers to help drive the implementation of the National Mental Health Policy. For example, the first plan detailed not only how the National Mental Health Policy would be implemented but came with $135 million of specific Commonwealth government funding over 5 years. The provision of this funding was through a special schedule (Schedule F) of the 1993–98 Commonwealth/State Medicare Agreements. This funding was contingent on State and Territory governments not only implementing the National Mental Health Policy but maintaining their own financial effort in mental health. This was to prevent the substitution of new Commonwealth government funding for State and Territory government funding (Whiteford 2001).
The information lever was also used. The Commonwealth, State and Territory governments all committed themselves under the 1993-98 Medicare Agreements to provide data on their progress in implementing the Policy. The data were used to inform a set of 49 national policy indicators, first collected for the 1992-93 year and published annually or biennially since (Department of Human Services and Health 1994a). These national mental health reports have been used by professional and community groups and the media as a form of public accountability (Lawn et al. 2008).

Policy implementation will be more successful if it has the support of the stakeholders who advocated for the policy to be adopted. Forging new alliances consolidates support and enhances implementation. In mental health such an alignment occurred between governments and the Strategic Planning Group for Private Psychiatric Services, now the Private Mental Health Alliance (PMHA 2011), established by the Australian Medical Association (AMA) and the RANZCP. The private psychiatric sector had not been involved in the development of the 1992 National Mental Health Policy and the establishment of this group was seen as a way of forging a new alliance to support policy implementation. Likewise the creation of the Mental Health Council of Australia (MHCA 2013) resulted, in part, from the need to have a broad-based non-government body working with governments to support the implementation of the National Mental Health Policy (Whiteford 2001).

Policy implementation requires sustained effort over time. By the time of the implementation stage, which usually lasts for many years, the political party in power when the policy was adopted may well have changed. However, if the coalition of stakeholders remains largely intact and there is public expectation of implementation continuity, progress should continue. There is however always a risk that new governments, which need to have policies which distinguish them from the party they replaced, will try and modify or even abandon implementation. In mental health policy, which has tended to attract support across political parties, the tendency of successive governments has been to modify
rather than entirely abandon the established policy direction. Flexibility in responding and adapting to emerging issues, which can create barriers and opportunities, is essential. At a local level, implementation of national policy will also tend to be piecemeal in response to specific problems and resources idiosyncratic to the local environment (Garfield 2009). As is discussed in Chapter 5, the implementation of the first National Mental Health Plan provided an example of how an originally unforeseen event led to an unplanned enhancement of the resources available. The Human Rights and Equal Opportunities Commission (HREOC) Inquiry into the Rights of Persons with Mental Illness released its report in 1993. The report identified the same service deficiencies that were addressed in the first plan, but in the face of extensive media coverage about these deficiencies, the new Commonwealth Health Minister, Senator Graham Richardson, announced additional Commonwealth government funding for the first National Mental Health Plan released the previous year. Politically it was considered necessary to be seen to respond to the HREOC Report. The additional funding effectively doubled the Commonwealth government allocation for the first plan (Whiteford 2001).

1.5 Evaluation

If many polices are not implemented as originally designed, even fewer are evaluated. By the time an evaluation is due to be conducted, many of the government officials originally involved in the policy development will have departed. During the implementation, organisations that support the policy may have wilted (or grown), and those who oppose it may be stronger. For an evaluation to have credibility, it must be as transparent and independent as possible. Ideally this means finding sufficient data that allows assessment of the extent to which the outcomes of the implementation aligned with the policy intent.

The results of the evaluation should be used to revise and improve the policy. In revising policy and implementation plans, it is important to be aware that there is often little advocacy for areas that
have been successfully addressed and a focus on areas that have been
the subject of criticism. Balance is important and there will always be
criticism where priority has been given to one area over another. As a
result, there will be a temptation for an evaluation to advocate a swing
away from an area that has been relatively successful to one which has
been less so, or to expand the policy agenda to include all areas that are
being advocated for. While the policy can be broad, it is important to
ensure that scarce resources necessary for policy implementation
remain focused on priority areas. If the effort is diffuse and resources
spread too widely, effectiveness will be diluted, with a loss of credibility
for the policy and its implementation. As is discussed in Chapter 8 this is
what happened in the national mental health reforms in Australia.

The policy cycle model, whilst providing a useful description of the
stages through which policy moves, has its limitations (Althaus,
Bridgman and Davis 2007, ed. Colebatch 2006). In addition to the
limitations that have been discussed, it does not provide an explanation
as to why a particular policy has developed in a particular way or why it
was adopted by government. To explore this question this thesis uses

2. Kingdon Model of Policy Streams and Windows

The main area this thesis explores is how issues gain the policy
attention of governments, and how and why a particular policy response
(in this thesis using the area of mental health) is developed and
subsequently adopted by governments. Of the many issues competing
for the attention of government the thesis examines how the issue of
mental illness reached the threshold for policy attention, during the
twenty year period from 1998 to 2008.

In his landmark 1984 publication Agendas, Alternatives and Public
Policies John Kingdon provided an important theoretical foundation for
policy-making. He built on the work of Cohen, March and Olsen (1972)
who described organisations as ‘organized anarchies’. Their approach
contradicted those that were based on the assumption that policy-
making was a rational process, arguing that policy decisions rarely arise from deliberate objective consideration of the various alternatives to solving a problem. In their ‘garbage can model’ Cohen, March and Olsen described four separate streams running through ‘organized anarchies’. These are problems, solutions, participants and choice opportunities. They described each stream as being independent and evolving largely unrelated to the others.

The model was adapted by Kingdon and specifically applied to government. Kingdon (1984, [1995] 2003) described policy adoption as being like natural selection in biology. Agreement on a problem and the technical feasibility of a response led to the selection of a small number of issues for further policy consideration with many problems, issues and possible responses discarded along the way. He identified those topics and issues most likely to reach the threshold for government attention as:

1. problems in existing programs that are of more interest than new problems;
2. issues that are attractive to politicians because of the challenge they pose to important values;
3. problems that attract unfavourable comparisons with other parts of the country or other nations;
4. problems which are attached to an important legal or ethical principle.

Kingdon ([1995] 2003, 16-7) identified three major streams: problem recognition; the formulation and refining of policy proposals; and politics. He described the first stream as one where various problems are identified and come to the attention of government. In the second stream a policy community, usually made up of specialists, generate policy proposals which can be coupled with problems to identify solutions. The third stream is the political stream where concepts such as national mood, electoral changes and political opportunism explain behaviour and decision making. When this stream connects with a sufficiently prominent problem that has a technically
satisfactory policy solution, a window for action by a government can be opened.

The first stream according to the Kingdon model defines problems and how they come to the attention of a government. Problems can achieve prominence due to new information coming to light or changes in indicators used by government (in health such indicators could be rates of disease, immunisation rates, or infant mortality rates). What is considered new information or significant changes in indicators from a scientific perspective are not automatically perceived as a problem by government. The interpretation placed on the changes in the indicators is what is important. However Kingdon did note that the value of indicators is that problems are more likely to be identified if they are ‘countable’.

Within the problem stream Kingdon identified that, even more important than new information or changes in indicators, are focusing events or crises. He described how these focusing events and crises have more impact if they are connected to powerful symbols such as equity or human rights. Crises can be focusing events that either reinforce a pre-existing perception of a problem or bring a problem to light. Kingdon described how the perception of problems can wax and wane. They often fade from attention to reappear at a later time.

Kingdon described the difference between a social condition, an indicator and a problem. He noted that social conditions, even when measured by a relatively objective indicator, become defined as problems only when it is believed that something needs to be done about them. He described how values, comparisons and categories contribute to the translation from conditions into problems. The perception that a matter is appropriate for government action is often a value judgment that brings a condition into the realm of being seen as a problem necessary for attention. He noted that comparisons made between governments can often be a reason for the view being taken that a matter needs attention. He also described how categorisation is important and the change of an issue from one category to another can
move a condition into the problem domain.

Kingdon noted problem recognition is not on its own sufficient to place a matter on the government agenda. There are many problems recognised by government and only a fraction of these are considered sufficient for government attention. Kingdon therefore identified two other important streams.

The second stream according to the Kingdon model is one that generates policy solutions. These are formulated by policy communities, composed of specialists in a given policy area such as health. They often exist independently of the problem stream. In concurrence with the Cohen, March and Olsen ‘garbage can’ model he described how this stream is independent of the problem stream. He described the characteristics of the policy communities, noting that when fragmented they are less likely to identify a coherent, broadly supported policy. A more tightly knit policy community can generate a more representative policy solution.

As discussed earlier Kingdon also identified the role of policy entrepreneurs and how they advocate for a particular policy solution. He also noted how they often have a particular policy position which can become a ‘solution ... looking for a problem to which it could be attached’. This approach by policy entrepreneurs allows them to promote their values and to affect policy directions in a manner consistent with their philosophical beliefs.

Kingdon noted that political scientists are more familiar with concepts of power, influence, pressure and strategy than the ideas in a policy solution. He asserts that the power of the ideas in the policy solution is as important as other factors in shaping policy. Policy solutions are considered more likely to survive if they have both technical feasibility and value acceptability.

Kingdon described how a policy community will often produce a relatively short list of ideas and how these ‘diffuse’ through the policy communities. For a policy solution to emerge there needs to be an awareness of the problem(s) to which the ideas and solutions will be
connected and agreement in the form of some broad consensus that the solutions are the right ones. Policy solutions and ideas then build momentum and the chances of a problem from the problem stream reaching the threshold for attention is dramatically increased if a policy solution is attached to it.

However, a clearly defined problem and a technically sound, broadly supported policy solution together are still insufficient for governments to act. These need to be connected to the third stream, the political stream. Kingdon described this stream as consisting of the public mood, pressure group influences and electoral political expediency. He described the importance of social movements and pressure groups and how they are more successful if well organised and well led. They can influence the national mood. Kingdon described how changes in government (elections leading to a change of political party in power) create opportunities for a change in the public mood with the perception that a new government will take action in a number of policy areas. He described the importance of consensus building in the politics stream and how this is more often the result of bargaining than persuasion (the latter being more common in the policy stream).

Finally, Kingdon described how these three streams can come together to open a policy window. He described the process of solutions being coupled to problems and these in turn being linked with political exigencies. Change usually occurs in response to developments both in the problem and political streams, not in the policy stream. Sometimes a policy window can be opened when a problem is perceived as so pressing or important that immediate government action is necessary. Often the policy window is opened by an event in the political stream, such as a change in government. The important conclusion of Kingdon was that while problems and politics by themselves can structure a government agenda, the probability of a decision being taken on a problem is contingent upon the joining of all three streams (problems, policies and politics). The problem needs to be perceived as sufficiently important to require action, a solution to that problem supported by a
policy community must be available and the solution must be politically feasible and attractive.

Competition for a place on the policy agenda is fierce and opportunities for windows to open are relatively scarce. Kingdon noted that there are times in government when policy reform is a priority and windows open more frequently, while at other times little reform occurs and windows are scarcer. He also described how window opening is sometimes predictable (for example, at the start of a new term of government or in connection with the budget cycle) and other times where windows open in what appears to be an unpredictable and random way.

When they do open, policy windows rarely stay open for long. They can close because of a perception that the problem has been addressed or that there is no action capable of addressing the problem, or because the crisis which opened the policy window has passed or because a change in personnel at the political, bureaucratic or advocacy levels has resulted in momentum being lost.

The Kingdon model has been critiqued as being overly vague, and failing to arrive at a definitive theory of agenda setting (Durant and Diehl 1989, King 1985, Mucciaroni 1992). A major criticism is that the model does not generate testable hypotheses (Mucciaroni 1992, Robinson and Eller 2010, Zahariadis 2007). This lack of specification prevents the use of the Kingdon model as a predictive tool (Zahariadis 2007).

A key assumption of the model - the independence of the three streams of problems, policy and politics - has been questioned by several authors, who contend that in reality the streams display varying degrees of interdependence (Durant and Diehl 1989, Mucciaroni 1992, Zahariadis 2007). The existence of linkages between the streams implies that the coupling of the streams is more intentional and strategic than Kingdon’s model implies (Zahariadis 2007).

The Kingdon model has also been criticised for neglecting the importance of historical and structural factors in the decision-making

Despite these limitations Kingdon’s work on multiple streams was considered to be a major theoretical breakthrough in the study of public policy (Sabatier 1999). His description of the three streams resonated with policy makers. His insight that, at critical points in time, the streams could be bought together and open a policy window allowing the issue to reach the threshold for policy attention, has been a useful organising concept. Robinson and Eller (2010) summarise the Kingdon approach:

Only when a prominent problem can be linked to a viable policy consistent with the national mood at a time when elective officials can make a decision will policy emerge (emphasis added).

The Kingdon model was originally utilised to empirically study the process of healthcare and transportation issues onto the federal agenda in the United States (Kingdon [1995] 2003). The model has since been used to explain policy formulation in a variety of other fields including agricultural policy (Ackrill and Kay 2011); prison privatisation (Culp 2005); financial reporting policy (Ryan 1998); employment discrimination policy (Gates 2010); foreign policy (Mazarr 2007); tax reform (Mucciaroni 1992); national identification system policy (Ni and Ho 2008); environmental policies (Boscarino 2009, Pralle 2006, Rinfret 2011); construction standards (Schwartz and McConnell 2009); education policy (Robinson and Eller 2010); social security reform (Weiner 2007); native affairs, the Canadian Constitution, the nuclear industry and capital punishment (Howlett 1998).

It has also proved a useful conceptual framework for health policy and health reform, including mental health policy, as is further discussed in Chapter 3 and Chapter 9 (De Vries and Klazinga 2006, Gulbrandsson, Bremberg and Back 2005, Gulbrandsson and Fossum 2009, Hamid and Everett 2007, Kruger 2001, Laraway and Jennings 2002, Lenton 2008, Ritter and Bammer 2010, Zwi et al. 2011)

3. Conclusion

This chapter briefly reviews a number of different models of policy-making, noting that each has its limitations and there is no perfect model. The policy cycle model which describes policy as being developed through a sequence of explicit tasks is discussed in more detail, with the steps of problem identification, development of a policy option and policy adoption (where a political decision is reached) informing the areas of policy analysis discussed in the thesis.

One of the limitations of the policy cycle model is that it does not provide a causal explanation for why a policy was developed. The Kingdon model of policy streams and windows was described as a framework for developing an understanding of how a particular area may gain the policy attention of governments, and how and why a particular policy response may be developed and adopted. Although it also has limitations, for example being tautological, lacking testability and not generating a long term research program, it remains one of the most influential models in the policy field, generating interest in numerous social policy areas including health.

In the next chapter I briefly review the mental health policy literature and summarise the mental health policy situation in key OECD countries and in developing countries.
CHAPTER 3 - Mental Health Policy Literature Review

The mental health policy literature describes cycles of reform that have taken place over the centuries. Alderidge (1979) described how health services had moved between institutional and alternative community based services in England periodically since the 13th century. Each attempt to provide a policy solution was accompanied by public scandal or political concern about rising costs (Levine 1979). These cycles have also been well recognised in Australia, characterised by reform followed by scandal followed by public inquiry followed by further reform (Lipton 1983).

The literature contains many accounts of the cyclical nature of mental health policy, and what influences these cycles. Rochefort (1998) described mental health system reform as alternating between peaks of intensive policy and program activity followed by periods of ‘stagnation and decline’. He explained how this pattern often accompanied the movement of mental health issues into and out of the public arena, often via the media. Within these cycles Rochefort noted how past policy themes were ‘rediscovered’, reemerging only to later recede into the policy background. He concluded that this lack of stability in mental health policy was related to a number of factors, including changes in the understanding of mental illness, exaggerations in mental health ideologies and rhetoric, the incomplete development of psychiatry as a scientific discipline, the ineffectiveness of mental health policies and programs, a mismatch between the goals of mental health policy and the means by which these goals were achieved, the impact of professional organisations and cyclical changes in public opinion brought about by evolving social changes. Rochefort also identified the political tenor of the time as an important factor in these cycles, for example noting that mental health reform was more likely during a period of broader political or social reform by an activist government. The ideological leaning of the government in power has been shown to be a
major influence on the content of reform in health generally (Toth 2010).

Much of the literature discussing mental health policy, particularly that which includes analysis of national examples, has as its focus descriptions of policy content or policy implementation (e.g. in describing changes in service delivery). Less attention has been paid in the literature to how and why a particular policy was adopted, although some authors have summarised the factors they believe have been influential on mental health resource allocation. For example, Corrigan and Watson (2003) identified the factors they thought had influenced policy makers to allocate resources to mental health: 1) perceptions of resource scarcity; 2) effectiveness of mental health programs; 3) consumer needs; 4) perceived personal responsibility and 5) political ideology. In all countries, the increased role of the consumer and carer movement in providing advocacy for mental health reform has been a dominant theme since the 1970s (Gawith and Abrams 2006, Smith and Gridley 2006).

Within the mental health sector there is a considerable literature on mental health policy. In 1974 a WHO expert committee considered how best to organise mental health services in developing countries. Recommendations included: (1) the development of national mental health policies and the creation of units within health ministries to implement policy; (2) the introduction of mental health budgets for workforce development, essential drug procurement, infrastructure development, data collection, and research; (3) the decentralisation of service provision and integration of mental health into primary health care; and (4) the training and supervision of primary health care providers in mental health using specialist mental health staff (WHO Expert Committee on Mental Health 1975).

In 1978, the International Conference on Primary Health Care in Alma-Ata in Kazakhstan, in what became known as the Alma-Ata Declaration (Lawn et al. 2008) reaffirmed the definition of health in the WHO constitution (WHO 1946) as ‘the state of complete, physical,
mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 2001b). It promoted health as a basic human right, endorsing the right of all citizens to participate in their communities and to maximise their self-reliance. Health reform began to encompass areas which had not previously been considered within the scope of medicine, such as the reduction of social inequalities, redistribution of wealth and political action (Navarro 2001).

The Declaration adopted a primary health care approach to service delivery with an emphasis on community care, intersectoral linkages and mutually supportive referral systems. It acknowledged that primary care requires a preferential share of health resources. The Declaration called on governments to formulate policies, strategies and plans that would sustain primary health care and achieve 'health for all' by 2000.

In 1982, the UN General Assembly adopted the World Programme of Action Concerning Disabled Persons at the end of the International Year of Disabled Persons. In this resolution, the UN General Assembly reiterated the equality of rights of all people with disabilities stated in earlier resolutions, including those with a mental illness and its resultant psychiatric disability. The resolution introduced concepts of equal opportunity and rights to full participation in medical treatment and it promoted the need for non-medical services to support people with psychiatric disability beyond medical treatment alone.

In 1991 the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care were adopted by the UN General Assembly, with a specific focus on the rights of people admitted to mental health institutions. The twenty-five principles emphasise quality of treatment and care in the community and address issues such as individual freedoms and basic human rights in hospital and the community. Principle 23 specifically addresses mental health policy and legislative reform, stating:

States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically; and should make
these Principles widely known, through policy.

The *World Health Report* which has a specific health related focus each year was dedicated to mental health in 2001 (WHO 2001b) and made ten recommendations for action. These were: to provide treatment for people with mental illness in primary care and not just specialist services; make psychotropic drugs more widely available; give care in the community rather than relying predominantly on hospitals; educate the public about mental health and mental illness; involve communities, families and consumers; establish national policies, programmes and legislation; develop human resources; link mental health with other sectors; monitor community mental health; and support research.

Recommendation Six noted that mental health policy, programmes and legislation are necessary for significant reform and that these should be based on current knowledge and human rights considerations. WHO noted that mental health reforms should be part of the larger health system reforms in which there is no discrimination against persons with mental disorders. Recommendation Eight noted that sectors other than health, such as education, housing, welfare, and justice sectors need to be involved in improving the mental health of communities and providing support for people with mental illness.

In 2007 the WHO released a Mental Health Policy and Service Guidance Package consisting of a policy and plan checklist and fourteen modules for policy development and service planning. The package was developed following a review of the literature, consultation with policy makers, planners and health professionals and was underpinned by best practice examples of policy development and planning from a range of low, middle and high income countries (Funk and Freeman 2011). The checklists provide summaries of process and content issues that have been identified as important to mental health policy. National policy review bodies as well as stakeholders are encouraged to use these to facilitate local policy making and planning. Examples of process issues when considering a given policy include: the extent of the political
mandate to develop the policy; whether the policy is based on a local needs assessment; the extent of the consultation process with stakeholders; and the level of research undertaken to develop the policy. Content issues include: the values and principles which have informed the policy; the inclusion of a statement of policy objectives; identification of areas for action; the use of language to describe action areas; and the degree to which the policy comprehensively addresses a range of areas such as human rights and prevention.

The consensus in the literature is that having a national policy on mental health is fundamental to promoting mental health in the population and delivering effective mental health services (WHO 2005b, Jenkins et al. 2002). The health and mental health policy literature identifies the context within which policy development takes place, the factors that influence the process and shape the content of the policy, the factors that impede or facilitate implementation, the extent to which an evidence base informs policy and the importance of the policy and its implementation in improving health in communities (Baker 1996, Lee, Buse and Fustukian 2002, Townsend et al. 2004, Walt 1994).

1. Mental health policy in OECD countries

According to the WHO Mental health atlas (2005a), by 2005 the governments of the majority of OECD member countries (27 out of 34) had endorsed a mental health policy, defined as

...a specifically written document of the Government or Ministry of Health containing the goals for improving the mental health situation of the country, the priorities among those goals and the main directions for attaining them.

Table 1 lists OECD member countries by national mental health policy status (WHO 2005a).
Table 1: OECD countries with a mental health policy in 2005

<table>
<thead>
<tr>
<th>Country</th>
<th>Mental Health Policy</th>
<th>Year formulated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Yes</td>
<td>1992</td>
</tr>
<tr>
<td>Austria</td>
<td>Yes</td>
<td>1999</td>
</tr>
<tr>
<td>Belgium</td>
<td>Yes</td>
<td>1988</td>
</tr>
<tr>
<td>Canada</td>
<td>Yes</td>
<td>1988</td>
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<tr>
<td>Chile</td>
<td>Yes</td>
<td>1993</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Yes</td>
<td>1953</td>
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<tr>
<td>Denmark</td>
<td>Yes</td>
<td>1991</td>
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<tr>
<td>Estonia</td>
<td>Yes</td>
<td>2002</td>
</tr>
<tr>
<td>Finland</td>
<td>Yes</td>
<td>1993</td>
</tr>
<tr>
<td>France</td>
<td>Yes</td>
<td>1960</td>
</tr>
<tr>
<td>Germany</td>
<td>Yes</td>
<td>1975</td>
</tr>
<tr>
<td>Greece</td>
<td>Yes</td>
<td>1983</td>
</tr>
<tr>
<td>Hungary</td>
<td>No</td>
<td></td>
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<tr>
<td>Iceland</td>
<td>No</td>
<td></td>
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<tr>
<td>Ireland</td>
<td>Yes</td>
<td>1984</td>
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<tr>
<td>Israel</td>
<td>Yes</td>
<td>1991</td>
</tr>
<tr>
<td>Italy</td>
<td>Yes</td>
<td>1994</td>
</tr>
<tr>
<td>Japan</td>
<td>Yes</td>
<td>1950</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Yes</td>
<td>1991</td>
</tr>
<tr>
<td>Mexico</td>
<td>Yes</td>
<td>1983</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Yes</td>
<td>1999</td>
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<tr>
<td>New Zealand</td>
<td>Yes</td>
<td>1994</td>
</tr>
<tr>
<td>Norway</td>
<td>Yes</td>
<td>1997</td>
</tr>
<tr>
<td>Poland</td>
<td>Yes</td>
<td>1995</td>
</tr>
<tr>
<td>Portugal</td>
<td>Yes</td>
<td>1995</td>
</tr>
<tr>
<td>Slovakia</td>
<td>No</td>
<td></td>
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<tr>
<td>Slovenia</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>Yes</td>
<td>1985</td>
</tr>
<tr>
<td>Sweden</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
The literature on mental health policy is usually country specific and primarily describes the content and implementation in that country. In part this is because much of the literature and policy advocacy comes from public inquiries into deficiencies in services which are concerned with which services are provided (and not provided) to which consumer groups. Relatively little attention is paid in the literature to the broader factors which led to policy formulation and adoption. However there is some information in the literature that gives insights into the mental health policy process in these countries. I have chosen to briefly review the literature from seven OECD countries with different health and mental health systems which allow these insights, and the many commonalities, to be highlighted.

(a) United States of America (USA)

The USA has no national mental health policy by WHO definitions (Goldman 2009). However mental health reform has been described and in many ways is similar to other OECD countries. Gerald Grob, one of the earliest US writers on mental health policy, described (1987) the shift in policy direction from the psychiatric hospital as a place of ‘asylum’ and the centre of the public mental health system to a new policy direction in the 1960s when providing treatment and care in the community began to be pursued. These changes, as they took place in Australia, are discussed further in Chapter 4.

Grob (1994), in his structural analysis of US government and mental health policy, noted that the changes in mental health policy arose from the interaction of many different variables. Sometimes policy was shaped by overriding agreement on a
specific priority area. For example, the initial creation of the psychiatric hospitals was centred on the belief that these were the ideal places for the care and treatment for those with severe mental illness. More often policy was shaped by the interaction of multiple factors, for example beliefs about the cause and nature of mental illness, changes in the psychiatric profession, changes in the composition of the patient population in hospitals, changes to funding mechanisms and to community attitudes.

Grob also noted how changes in intergovernmental relations that shape and transform social policy apply to mental health policy. In the USA, as in Australia, the federal government played little role in mental health policy for much of its history. However, in both countries the expanding role of the federal government created interdepartmental relationships which shaped both policy and service delivery. The US federal government introduced landmark mental health legislation in 1946 which greatly expanded the role of the federal government. This legislation promoted community based care and was subsequently followed by State legislation, with similar policy intent.

Grob (1994) concluded from his analysis of mental health policy and reform in the United States that intergovernmental relations (between the federal and State governments) mediate and transform the content of a policy. This arises from the different roles of the federal and State government and the financial incentives provided by the federal government to the State governments. Grob noted that funding by the federal government was a powerful motivator that could act as a perverse incentive to policy distortion, if State level policy makers failed to take a sufficiently broad and balanced view of policy development and funding capture became an end in itself. While the USA has no national mental health policy, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services (Power 2010)
states that behavioural health care reform at a federal level has in recent years been guided by three documents: (1) the first Surgeon General’s report on mental health in (Office of the US Surgeon General 1999); (2) the President’s New Freedom Commission report on mental health (2003); and (3) the National Academy of Science’s Institute of Medicine report *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2005). Soon after the New Freedom Commission’s final report, SAMHSA was charged with leading the efforts to transform the mental health system. SAMHSA reports (2005, 2008) chart this vision and describe the objectives required to achieve it (Power 2010).

It has been suggested that the groundswell of interest in mental health, coupled with efforts to reform the broader health care system, may have opened a policy window for mental health in the USA, with the focus being to improve the health and wellbeing of the most vulnerable populations (Druss and Bornemann 2010).

Another policy window opened to enable the passing of the *Mental Health Parity and Addiction Equity Act* in 2008. This legislation was designed to eliminate historical disparities in insurance coverage for mental and addictive disorders relative to physical conditions, a problem which had been framed as discriminatory (Barry, Huskmamp and Goldman 2010, Barry 2006, Levinson and Druss 2000). At the national level, the first attempt to extend insurance coverage for mental disorders occurred during the Kennedy administration in the early 1960s (Barry, Huskamp and Goldman 2010, Barry 2006). Kennedy has been described as one of the most active innovators of all US presidents in the field of mental health, and this is largely attributed to his personal experience of the consequences of ineffective mental health care provided for his younger sister (Stoil 2006). While, as Grob (1994) noted, the establishment of
the US Joint Commission on Mental Illness and Health received bipartisan political support when it was signed into law by President Kennedy in 1963, a dichotomy was established and subsequently increased between State psychiatric hospitals and federally funded community mental health services. For example, the expansion of US federal entitlements to disability programs and programs for elderly Americans led to an exodus of large numbers of elderly patients from State mental hospitals into community programs funded by the federal government. A similar 'cost shifting' occurred in Australia (Eisen and Wolfenden 1988, Mental Health Task Force 1991).

Barry, Huskamp and Goldman (2010) described the years of political impasse on parity legislation that followed the Kennedy years, until a number of developments created the necessary conditions for the passage of the federal parity law in 2008. Firstly, new research demonstrated that comprehensive parity would not 'break the bank.' Secondly, key parity advocates (most notably Senators Domenici and Wellstone and Congressmen Jim Ramstad and Patrick Kennedy) successfully garnered support in attributing personal experiences with mental illness as critical to their leadership and support of the reforms. Thirdly, the shrewd political strategies adopted by congressional champions of parity in the Senate and House of Representatives were critical to success.

Similarly to the experience of other countries, mental health policy reforms in the USA have occurred in the wake of tragedy. Following the 2007 'Virginia Tech massacre' involving the murder of 32 students and faculty and the suicide of a 'deeply disturbed' student, political support for mental health reforms which had already been proposed was galvanised and progress was accelerated (Bonnie et al. 2009, Hogan and Sederer 2009). The massacre highlighted numerous problems with the mental health service system in Virginia, which were already being
studied by a Commission that had been established by the Chief Justice of the Virginia Supreme Court (Bonnie et al. 2009). Immediate action was the political imperative, the timeline for the Commission’s report was accelerated, and State legislative reforms were adopted less than one year after the tragedy (Bonnie et al. 2009). Similar experiences had been documented earlier in New York State. In 1999 Kendra Webdale was pushed under a subway car by a man with a lengthy history of ‘revolving door treatment’ (Hogan and Sederer 2009). The incident drew attention to a fragmented mental health system, and led to the enactment of ‘Kendra’s Law’ which granted judges the authority to issue orders for compulsory treatment (Hogan and Sederer 2009).

(b) United Kingdom (UK)

Mental health reforms that moved the focus of the service system from hospital to community occurred in the UK as in virtually all other OECD countries. More recent mental health policy development has been strongly influenced by the presumed need to prevent violence and alleviate public anxieties regarding the dangers of mentally ill people residing in the community (Davidson 2002, Hewitt 2008, Holloway 2006). Relative to other countries, risk management has been a more dominant policy driver in the UK (Davidson 2002, Hallam 2002). In an analysis of UK mental health policy as a ‘wicked problem,’ Hannigan and Coffey (2011) noted that the early policy focus on community care can be explained by concerns over homicides by people with mental illness, plus disquiet within the system regarding the ‘revolving door’ of overstretched and underfunded services. Hewitt (2008) also discussed the influence that the threat of violence by people with mental illness had on mental health policy. She argued that mental health policy development since the 1990s in the UK had become increasingly influenced by the
public perception that people living with mental illness in the community posed a danger to the general public. Similarly Pilgrim and Ramon (2009) identified the prioritisation of safety issues over treatment and care in UK mental health legislation during the 1990s. Although making up only a small proportion of people with mental illness, dangerous people with a mental illness had a disproportionate impact on policy, with relative neglect of the policy needs of much larger number of patients in primary care.

Specific government policy initiatives have been linked to individual cases. The UK ‘Care Programme Approach’ which emphasises risk management, care coordination and regular review was introduced in 1990 following the 1984 homicide of social worker Isabel Schwartz by a mentally ill former client, and a well-publicised inquiry (Davidson 2002, Glover 2007, Holloway 2006). Two further influential sentinel events occurred in 1992. The first was the unprovoked attack and murder of a London tube passenger by Christopher Clunis, and the second was the case of Ben Silock, who was mauled by a lion when he climbed into an enclosure at the London Zoo (Davidson 2002, Hallam 2002, Hewitt 2008, Holloway 2006). Both men were suffering from schizophrenia, and both cases highlighted breakdowns in service provision. The report into the care and treatment of Christopher Clunis published in 1994 has been described as an ‘iconic’ source of information regarding dysfunctional mental health care in the UK, and a ‘defining moment’ in policy and public perception of risk (Hallam 2002, Holloway 2006). Following the considerable media attention devoted to these and similar cases, the Department of Health implemented the Mental Health (Patients in the Community) Act 1995, with provisions for compulsory treatment in the community (Davidson 2002, Hewitt 2008, Holloway 2006).

Assertive Outreach Teams (AOTs) designed to reach ‘hard to engage’ patients with severe mental disorder like Christopher Clunis have been seen as a success in policy terms within the UK.
(Holloway 2006). Holloway links a number of factors relevant to the Kingdon streams to the success of AOTs in the UK. Firstly, AOTs address a longstanding and well publicised policy concern, that is, the failure of community care to follow-up high risk patients. Secondly, other simpler and cheaper measures (the Care Programme Approach and generic community mental health team model) had failed. Thirdly, the AOT model was an internationally recognised service delivery model with a clear and easily explained rationale. Fourthly, key stakeholders with high credibility and influence on policy (e.g. the Sainsbury Centre for Mental Health) were persuaded of the value of the AOT approach. Fifthly, measures of the fidelity of the model were available and finally, introduction of AOTs has been performance-managed by novel mechanisms of central control.

Cairney (2009) described mental health reform in England and Scotland, identifying two different approaches based on different policy imperatives. The UK, through its mental health legislation, emphasised public safety as the priority, rather than patient rights. Cairney noted that this alienated many groups and resulted in a stand-off between advocacy groups and the government, which was not resolved through bureaucratic accommodation. Cairney identified that the English mental health policy reforms were driven by

an unintended consequence of a reduction in hospital beds...[and] ... a rise in media and public concern towards dangerous people with mental disorders living in the community.

Cairney noted that this was exacerbated by the inquiries which kept the issue of mental health related homicides high on the media agenda. There was a perception that governments could be held responsible for not keeping the public safe. Thus, as previously identified, public safety became the overriding policy intent. Cairney noted that this was linked to the government’s emphasis on crime and public order, thereby harmonising it with
other social policies. The experience of Scottish policy was
different, with a stronger emphasis on patient rights. In Scotland
there were more hospital beds, fewer high profile homicides and a
greater separation between mental health and crime, which
meant different factors drove the policy agenda in Scotland to
those in England.

The role of the media as an influence on UK mental health
policy is prominent in the literature. Hallam (2002) noted that the
policy of community care for people with mental illness came
under intense media and public scrutiny during the 1990s
following the disturbing incidents noted earlier. Hallam analysed
the media coverage that two particular incidents received at the
time and over the next eight years. She noted emotive and
‘headline catching language’ was used to describe the incidents
related to Christopher Clunis and Ben Silock. She concluded that
the sensationalisation of the cases by journalists who appeared to
have a limited knowledge about mental illness heightened the
public’s concern about the risks and dangerousness of people with
mental illness generally. However she also noted that mental
health advocates used the media coverage to campaign for
increased resources for people with mental illness living in the
community. Hallam also raised the concern that the responsibility
for system failure was attributed to individual health service
professionals and that this may have had long-term adverse
implications for recruitment and morale in health and social
services.

Scheid (2008), in attempting to understand the competing
demands on mental health policy, described how an emphasis on
efficiency, outcome assessment and cost containment can conflict
with the goal of quality and access to effective services. She
described the policy and organisational challenge to balance the
conflicting demands for efficiency (cost containment) and
effectiveness (quality and access). McGonagle and colleagues also
make the point that when policy changes occur rapidly there is often insufficient time to implement the reforms, especially as many require changes in workforce numbers and practice, before the next policy change is adopted (McGonagle, Jackson and Baguley 2009).

(c) Canada

Public inquiries also appeared to have played a significant role in the mental health reforms which have occurred in Canada. Until recently, Canada did not have a national mental health strategy (Mental Health Commission of Canada 2012, Kirby 2008). The strategy was developed largely in response to the findings of the first national Canadian report on mental health – the Senate committee report Out of the Shadows at Last (also known as the Kirby Report) (Kirby and Keon 2006, Kirby 2008). The Kirby Report provoked public debate and major mental health reform, including the establishment of the Mental Health Commission of Canada in August 2007, the articulation of a national framework for mental health in 2009, and the identification of recovery as the central guiding principle for mental health reform (Kirby 2008, Piat and Sabetti 2012).

Mental health reform in Canada also appears to have been impacted by what Kingdon ([1995] 2003) refers to as 'predictable' policy windows which occur, for example, in the wake of a newly elected government, in this instance in Ontario. In 1987 the Ontario Minister of Health appointed a working committee whose final report The Graham Report: Building Community Support for People, released in 1988 identified the need for collaboration between consumers, families and service providers and the income, employment and housing sectors (Hartford et al. 2003, Lurie 2005). The Graham Report also highlighted that whilst community mental health spending was increasing, mental health spending was actually declining as a proportion of health spending...
(Hartford et al. 2003, Lurie 2005). Although a committee was established to implement the recommendations of the Graham Report, another change of government in Ontario in 1990 meant the direction of mental health reform was outlined under a new rubric: ‘Putting People First’ in 1993 (Hartford et al. 2003, Lurie 2005). There was another change of government in the province in 1995, and the Minister of Health was presented with concerns from stakeholders with regard to the lack of progress on mental health reform (Lurie 2005). Whilst stakeholders supported the policy directions of the Graham Report and ‘Putting People First,’ they were disappointed with the lack of implementation (Lurie 2005). The new minister accepted their criticisms and announced that a new policy framework would be developed to guide the implementation of mental health reform in Ontario, in addition to new funding to establish community mental health services (Lurie 2005).

(d) New Zealand

In New Zealand, as in Australia, public inquiries have been the catalyst for many significant mental health policy changes (Brunton 2005, Gawith and Abrams 2006). Brunton (2005) conducted a review of the literature on the evolution, functioning and achievements of public inquiries as instruments of government policy making on mental health in New Zealand. Five inquiries were identified which contributed to national mental health policy in New Zealand since the institution of Parliamentary government in 1854. They were: (1) the Select Committee of the House of Representatives on a General Lunatic Asylum (1858); (2) the Joint Parliamentary Committee on Lunatic Asylums (1871); (3) the Board of Health Committee on Psychiatric Services in Public Hospitals (1957–60); (4) the Royal Commission on Hospital and Related Services (1972–3); and (5) the Ministerial Inquiry in respect of Certain Mental Health Services
(1995–6) (also known as the Mason Inquiry).

The last of these, which produced the largest report of the five inquiries, was ordered following two fatal police shootings of persons with mental illness (Brunton 2005). The Mason Inquiry drew attention to funding issues, stigma and discrimination, and workforce problems as significant impediments to the delivery of mental health services in New Zealand (Gawith and Abrams 2006). The New Zealand Mental Health Commission was established in response to an adaptation of one of the recommendations of this landmark report (Brunton 2005, Gawith and Abrams 2006). Brunton (2005) notes that each inquiry was formed when a systemic policy issue reached a level of political sensitivity and public significance sufficient to create a ‘climate for action.’ This idea of a ‘climate for action’ seems comparable to that of the opening of a Kingdon policy window.

(e) Turkey

Sometimes a major natural disaster triggers policy reform, and this even applies to mental health. In Turkey there were two major earthquakes in 1999 that drew attention to major deficiencies in the capacity of mental health services to respond to the psychological trauma and social dislocation caused by the earthquakes. Munir, Ergene, Tunaligil and Erol (2004) describe how the debate about the failings in the organisation and provision of mental health services in response to the earthquake escalated to encompass the broader, country-wide deficiencies in services. This opened a window of opportunity and created the political will for a coherent and clearly articulated national mental health policy. Although it took over a decade the Turkish government developed and finally adopted its first National Mental Health Plan on World Mental Health Day (10 October) in 2011.

(f) Sweden
Parliamentary commissions have also influenced Swedish mental health policy. In 1992 a Parliamentary commission (the Committee on Psychiatric Care) reported that the psychiatric and social services for people with severe mental illness remained largely inadequate (Hansson 2006). The commission’s report resulted in the adoption of mental health reforms in 1995 which aimed to address service provision for individuals suffering from severe and persistent mental illnesses (Hansson 2006). Hansson also describes the conditions which interacted in 2000 to facilitate a marked change in Swedish case management policy. These included academic evidence of the effectiveness of case management, influence from the ‘user’s movement’ and a new political willingness and readiness of the government to adopt case management on a national level. Hansson (2006) links the ‘political readiness’ to financial support from state subsidies for case management services. He goes on to highlight that despite several decades of international academic research demonstrating the effectiveness of case management services, it was not until a single Swedish study of 10 pilot services was published that case management was introduced on a national scale. Hansson believes that the policy may never have been adopted if there had not been strong concurrent humanitarian-based support from the user’s movement, or the necessary political and financial readiness to endorse the reforms.

(g) Germany

Sometimes the history of a country impacts on mental health policy development. There are few OECD countries where this is more evident than in Germany. The events of World War II, including the cooperation with the Nazi regime, left the international reputation of German psychiatry in ruins. As such, discussions of German mental health care reforms tend to begin approximately 15 years after other western nations became
engaged in the policy project of de-institutionalisation and community care, which took place during the 1950s (Bauer 1994).

It was only in the late 1960s, when the government changed from a conservative Christian democratic administration to a coalition of social democratic and liberal parties, that psychiatry and mental health again became a public issue. The atrocities by the Nazis against mentally ill people were brought to public discussion. By the early 1970s, the German Physicians' Conference, the Alliance for the Mentally Ill and the German Association for Social Psychiatry started to advocate for reform. In 1975, an expert commission identified shortcomings in the provision of treatment and demanded reform which included restructuring of the larger psychiatric hospitals, the integration of psychiatric departments into other hospitals, the development of closer-to-home community services, the provision of assistance to support groups and the support of education and further training (Expert Commission 1975). The reunification of Germany resulted in East German psychiatry becoming progressively more aligned with Western rather than Soviet psychiatry.

Consistent with other OECD nations, national reports continued to be influential in the mental health reform process in (West) Germany (Bauer et al. 2001). Three national reports in particular are ascribed a foundational role, starting with the 1975 national enquiry into mental health care commissioned by the federal Parliament (Psychiatrie-Enquete) (Deutscher Bundestag 1975). The second was the 1988 report of the expert commission (Bericht der Expertenkommission) (Bundesministerium für Jugend, Familie, Frauen und Gesundheit 1988) and the third the 1992 Federal directive on staffing in mental health inpatient services (Psychiatrie-Personalverordnung) (Kunze, Kaltenbach and Auerbach 1992), all consistent with WHO mental health policy.
directions and aimed at bringing German mental health policy back into the mainstream.

2. Mental health policy in developing countries

Despite the relative lack of resources compared to their OECD counterparts, developing countries have also been involved in considerable mental health policy development and reform. It is beyond the scope of this thesis to provide a comprehensive review of these, however the countries mentioned, from South America, Africa, South East Asia, Eastern Europe and the Pacific islands, provide examples of the policy development that has been undertaken in these regions.

Alarcon and Aguilar-Gaxiola (2000) in their analysis of mental health policy developments in Latin America focused on changes in the structure of mental health services. They found that using information, in this case the introduction of indicators which helped assess the overall impact of mental health, was a catalyst for countries to update or redevelop their mental health policies. They also emphasised as influential the role of international agencies, for example the Pan-American Health Organization, a state of affairs seen more in developing countries than in established market economies.

Gureje and Alem (2000), describing mental health policy development in Africa, noted the importance of public beliefs and opinion in shaping policy. Stigma and lack of information about the nature and impact of mental disorders resulted in a low priority being given to mental health policy development, especially in the poorer African countries. They noted that mental health reform was more likely to be implemented when policies were embedded within initiatives for higher priority areas such as chronic or infectious disease, or post-conflict reconstruction. Draper and colleagues (2009) while primarily describing the barriers to the implementation of South Africa’s 1997 mental health policy guidelines, noted the importance of national leadership in policy development and adoption, especially for overcoming regional fragmentation.
Stockwell and colleagues (2005) examined mental health policy development in Cambodia as a case study. They identified the key issues which influenced not only the content of mental health policy but also why mental health was able to gain attention on the public policy agenda in this developing country. They found that the impact of the post-conflict context was important, as were the evolution and influence of stakeholder groups, the timing of policy development, key individuals within the government and the existence of clear directions in a plan. All these factors influenced both the content and the political adoption of a mental health policy.

Mental health reform in post-conflict countries was considered by De Vries and Klazinga (2006) in relation to Bosnia, Herzegovina and Kosovo. They examined how mental health reached the threshold for government policy attention in countries dealing with the legacies of armed conflict and, as had been determined by Stockwell et al. in the case of Cambodia, found that external agencies (such as the Post-Conflict Fund at the World Bank) were important. Agencies assisting in post-conflict reconstruction promoted mental health as an important part of social cohesion and enhancing human capital. However they were also a threat to the sustainability of reform once they withdrew. De Vries and Klazinga identified the potential for a lack of local ownership over the policy, disorganisation resulting from overlapping short-term mental health programs (especially those directed towards traumatised populations), rapid changes in healthcare financing and a rapid decentralisation of healthcare responsibilities. The authors concluded that to achieve sustainable mental health reform in post-conflict countries, there needed to be a balance between foreign influence and involving the local bureaucratic structures and stakeholder groups.

Zwi and colleagues (2011) discuss factors which influenced the development of mental health and psychosocial policy in the Solomon Islands. Again the importance of international players in influencing mental health policy and service reform was seen. They identified factors influencing policy change as sociocultural issues, bureaucratic
motivation, the impact of international aid and the influence of research and evidence, with all this occurring in the context of political, security and economic concerns. Mental health was seen to be important because it represented a politically sensitive health and social problem in the community given the impact on the population of the preceding conflict. The analysis by Zwi and colleagues found strong support for Kingdon's proposition that problems, politics and policy come together to drive agenda settings. At a local level, Zwi and colleagues identified three influences - decision makers who are sensitive to the issues, donors and the resources they provide and data which highlights the need to revise the policy and improve services. Similarly to Gureje and Alem (2000) they concluded that the positioning of psychosocial and mental health in policy was enhanced by links to priority policy areas being pursued such as the contribution of mental illness to subsequent disability, to family and community instability, to violence and as an impediment to social and economic development.

3. Conclusion

This chapter provides a brief overview of the mental health policy literature and finds there is a consensus in the literature that having a national policy on mental health is fundamental for a country to promote mental health in the population and deliver effective mental health services. Cycles of policy and service reform have been taking place in mental health for centuries. Often these cycles are driven by local factors. Sometimes international developments are important. For example the decision of the World Health Organisation to dedicate the 2001 World Health Report was to mental health (WHO 2001b) with recommendations for action was globally influential, as was the Global Burden of Disease (GBD) Study demonstrating that mental disorders were the leading causes of health-related disability in most countries (Murray and Lopez 1996b). These international actors raised the profile of mental disorders with governments.

In many countries, including Australia, each attempt to provide a policy solution seems to have been accompanied by an emerging
problem (such as public scandal or concern about costs) requiring a new or modified policy response. Mental health policy has been described as 'unstable' with the literature identifying reasons for this over time as due to changes in the understanding of mental illness and the development of psychiatry as a scientific discipline, exaggerated fluctuations in mental health ideologies and rhetoric, the mismatch between the goals of mental health policy and the means by which these goals were achieved and cyclical changes in public opinion with evolving social changes. Much of the mental health policy literature comes from within the mental health sector itself and it is therefore perhaps unsurprising that most literature is about policy content or policy implementation and much less is about how and why the policy was adopted, which is the focus of this thesis.

The chapter concludes with a summary of the mental health policy situation in key OECD countries and in developing countries. This summary identified the importance of the history of a country and its political system (including the federated system of government as in Australia), concerns about cost blowouts, the influence of public inquiries and commissions in initiating policy change, the impact of a crisis or individual tragedy (e.g. violence by a person with mental illness or a natural disaster), the role of the media and public attitudes and beliefs about mental illness, and (for developing countries) the role of external funding agencies (with the conditions they attached to grants and loans). To a greater or lesser extent, each of these played a role in the development of Australian mental health policy discussed in Chapter 5 and in the twenty years covered by this thesis, as discussed in Chapter 5 to Chapter 7.

In the next chapter I describe the methodology and research design used in the thesis.
CHAPTER 4 – METHODOLOGY and research design

Seven steps were undertaken in carrying out the research for this thesis. The first was to clearly formulate the questions to be addressed. The second was to describe the sources examined to answer these questions. The third was to collect the data. The fourth was the analysis of the data from all sources to identify the key themes in mental health policy associated with three major periods within the twenty years under study. The fifth was to identify the problems, and policy solutions being proposed, for each theme, for each of the three time periods being studied. The sixth was to identify from the data sources how and why the policy window opened for the Commonwealth government to take specific political action ('opening of the policy window') in each of the three time periods. The seventh was to review the Kingdon model and the extent to which it adequately explains the data. The first four steps are described in this chapter. Steps five and six are described for each policy window in turn, in Chapter 6, Chapter 7 and Chapter 8. Step seven is addressed in Chapter 9. The research was approved by the Human Ethics Research Committee at the Australian National University (Protocol: 2011/279).

Historical works are often classified by their authors as belonging to one of two major types: narrative history, which describes events in a non-analytical manner, and interpretational history and which seeks to explain, evaluate and interpret relationships. Whilst the separation of narrative and interpretational history is somewhat artificial (Porter 1981, Previts, Parker and Coffman 1990), this thesis aims to interpret the major events that occurred in national mental health policy formulation between 1988 and 2008.

In choosing events or developments to subdivide the twenty years under analysis I looked beyond the obvious transition points of changes in government following elections, and the five year spans representing Commonwealth/State funding agreements (1993-98, 1998-2003 and
2003-08). While these historical events provide convenient markers for periods of time in which policy directions were revised, the processes over the lifetime of major policy reforms do not fit neatly inside these boundaries. Therefore I have taken other events into consideration in drawing boundaries, as described in detail below.

The first time period starts in 1988. In that year the Commonwealth Labor government began to consider national mental health reform. That year is chosen because it was when the Commonwealth government received a report it had commissioned on the state of mental health services and authorised the formation of a working group to advise the government on possible responses. Over the subsequent five years negotiations took place between the Commonwealth, State and Territory governments and key stakeholder groups, which led to the adoption of the *National Mental Health Policy* in April 1992. The *National Mental Health Plan 1992* (the first plan), which was unpublished, was also considered and accepted by health ministers in 1992. This plan became part of the 1993 to 1998 Commonwealth/State Medicare Agreements. Therefore, the first period chosen for consideration commences in 1988, includes the adoption of the *National Mental Health Policy* and the first plan in 1992 (the first major policy window being considered) and ends in 1996 with the change in Commonwealth government.

The first plan ran from 1993 to 1998 and formed the content of a specific schedule (Schedule F) in the 1993 to 1998 Medicare Agreements. It would therefore seem reasonable that a revision of mental health policy would coincide with the expiry of the plan and the Medicare Agreements in 1998 and form part of the negotiations which surrounded the 1998 to 2003 Health Care Agreements. However there had been no Commonwealth commitment in 1992 to any new five year plan, and renegotiation of the Health Care Agreements at a Commonwealth level was carried out after the election of a Coalition government on 2 March 1996. As is discussed in Chapter 6 the reaction of the Howard government, and Health Minister Michael Wooldridge, was
to revisit the Commonwealth government’s involvement in national mental health reform. There was no new mental health policy but a new five year mental health plan was developed and adopted in April 1998 (the *Second National Mental Health Plan*), and this continued the implementation of the 1992 *National Mental Health Policy*.

The second time period considered in the thesis starts in 1996 with the election of the Coalition government, includes the 1998 decision by the Commonwealth government to endorse the *Second National Mental Health Plan* and to maintain involvement in mental health reform as part of the 1998 to 2003 Health Care Agreements (the second major policy window being considered). The time period ends with the conclusion of the second plan and the Health Care Agreements in June 2003.

In July 2003 a *National Mental Health Plan 2003-2008* (the third plan) was endorsed by Australian health ministers. Despite the preceding ten years of national mental health reform, there continued to be criticisms of the quantity and quality of mental health services delivered in Australia. These concerns reached the threshold where, in 2006, mental health was placed on the COAG agenda. The issues which led to mental health being considered by COAG, and the subsequent adoption of the COAG *National Mental Health Action Plan* in 2006, is the third major policy decision considered in the thesis. COAG’s focus on mental health is widely considered more important than the adoption in 2003 of the third plan. A review of the relevant policy literature and the opinion of key stakeholders confirm that the second and third plans were very similar and the decision of the incumbent Coalition government to adopt the third five-year plan did not involve a major change in policy direction. A far more comprehensive policy review took place with the consideration and adoption of the COAG *National Mental Health Action Plan*. The third time period being considered therefore is from 2003 until 2008.

The time periods examined in the thesis are summarised in Error! Reference source not found..
Table 2: Time periods and policy windows examined in the thesis

<table>
<thead>
<tr>
<th>Policy Period</th>
<th>Policy Window</th>
<th>Health Care Agreement</th>
<th>National Mental Health Plan</th>
</tr>
</thead>
</table>

1. Research Questions

This thesis identifies the problems in the mental health sector confronting governments in Australia during three time periods (1988-96, 1996-2003, 2003-08), what policy solutions were proposed to respond to those problems and why particular policy directions were adopted by the Commonwealth government during this time. Specifically the aim is to identify the issues that influenced the Commonwealth government’s mental health policy decisions at three specific points in time (the opening of the policy windows).

- Research question 1 - what led the Labor government in 1992 to adopt the National Mental Health Policy and first plan?
- Research question 2 - what led the Coalition government in 1998 to adopt the Second National Mental Health Plan?
- Research question 3 - what led the Coalition government in 2006 to adopt the COAG National Mental Health Action Plan?

These overarching research questions are intentionally broad and open-ended to allow a wide-ranging analysis of the influences that led to the policy change. This approach was taken to guard against the potential for my own views as an expert key participant to affect the outcome through the framing of the questions to be asked, an issue that is discussed in more detail later in this chapter.

2. Data Sources
To answer these questions I devised a research design to collect data from four sources:

- a systematic review of published literature to identify primary and secondary sources, using standard methodology for systematic literature review
- a review of Parliamentary records, primarily Hansard, for the relevant periods
- interviews with key informants
- my observations as an expert key participant in mental health reform

Each data source was chosen so as to examine and collate information from different perspectives, each of which bears on the research questions.

3. Data Collection

3.1 Systematic review of the literature

A systematic review was conducted in accordance with the guidelines proposed by the Meta-Analysis of Observational Studies in Epidemiology (MOOSE) group (Stroup et al. 2000). The major international health, psychology, psychiatry, and biomedical electronic databases Medline, PsycINFO and EMBASE were searched via OVID. Other electronic databases indexing the social sciences, public affairs, and news and commentary in the media with a focus on Australia (APAFT, Humanities and Social Sciences Collection, TV News, Rural & Remote Health Database, AMI, APAIS-HEALTH, CINCH-HEALTH, Health and Society Database, Health Collection, Media Scan) were interrogated via Informit. The following search string was used to retrieve documents containing these terms/phrases in abstracts and titles: Australia* AND (National OR Federal OR Government* OR Commonwealth) AND (Reform* OR Strategy OR Plan OR Policy) AND (Mental Health OR Mental Illness* OR Mental Disorder* OR Psychiatric Disorder*). Specific search strings were also tailored to databases with controlled subject retrieval via a thesaurus of indexing terms (Medline, PsycINFO, EMBASE, APAFT,
Health and Society Database, and AMI). These were designed to increase the 'conceptual saturation' desired for qualitative search strategies (Thomas and Harden 2008). These search strings are included as appendices A–F. All search strings were developed with the assistance of a research librarian. Databases were searched from January 1980 until April 2011. There were no limitations to the language of publication.

Citations were downloaded or manually entered into an Endnote X3 bibliographic database, where duplicates were removed and titles and abstracts were assessed for relevance. Reference lists of these articles were also searched manually to identify additional material. The mental health section of the Commonwealth Department of Health and Ageing website (http://www.health.gov.au/internet/main/publishing.nsf/Content/publications-Mental%20health) was also hand searched for further relevant publications.

To be considered for inclusion articles were required to provide information which related to the adoption of one of the three policy decisions, the adoption of the *National Mental Health Policy* and first plan in April 1992, the second plan in April 1998 and the COAG *National Action Plan on Mental Health* in July 2006.

Once identified the literature was separated into primary and secondary data sources.

### 3.2 Search of Parliamentary records

Commonwealth Parliamentary records for the three periods were searched via the website of the Australian Parliament (http://parlinfo.aph.gov.au). The collections searched were House of Representatives and Senate Hansard, Committees (including Senate, House of Representatives, Joint and Estimates), Bills and Legislation, The Australian Constitution and Publications (House and Senate Publications, tabled papers, budget papers).

These collections were searched for the terms mental* OR
psychiatric* recorded during the following periods (which it was considered would capture the majority of the comments relevant to the budget decisions or adoption of the relevant policy decision):

- 1 April 1991 (one year before the endorsement of the National Mental Health Policy) up to 30 June 1994 (one month after the 1994 Commonwealth Budget);
- 1 April 1997 (one year before the adoption of the second plan) up to 30 June 1998 (one month after the second plan was incorporated into the Australian Health Care Agreements); and
- 1 April 2005 (one year before Prime Minister Howard announced Commonwealth funding for the third plan) up to 31 August 2006 (one month after the third plan was signed).

### 3.3 Interviews with key informants

Advantages and caveats in the use of key informants were described by Sjoberg and Nett (1968). Interviews with key informants provide information which complements that found in the literature. Interview data can provide information on the motivation of various groups or individuals who were influential in the policy process. However, well identified problems with key informant interviews are recall bias and interviewer error (where the respondent fails to fully report what they know) (Romney, Weller and Batchelder 1986).

Fifteen key informants were selected because they held positions within and outside government which are considered to have provided them with a perspective that allowed them to comment on the period being studied. The key informants are drawn from four groups, with some informants having worked in areas encompassing more than one group.

- Group 1 – the government minister responsible for mental health (for the first policy window) or the ministerial advisor with responsibility for mental health (for the second and third policy windows);
- Group 2 – Commonwealth and State/Territory government
officials – the senior Commonwealth government bureaucrat covering the period from the time of the establishment of the Commonwealth mental health policy area and State directors of mental health from five State government (New South Wales, Queensland, Western Australia, South Australia and Tasmania) who between them cover the periods in which the three policy windows opened;

• Group 3 – four community advocates who were mental health experts and/or representatives of non-government organisations and who between them were advocates for mental health reform across the period covered by the thesis;

• Group 4 - two independent consultants who were contracted to provide technical advice on mental health reform to the Commonwealth government and who between them were consultants continuously from 1990.

For Group 1, attempts were made to contact each person who held the position of Minister of Health (Brian Howe, Michael Wooldridge and Tony Abbott) at the relevant time. Mr Howe and Dr Wooldridge agreed, although Dr Wooldridge was subsequently unavailable for personal reasons. Mr Abbott was still a Member of Parliament and his office declined. For Group 2, each person who held the position of Commonwealth Director of Mental Health at the relevant time was contacted and all agreed. Although the Commonwealth was focus of the thesis it was considered important to include a state perspective and four former state Directors of Mental Health (one of whom had served in two states) and who between them covered the three periods in which the policy windows opened agreed to be interviewed. For Group 3 a large number of possible individuals could have been interviewed and I chose the CEO of the Mental Health Council of Australia (the peak Commonwealth government advisory body), the CEO of a national NGO primarily dealing with individuals with severe mental illness (Mental Illness Fellowship of Australia) and the CEO of a national organisation primarily dealing with individuals with common mental disorders.
(beyond blue). To provide a state perspective I included the CEO of a peak state mental health NGO (Queensland Mental Health Alliance). To provide a professional provider perspective I chose the Royal Australian and New Zealand College of Psychiatrists as this was the only group actively involved with the Commonwealth across the twenty year period. The two technical consultants interviewed were considered to be the most influential consultants used by the Commonwealth in the twenty year period.

The names, positions held by the key informants and dates of interview are provided in Appendix 3. Interviews were conducted by the candidate either by telephone or face-to-face and transcribed in full. Each interview was semi-structured and each interviewee was asked to provide responses disregarding any previous professional or personal relationship with the candidate). The first question was open ended:

• Why do you think the Commonwealth...?

Then more specific questions were asked about:

• the factors that led to mental health becoming recognised as a problem requiring policy attention;
• how the government responded to these factors; and
• how the government provided a policy solution.

Answers to the following were also elicited during the interview:

• was the policy decision consistent with party policy and principles?;
• was there consultation with political advisors?;
• was there agreement amongst policy elites?;
• what were the expected electoral impacts?; and
• what was the expected media reception?

When the information provided by the key informant during the interview is used as a data source, the reference ‘key informant interview’ in brackets appears after the name of the key informant.

4. My role as an informant

I was an expert key participant as well as an observer of mental health
reform in Australia during the period covered by the thesis. Being a participant working in the environment and engaged in the process allowed for observations and a description of events unobtainable through other techniques (Ross and Ross 1974).

In 1989 I was appointed Director of Mental Health in the Queensland Department of Health and until the end of 1996 when I was appointed Director of Mental Health in the Commonwealth Department of Health and Ageing, I represented Queensland at Commonwealth/State meetings and on national working groups during which the proposals for the National Mental Health Policy and first plan were developed. Specifically I was the Queensland representative on an advisory group and then a mental health taskforce established by the Australian Health Ministers’ Advisory Council (AHMAC) to advise them on the options for a national mental health policy in response to the Eisen and Wolfenden report. I was then the Queensland representative on the Commonwealth/State working groups that drafted both the National Mental Health Policy and the first plan.

In 1992 I was a member of the working group which drafted Australia’s mental health goals and targets for the Commonwealth government. From 1992 to 1993 I was the Queensland government’s representative on the strategic planning group for the Commonwealth/State Medicare Agreements in which mental health was incorporated for the first time, as Schedule F to the 1993-98 Medicare Agreements. Between 1993 and 1998 I was chair of the AHMAC National Mental Health Working Group (NMHWG) which oversaw the implementation of the first plan. Also between 1993 and 1995 I chaired the National Mental Health Information Strategy Committee. In 1996 I chaired the Commonwealth ministerial taskforce which established the national mental health peak body, now the MHCA.

During 1997 and 1998 I was the Director of Mental Health in the Commonwealth Department of Health and Ageing. In 1999 I was appointed mental health specialist at the World Bank in Washington DC. In 2001 I took up my academic position at the University of Queensland
and from this position served as an advisor to the Commonwealth Department of Health and Ageing.

In 2002 I was the joint chair of the reference group established by AHMAC to provide advice on the 2003 to 2008 Australian Health Care Agreements. During 2002 and 2003 I chaired the steering committee which evaluated the second plan and during 2002 and 2003 I also chaired the steering committee which drafted the third plan 2003-2008. Between 2006 and 2008 I chaired the steering committee to revise the National Mental Health Policy.

During the period covered by this thesis, and since, I individually and with colleagues have published on the developments in Australian mental health policy. A summary of the positions I held during the relevant periods covered by the thesis and my main publications relevant to the thesis is at Appendix 4.

Participant observation is a well described methodological approach applied within the social sciences, particularly anthropology and sociology (Guest, Namey and Mitchell 2012, Kawulich 2005, Macionis and Plummer 2008), for collecting information. During participant observation research, the observer is engaged, either overtly or covertly, in the social environment which is being studied. In most participant observation research the social scientist is an observer but not often an authentic participant (Guest, Namey and Mitchell 2012, Lee 2001). My role was as an authentic participant.

Participant observation has considerable utility in a field such as political science, although such techniques are an underused methodology (Bostitis 1988, Gillespie and Michelson 2011, Lee 2001, Ross and Ross 1974). Political scientists have studied US Congress whilst employed as legislative assistants and committee staff, allowing them direct access to the behaviours they wished to observe (Bostitis 1988, Ross and Ross 1974). For example, as a participant in the daily routines of the Senate, political scientist Ralph Huitt was privy to intimate details of conversations, exchanges of favours, informal communication networks and patterns of deference and dominance.
(Bostitis 1988, Ross and Ross 1974). This information allowed him to analyse and describe the internal power system of the Senate, and its resistance to reform. Such an analysis would not have been possible without Huitt’s active participation in the Senate. Similarly, former member of the Wisconsin State Assembly and State Senate Mordecai Lee reported on his experience as an active participant observation in the Wisconsin Legislature (Lee 2001). Based on participant observation, Lee evaluated the nature of relationships between the politicians he served and administrators. He concluded that elected officials make decisions based on political expediency as opposed to a comprehensive norm defining their relationship with administrators.

The ‘observer effect’ where individuals being studied modify their behaviour due to awareness of the researcher’s presence is avoided when the observer is a legitimate, active participant, as was my situation. However, a common problem is that some loss of objectivity can occur through being part of the group (Macionis and Plummer 2008). To address this problem the thesis uses my observations as only one source of information; cross-correlating the information from all four sources together helps control for limitations and bias from any particular source.

The influence of my perceptions on the research including on the thematic analysis below is a source of potential bias. Efforts were made to overcome this by having the coding of the themes independently confirmed by a research assistant. With respect to the interviews with the key informants, as noted all were asked to respond without being influenced by any current or prior personal or professional relationship with the candidate. Whilst I believe each person did respond in this way, I have no way to independently confirming this.

5. Data analysis

The nature of the research questions and data collected precluded the adoption of a conventional meta-analytic approach. Thematic analysis has been identified as a solution to the synthesis of qualitative data
(Braun and Clarke 2006, Dixon-Woods et al. 2005, Thomas and Harden 2008) Thematic analysis:

...involves the identification of prominent or recurrent themes in the literature, and summarising the findings of different studies under thematic headings (Dixon-Woods et al. 2005).

Guidelines for the conduct of a thematic analysis vary (Braun and Clarke 2006); this thesis follows the stages of data coding described by Fereday and Muir-Cochrane (2006).

Eligible documents for which full text versions could be identified were imported for coding into the qualitative analysis software program QSR - NVivo (version 9.2). An initial deductive coding manual was created (see Figure 3), which was informed by a preliminary examination of the available data. Given the large volume of literature to be searched the thematic analysis was limited to critical sections of documents. For large reports and documents executive summaries and introductions were analysed. The results, discussions and conclusions sections of peer reviewed journal articles were coded. For articles which were editorial in style or without explicit sections, the entire document was considered.
5.1 Results

The search strategy identifying the number of data sources is summarised in Figure 2.

Figure 2: search strategy flowchart

Unique citations from search strings tailored to database subject headings
- EMBASE (n = 601)
- MEDLINE (n = 409)
- PsycINFO (n = 212)
- AMI (n = 108)
- Health & Society (n = 251)
- APAFT (n = 326)

2,586 unique, potentially eligible sources

Title and abstract review.
Excluded for lack of relevance (n = 1,979)

607 unique, potentially eligible sources retrieved and read in full

Full text review
Excluded for lack of relevance (n = 289)

318 sources with data eligible for thematic analysis
- Grey literature sources (n = 142)
- Peer reviewed journal (n = 132)
- Media, conference or web based sources (n = 37)
- Books (n = 7)

All identified Hansard records eligible for thematic analysis using themes derived from analysis of the literature review.

Hansard data sources
- 1st window (n = 914)
- 2nd window (n = 883)
- 3rd window (n = 14,457)

3rd window (n = 11)

Unique citations from snowballing techniques and other sources (n = 178)
- Via OVID (n = 181)
- Via Informit (n = 320)

2,586 unique, potentially eligible sources

Key informant data sources
- 1st window (n = 7)
- 2nd window (n = 7)
- 3rd window (n = 11)

Interview data utilised for triangulation purposes.
During the thematic analysis of literature sources, 5 themes became evident (see Figure 3).

**Figure 3: First coding template**

- **Human rights violations**
  - Outrage
  - Shame
  - Scandal
  - Embarrassment
  - Discrimination
  - Stigma

- **Economics**
  - Service efficiency
  - Cost effectiveness
  - Quality control
  - Benchmarking

- **Deinstitutionalisation**
  - Shortcomings/ failures
  - Intersectoral linkages
  - Homelessness
  - Housing
  - Employment
  - Welfare
  - The justice system
  - Fear

- **Population health**
  - Prevalence
  - Promotion
  - Prevention
  - Early intervention
  - Burden
  - Disability
The progression through documents led to the identification of new inductive codes which were subsequently applied to earlier data sources. The coding manual was refined through discussion and juxtaposition of codes to ensure an accurate representation of the material was being developed. The final set of codes and themes is in Figure 4.

**Figure 4: Final set of codes and themes**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Coding for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human rights and community</td>
<td>- Human rights violations/ inequality/discrimination</td>
</tr>
<tr>
<td>attitudes</td>
<td>- Community attitudes, stigma</td>
</tr>
<tr>
<td></td>
<td>- Scandal/ outrage</td>
</tr>
<tr>
<td></td>
<td>- Shame/ embarrassment</td>
</tr>
<tr>
<td>Community need</td>
<td>- Population burden</td>
</tr>
<tr>
<td></td>
<td>- Unmet/ met need</td>
</tr>
<tr>
<td>Service structure</td>
<td>- Deinstitutionalisation – shortcomings, failures, consequences</td>
</tr>
<tr>
<td></td>
<td>- Linkages – intersectoral (between health and housing, employment, welfare), and within the health sector</td>
</tr>
<tr>
<td></td>
<td>- Service focus/ responsibilities – promotion, prevention, early intervention, diagnostic severity/ emphasis, State vs. federal</td>
</tr>
<tr>
<td>Service quality and effectiveness</td>
<td>- Infrastructure</td>
</tr>
<tr>
<td></td>
<td>- Financial</td>
</tr>
<tr>
<td></td>
<td>- Human - workforce</td>
</tr>
<tr>
<td>Resources</td>
<td>- Outcomes</td>
</tr>
</tbody>
</table>

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In a subsequent analysis, these themes were applied to Parliamentary records. This complementary analysis aimed to investigate the level of agreement between themes identified during the analysis of literature sources, and the relevant content discussed in the Commonwealth Parliament and its committees during the periods of interest.

There was a steady increase in the frequency of references to mental health over the twenty year period covered by the thesis. When limited only to the Hansard search there was a steady increase in references to mental health issues over the period with a dramatic increase just prior to the COAG meetings in 2006 (Figure 5).
Figure 5: Record over time of the number of references to 'mental, mentally, psychiatric, psychiatry, or psychiatrist' in Senate and House Hansard.
When all Parliamentary collections were searched, the number of references to mental health increased dramatically from 2000, to over 10,000 references in 2005 (Figure 6).

Figure 6: Record over time of the number of references to 'mental, mentally, psychiatric, psychiatrically, psychiatry or psychiatrist' in all Parliamentary collections.
6. Conclusion

To conclude, a systematic search of the published literature from January 1980 until April 2011 produced 318 primary and secondary sources with data eligible for thematic analysis. From the thematic analysis, five themes within mental health policy were evident – human rights and community attitudes; community need; service structure; service quality and effectiveness; and resources. A search of the Parliamentary records was also undertaken covering the three relevant periods, 1 April 1991 to 30 June 1994; 1 April 1997 to 30 June 1998; and 1 April 2005 to 31 August 2006. The information from the key informant interviews, when combined with that from the literature search and Parliamentary collections search, allow data triangulation (Patton 2002). My views as an expert key participant observer provide a fourth perspective.

The information generated by the literature reviews on both the problems facing mental health, and policy solutions proposed, is organised under the headings of these five themes for each policy window in chapters 6 to 8. Quotations from primary and secondary source literature and the key informant interviews are provided where relevant to illustrate the content coded within each theme.

In the next chapter I describe the developments that have occurred in mental health services historically and more specifically in Australia in the decades prior to 1988. By doing this the chapter sets the context for the mental health policy and service reform that occurred between 1998 and 2008.
CHAPTER 5 – The Context for Mental Health service reform

Chapter 3 provided a brief overview of the mental health policy literature. This chapter describes the developments in mental health services generally and in particular focuses on the provision of mental health services in Australia prior to 1988. This context is important as mental health policy and service reform is, as already noted, cyclical and the developments that are described over the 20 years in this thesis occurred within the context of the preceding policies and services.

1. Historical context for mental health services

It is beyond the scope of this chapter to provide a comprehensive overview of the history of mental health services, which has been well documented elsewhere (e.g. Lewis 1988, Shorter 1997). Identifiable descriptions of states we would today call mental disorders or illness are known from the world’s surviving ancient medical texts as well as traditional beliefs persisting in modern societies. Maladaptive mental states, persistent distress, altering of the psyche, changes in socialisation and other diagnostic features may predate written records and the origins of agriculture (Millon 2004, 460). Historically, management of mental illness has been characterised by variations in approach due to evolving and conflicting influences in the wider social environment (Lewis 1988, Shorter 1997, Zaehner 1969). Factors which have been shown to influence mental health policy and the management of mental illness include prevailing ideology about the causes of mental illness, societal stigma, economic and political conditions, and the influence of key public figures (WHO 2001a, Lewis 1988, Rocheford 1997, Shorter 1997).

Historically the societal stigma attached to mental illness, cultural conservatism and an intolerance of abnormal behaviour often led to the marginalisation within society of people with mental illness. The
industrial revolution between the mid-18th and mid-19th centuries resulted in major social and economic changes in Europe and North America. In many countries, urbanisation resulted in crowded living in larger population centres and a breakdown of extended family supports often found in smaller provincial towns and villages which had traditionally provided for care for disabled individuals (including people with psychiatric disability arising from mental illness). The societal response was to remove individuals whose behaviour was considered deviant (for example those with mental illness, substance abuse or neurological conditions) into custodial settings and alms houses (Mandiberg 1996, Munakata 1986, Shorter 1997).

Over time these facilities grew in size and became known as asylums. Asylums were established in virtually all the colonies occupied by European countries and today asylums are found throughout Africa, the Indian subcontinent, Asia, North and South America as well as Australia and New Zealand. The movement of people with mental illness into asylums was in some countries based on the assumption that relocating these people, with poorly understood illnesses and disabilities, from the newly industrialised centres into rural areas would in some way improve their condition. However the asylums were not well supported by financial or human resources and very few effective treatments for mental illness were available. As a result physical and behavioural restraints and institutional control became the norm and human rights abuses were commonplace (Shorter 1997).

Moves to improve the conditions in the asylums were promoted by individuals such as Philippe Pinel (1794-1826), William Tuke (1732-1822), and Dorothea Dix (1802-87). They were critical of the harsh conditions and custodial settings which gave rise to the abuse of human rights, and questioned the practice of institutionalisation as an instrument of social control over those with mental illness. By the late 1800s, changes had been made to the environments of some asylums in an attempt to provide more humane care.

Other attempts to provide better care introduced in asylums in
North America and Europe included moving individuals to smaller communities in rural settings. This involved individuals with mental illness being encouraged to undertake manual work (Friedman 1990). However the lack of effective treatments for mental illness still meant that care was largely custodial and punitive behavioural management was often used to control the more overt disturbances caused by mental illness.

There were virtually no effective medical or psychological treatments for mental illness until the early 1900s. Freudian psychoanalysis was introduced in the 1890s and early 1900s but did not prove effective for those patients in the asylums (but was arguably more effective for mild mental disorders which were treated in non-inpatient settings). In 1917 in Vienna, Julius Wagner-Jauregg (1857-1940) successfully treated some patients with psychosis by inoculating them with malaria to induce high fever. These patients had a mental illness caused by neurosyphilis (then called general paresis of the insane). For this work Wagner-Jauregg won the 1927 Nobel Prize in Medicine. The discovery of the bacterial basis of brain diseases (which paralleled developments in other areas of medicine) started to change the therapeutic pessimism which existed amongst many mental health practitioners.

There were further developments in therapy including the introduction of electroconvulsive treatment by Ugo Cerletti in 1937 and the discovery of the first effective antipsychotic medication, chlorpromazine, in 1952 by Delay and Deniker (Lopez-Munoz et al. 2005). There followed a series of effective pharmacological treatments which controlled the symptoms of, but did not cure, mental illnesses.

Prior to the introduction of these effective pharmacological agents asylums had become ‘vast warehouses for the chronically insane and demented’ (Shorter 1997). Grob described the factors that shaped the transformation of public policy from an institutional to community focus, between the 1940s and 1960s in the United States and these also applied to varying degrees in Australia. One of the drivers was the
changing profile of the patient populations in those hospitals, with short stay acute admissions gradually replacing long-term institutionalisation. He described how this change in the patient population contributed to the creation of a more ‘depressing internal institutional environment that appeared to have few redeeming qualities’ (Grob 1987). As the patient population changed over decades, the initially therapeutic intent of these facilities changed to a more custodial role.

At the same time, advances in academic psychiatry were predominantly in areas (such as psychoanalysis) that provided treatments for individuals with less severe mental disorders, not those disorders seen in the psychiatric hospitals. Similarly, attention directed to improving treatment of military personnel returning from World War I and World War II did not benefit the long term institutionalised patients, as they used clinical interventions that were short-term and undertaken outside hospitals. These developments further marginalised psychiatric hospitals from ‘modern’ psychiatric practices.

By the early 1960s the place of the psychiatric hospital as the centre of mental health policy was over. The development of new psychotropic drugs and a change in community attitudes to institutional care as well as media criticism of the conditions in the psychiatric hospitals all led to the promotion of community care as a viable policy alternative. Community mental health services expanded throughout most developed countries during the 1960s, 1970s and 1980s, although the extent to which these services provided adequate care for those individuals discharged from, or who could no longer be admitted to, psychiatric hospitals was very limited (Drake et al. 2003).

2. Mental health and related services in Australia before 1988

The history of mental health services in Australia to 1980 has been well documented (Lewis 1988). Along with other countries Australia has seen enormous changes to mental health services since Governor Macquarie established the first psychiatric hospital in a converted farmhouse at Castle Hill in Sydney in 1811. Prior to this psychiatric hospital (asylum)
being opened patients were kept in Parramatta gaol. In 1825 the farmhouse at Castle Hill was found unfit for habitation and patients were moved to Liverpool Court House, which served as an asylum until 1838 when the first purpose-built mental asylum was built, the Tarban Creek Asylum which eventually became part of the Gladesville Psychiatric Hospital. Psychiatric hospitals were subsequently established throughout New South Wales starting with the asylums at Parramatta in 1848, Newcastle in 1872 and Goulburn in 1894 (New South Wales Government n.d.). Psychiatric outpatient clinics were also subsequently established at general hospitals.

Psychiatric hospitals were established in every State, although not in the Northern Territory or the Australian Capital Territory because of their smaller populations. In Victoria the Yarra Bend Asylum opened in 1848, the Ararat Asylum in 1865 and the Kew Asylum in Melbourne (later known as Willsmere Hospital) in 1871 (Malcolm 2009). Before the turn of the century five more asylums were built in Victoria (Stoller and Arscott 1955). Queensland’s first asylum, Woogaroo Asylum, was opened at Goodna near Brisbane in 1865 and patients were transferred by river to the hospital from Petrie Terrace jail. Following the establishment of Woogaroo facilities were opened in Toowoomba and Charters Towers in north Queensland (Patrick 1987). In Western Australia, the Fremantle Asylum was established in 1861 and in 1903 the Claremont Hospital for the Insane near Perth was opened (Skerritt et al. 2001). In South Australia a rented house was gazetted as a public asylum in 1846. In 1852 the Adelaide Asylum was opened and in 1870 the Parkside Asylum (now Glenside Psychiatric Hospital) opened (Goldney 2007). In Tasmania, New Norfolk, 22 miles from Hobart, the Convict Invalid Hospital (later The Hospital for the Insane) opened in 1831 and was used as the first asylum in that State (Piddock 2001).

At Federation on 1 January 1901 the six self-governing British colonies became the original States. Section 51 of the Australian Constitution allocated a very small role for the Commonwealth government in health matters, essentially assigning only quarantine
powers to prevent disease entering the country (ABS 1980, 225). In the period up to World War II, State government raised funding to provide services through a range of State based taxes, the most important of which was personal income tax. In 1942 the Commonwealth government unilaterally used its expanded wartime powers to assume control over income taxation. The loss of States tax powers made them reliant on Commonwealth government grants for a large proportion of the revenue they require for expenditures in their areas of responsibility such as health services. The response to this mismatch between revenue raising and expenditure responsibilities, known as vertical fiscal imbalance, was for the Commonwealth government to make transfers to State governments to help fund State run services.

Prior to 1948, the Commonwealth government had no involvement in the provision of public mental health services. In 1946 the Chifley Labor government introduced an amendment to Section 51 of the Constitution, which enabled the Commonwealth government to legislate on ‘pharmaceutical, sickness and hospital benefits and medical and dental services’. As part of these reforms in 1946 the Commonwealth government introduced hospital benefits for patients in public hospitals. No provision was made for patients in psychiatric hospitals at that time.

However, to help meet the cost of maintaining patients in these hospitals the Commonwealth Parliament passed the Mental Institutions Benefits Act in 1948. This Act allowed the Commonwealth government to enter into agreements with the State governments. These agreements provided that State governments would cease making charges for the maintenance of psychiatric patients and in return the Commonwealth government would pay the State governments a benefit based on the amount which had been previously collected by the States from the relatives of patients in psychiatric hospitals by way of charges for maintenance. These agreements operated for five years and terminated in the latter half of 1954. The amount contributed by the Commonwealth government during the operation of the agreements was
approximately one shilling (ten cents) a day for each patient (Bureau of Census and Statistics 1966, 560).

Victoria was the first State to commence the reforms to the psychiatric hospitals (Lewis 1988). As early as 1948, Director of the Victorian Mental Hygiene Authority Dr Alan Stoller (1948) had argued that mental health services needed to be broadened to take a public health approach and that mental health policy should not be dominated by the role of the psychiatric hospitals. Stoller argued that the Commonwealth government should assume responsibility, including financing, for mental health care. When the Mental Institutions Benefits Act agreements terminated in 1954, the Commonwealth government, with the cooperation of the State governments, held a national inquiry into the state of the psychiatric hospitals carried out by Stoller and Arscott (1955). Their report argued that while overcrowding in the hospitals was a major problem and the provision of more beds the most urgent need, other accommodation and rehabilitation facilities were also required. The history of the lack of suitable care for patients in these hospitals is well documented (Lewis 1988).

Another report by the Australasian Association of Psychiatrists (the predecessor of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) formed in 1946) criticised the overcrowding and poor conditions in State psychiatric hospitals in 1950 (Pargiter, 1991). In response to these reports the Commonwealth government changed its involvement from providing a bed day subsidy to providing funding for capital works (Pargiter, 1991).

The Health Minister Earle Page told the Commonwealth Parliament in September 1955 that overcrowding was the most urgent problem, and that the Commonwealth government would provide State governments with £10 million towards the cost of 10,000 new beds, on the basis of a £1 subsidy for each £2 spent by the State governments (Parliament of Australia 1955). This funding was provided through the States Grants (Mental Institutions) Act of 1955 which revoked the Mental Institutions Benefits Act 1948. All State governments accepted
the Commonwealth government offer of additional finance for these beds but were left with bearing the full costs of maintaining patients in the psychiatric hospitals (Lewis 1988, 78).

Because each £1 of Commonwealth government funding had to be matched by £2 from the State governments, by 1963 one quarter of the total grant under the States Grants (Mental Institutions) Act 1955 had not been distributed. Nevertheless, the Commonwealth government announced in November 1963 its intention to continue assistance to the State governments towards capital costs on a similar basis for a period of three years. In May 1964 the States Grants (Mental Institutions) Act 1964 was passed to provide for the continuation of Commonwealth government aid of £1 for every £2 of capital expenditure by the State governments on mental health facilities. The provisions of this Act continued until 30 June 1973 when it was replaced by the Mental Health and Related Services Assistance Act 1973 which was introduced by the Whitlam Labor government that had been elected the previous year. The new government promoted community care in health and disability services and took a wider view of mental health services. The capital grants under this legislation provided funding for community services including alcohol and drug dependence services (ABS 1975, 456). The funding was not to be used for psychiatric hospitals but did include funding for supported accommodation facilities in the community. In addition to the funding for capital works, the legislation provided grants to meet the maintenance costs of approved non-residential services as well as teaching, research and evaluation programs in the mental health sector (Scotton and Ferber 1980, 246). In the first two years $7.5 million per year was provided.

Final payments under the States Grants (Mental Health Institutions) Act 1964 were made in 1973-74. Expenditure after this was made under the Community Health Program and the Hospital Construction Program, controlled and funded by the Hospital and Health Services Commission (ABS 1976, 460). From 1973-74 to 1974-75 grants totalling $45.7 million were made to the State governments.
under the Community Health Program. The grants were directed to the development of community-based health services such as health centres and centres providing services for mental health, alcoholism, drug dependency (ABS 1976, 575) and the treatment of repatriation patients (ABS 1978, 232). The Labor government provided funding for 90% of the operating costs in 1974-75 but the Coalition government reduced this to 75% in 1977-78 and 50% in 1978-79 (Lewis 1988).

The Whitlam Labor government’s Medibank scheme, Australia’s first universal health insurance scheme, commenced on 1 July 1975. The Medical Benefits Schedule released in April 1975 included subsidies for private sector general practitioners and psychiatrists treating patients with mental illness.

The ‘Hospitals’ section of the Medibank scheme resulted in agreements between the Commonwealth government and the State governments for the Commonwealth government to share equally with the State governments the net operating costs of recognised (i.e. public) hospitals covered by the agreements. The agreements commenced on the following dates: South Australia and Tasmania, 1 July 1975; Victoria and Western Australia, 1 August 1975; Queensland, 1 September 1975; and New South Wales, 1 October 1975 (ABS 1976, 450). The agreements included psychiatric patients admitted to psychiatric wards in general hospitals, but not those in separate psychiatric hospitals, even if they were acute patients similar to those admitted to general hospitals.

In 1976, after the Fraser government was elected, the State governments attempted unsuccessfully to have Commonwealth government funding provided for psychiatric patients, as the following response to a question on notice in Parliament by the Health Minister Ralph Hunt indicates (Parliament of Australia 1977):

Under the provisions of the Health Insurance Act, psychiatric patients in private hospitals and in public/general hospitals are eligible for insurance coverage of their hospital expenses, but patients treated in State mental hospitals are not.

At the 1976 Health Ministers’ Conference a submission was made by the States that patients in acute psychiatric hospitals-defined
as hospitals or designated portions of hospitals which provide facilities, services and treatments equivalent to those provided by similar sections of public hospitals—come under the Medibank cost-sharing arrangements. This submission was closely examined and, while I have some sympathy for the views of the States, I would find it particularly difficult to put forward such an increase in costs to the Commonwealth in the present economic climate.

The Government could not accept these changes at the present time, but we will be looking at the issue with the aim of achieving the best results for these patients. Nevertheless, I must point out that the raising of charges is a State responsibility.

Funding for non-clinical community services had been provided initially under the Commonwealth Handicapped Persons Act of 1974 and social income support and labour market programs underwent a major overhaul to meet the requirements of people with disabilities. However these focused predominantly on people with physical, sensory and intellectual disability. During the 1980s new Commonwealth government policy frameworks were introduced for people with disabilities living in the community. Following the re-election of the Labor government in December 1983, the Home and Community Care Act 1985 established a framework for the delivery of community care services in Australia. It was a joint Commonwealth/State program funded under section 96 of the Constitution. The program was designed to assist State, Territory and local governments and non-government organisations (NGOs) to provide basic community support and maintenance services, particularly for the aged and disabled in need of long-term care in the community at risk of long term institutionalisation. Services included domestic assistance, personal care, respite, nursing care and transport.

The Home and Community Care Bill 1985 (Miscellaneous Amendments) amended four existing Acts (the Delivered Meals Subsidy Act 1970, the Home Nursing Subsidy Act 1956, the States Grants (Home Care) Act 1969, and the States Grants (Paramedical Services) Act 1969), and consolidated them within a single program, the Home and Community Care (HACC) Program. From its inception HACC was oriented towards the needs of older adults. However, younger people with moderate to severe disabilities were also recognised within the
legislation as a target population. Numerous groups advocated for the HACC program to include people with psychiatric disability as qualifying people for new services (Parliament of Australia 1985b, 3074). However, there was concern from the Commonwealth government that, given the large (but unmeasured) proportion of the HACC target population classified as psychiatrically disabled, the State and Territory governments may shift costs from psychiatric institutional care (a State responsibility) to the Federal Budget. According to the responsible Minister, Senator Grimes (Parliament of Australia 1985c, 569):

...The home and community care program is designed to provide home services for people who need them, again to keep them out of institutions, both people who are disabled and people who are aged. Obviously, some people under this care will be classified as being psychiatrically ill and, therefore, one cannot arbitrarily exclude them from such a program.

I qualify all that by saying that I do not believe it would be right for State governments – I am not suggesting that any State government would be so outrageous as to do so – to believe they could take advantage of these programs to transfer the funding from programs that were traditionally theirs to the Federal Budget. Should they do so they will not get much co-operation from me or from the Treasurer.

This view was reinforced during the second reading speech for the Bill by Senator Grimes in December 1985 (Parliament of Australia 1985a):

I suppose if I had any aims or a dream in this area it would be that one day we would have in this country the provision of adequate services for people who need them for post-acute care, for palliative care, for people who have psychiatric as well as physical disorders, for disorders of the aged and other disabilities ... [however] we are inhibited from developing such a utopia, I suppose, by basically two things. The first, obviously, is a lack of funds. The cost of producing such universal services is considerable ... The second thing that bedevils us is history ... the States will do what they have done since Federation - they will attempt, without any ill will, to transfer the cost of their programs to the federal government. It was for this reason that we decided that the predominant services that we would provide under the home and community care program would be for aged and chronically disabled people. We decided that psychiatric services would be excluded ... but people with psychiatric disabilities have access to HACC services if they are otherwise assessed as being in need of these home and community care services and these services are not being used as a substitute for State services.
The policy interpretation placed on this was that people with a mental illness could access HACC services if they met the eligibility criteria, other than for their psychiatric disability. Similarly people with psychiatric disabilities were initially excluded from coverage in the *Disability Services Bill* 1986, however there was mounting public and political opposition from both the Opposition and the Australian Democrats to this exclusion evident when it was being debated:

One of our most compelling concerns relates to the need to ensure equity as between people with a disability. By excluding those organisations for people with a predominantly psychiatric disability from becoming eligible organisations for the purposes of this legislation, we think the equity principle has been breached ... Therefore, we will move the amendment we have circulated or support the amendment that the Australian Democrats have circulated, to include those with psychiatric disability within the purview of the Bill as a target group, because we think that is fair and logical (Parliament of Australia 1986d).

It is of concern, however, to the Australian Democrats that people with psychiatric disabilities are excluded from the ambit of this legislation ... people with psychiatric disabilities have particular needs ...[a] very similar list to the list of needs which people with other disabilities are recognised as having. The Minister has argued that psychiatric disability should remain a State responsibility [but] the Commonwealth government gets involved in a range of areas which can be seen to be significantly within the responsibility of State governments. The exclusion of the psychiatically disabled has been noted by the Human Rights Commission as being a breach of human rights ... people with disabilities, whatever the origin, nature, type and degree of disability, have the same fundamental rights as all members of Australian society (Parliament of Australia 1986b).

The Opposition and Democrats forced an amendment to have psychiatric disability included in the legislation and the government accepted this (Parliament of Australia 1986c):

There are certain problems with the legislation ... The first difficulty are the exclusion, as some honourable senators see it, from the target group of people with psychiatric disability. The Opposition and the Australian Democrats wish to, and apparently will, add to the definition by including the term 'psychiatric'. The legislation will not fall as a result of that inclusion. The world will not change. If the Parliament wishes to include it I will have to accept it.

Therefore under the *Disability Services Act* (DSA) 1986, clinical treatment for people with psychiatric disabilities remained a State and
Territory government responsibility but these individuals became eligible for support services provided by the DSA. However the Commonwealth government maintained that the DSA created no obligation or responsibility on its part to provide these services. It was careful to distinguish eligibility from responsibility and this remained a contentious issue after the passage of the legislation, with different jurisdictions interpreting the legislation in different, and sometimes contradictory, ways (Lindsay 1996).

In practice, despite the amendment forced by the Senate, people with psychiatric disability were still informally excluded by being given low priority in access to DSA services with restrictive guidelines and informal barriers. This continued to be a matter of political and bureaucratic controversy as, for example, during the October 1989 Senate Estimates Hearings with Senator Baume questioning the First Assistant Secretary, Disability Programs Division, Department of Community Services and Health (Parliament of Australia 1989):

SENATOR PETER BAUME- Would it be unfair then to ask whether this is not a case where the Parliament has determined one thing and the Executive government has determined to do another thing?

MR FLETCHER- I think that is a matter of policy.

SENATOR PETER BAUME- It is a matter of fact, I think. I am not asking advice, I am asking what the facts are. The Parliament has determined, over the objections of the Government, that those with psychiatric disabilities should be included. The Government has taken no action to include them. I think that is the fact, is it not?

MR FLETCHER- When you say 'taken no action', it has not positively gone out and said 'They are excluded' in the strictest possible sense. What it is saying is that, given the rationing of the resources that are available, there are other disability types and services that need to be provided to them which would be given priority.

And again in Parliament (Parliament of Australia 1990):

Senator POWELL- My question is directed to the Minister representing the Minister for Community Services and Health and relates to the Government's treatment of the psychiatrically disabled under the provisions of the Disability Services Act. I remind the Minister of the statement made by Senator Grimes,
the responsible Minister at the time of passage of that Act, that -
and I quote from Hansard of 20 November 1986-'the world will
not change' and 'the way I administer the legislation, in fact, it
will not cost anything at all'. This statement was made during
debate on the successful Australian Democrats amendment which
included, as a target group, the psychiatrically disabled. What is
the Government's current policy on funding of services targeted
for people with psychiatric disability?

Senator TATE- Senator Powell was kind enough to give a little
preliminary notice of this question, and I have received an answer
from the Minister. There is no question that people with
psychiatric disabilities are eligible for services under the Disability
Services Act. At the present time, policy is that new services
primarily targeted for people with psychiatric disabilities will
receive a lower priority for funding under the disability services
program. However, they are not excluded from services, and
some are already receiving services.

A 1991 census which reviewed Commonwealth-funded disability
services found that, although 26% of people receiving disability-related
income support had psychiatric disability, people with psychiatric
disability accounted for only 4% of long-term funded services and 2.2%
of all new services (1991). Thus individuals with mental illness living in
the community not only had limited access to clinical services but were
largely excluded from accessing government-provided or subsidised
accommodation and support services necessary to sustain a reasonable
quality of life.

With the Commonwealth government remaining disengaged from
mental health and each State and Territory retaining responsibility for
planning, funding and delivering their public mental health services
(Dewdney 1987) ad hoc reforms continued. Notwithstanding the
concerns about their physical conditions and quality of care, psychiatric
hospitals remained at the centre of the public mental health service for
over a century. The relative size of the psychiatric hospitals remained
constant from around 1900 until the mid-1950s (Doessel et al. 2005).
Mental health services continued to be the subject of criticism or scandal
often leading to a public inquiry after which there was a brief period of
reform but then years of neglect. Lipton (1983) noted that as of the
early 1980s there had been eleven boards of inquiry or select
Parliamentary committees in Victoria alone. Most of these followed a
media campaign indicting the government for the poor and inhumane care it had provided in the psychiatric hospitals. The other Australian State and Territory governments had similar experiences. However, following these repeated and increasingly well-publicised inquiries, the introduction of effective psychiatric drugs and international trends toward less restrictive modes of treatment, the State and Territory governments began to decrease the number of beds in the psychiatric hospitals from around the late 1950s (Doessel et al. 2005, Lewis 1988). The reduction in size of these hospitals followed a process of preventing inappropriate admissions as well as discharging patients into the community. Dax (1961) described these two stages, with ‘suitable patients from hospitals’ discharged to various accommodation options in the community and patient certification and hospital admissions being avoided. This process was accompanied by the growth of private treatment and private hospitals and the establishment of psychiatric wards in general hospitals.

The population of the psychiatric hospitals declined from 29,500 in the early 1960s, when Australia’s population was 10.5 million (281 beds per 100,000) to 6750 inpatients for a population of 17 million in 1992 (40 beds per 100,000) (National Health Strategy 1993). This deinstitutionalisation was uncoordinated and under-resourced with funding generally not following patients to provide community mental health services. Even as recently as the early 1990s, over 70% of the State and Territory governments’ mental health budgets were consumed by hospital services (National Health Strategy 1993).

Many people with mental illness who were moved into the community could not access sufficient clinical care, as much of the State and Territory governments’ mental health budget were still being spent in the hospitals and most of the Commonwealth government-funded community support services remained inaccessible. The outcome was often that people became homeless, lived in unsatisfactory residential facilities in the community or were inappropriately placed in nursing homes or correctional facilities.
3. Conclusion

There had been has been a general view that the Commonwealth government was not involved in assisting the States in the care of people with mental illness prior to the National Mental Health Policy and first plan in 1992. It is true that, prior to 1948 the Commonwealth government had no involvement in the provision of public mental health services. However in 1948 the Commonwealth government started contributing to care of patients in psychiatric hospitals. From 1955 the focus of Commonwealth support changed to a contribution to the cost of new beds, in an attempt to address overcrowding in psychiatric hospitals. This support continued until 1973 when it was replaced by support for services in the community, including supported accommodation, but not for psychiatric hospitals. Under Medibank, introduced in 1975 the Commonwealth government contributed to the operating costs of public hospitals, including psychiatric patients in general hospitals but not to those in separate psychiatric hospitals.

The major Commonwealth funding initiatives for community support services, social income support and labour market programs for people with disabilities during the 1970s and 1980s did not provide for the inclusion of people with psychiatric disability, in large part due to concern the State and Territory governments might shift costs from psychiatric institutional care (then clearly seen as a State responsibility) to the Commonwealth. In addition State governments did not ensure adequate clinical services were provided in the community. This lack of access to services in the community was the major contributor to the personal and social problems that arose from de-institutionalisation, creating a major health and social policy problem for Australia (as was the case in other countries) as is discussed further in Chapter 5.

The next three chapters cover the periods 1988 to 1996 (Chapter 6), 1996 to 2003 (Chapter 7) and 2003 to 2008 (Chapter 8). For each period I identify the problems that were prominent at the time, the solutions proposed for those problems and the prevailing Commonwealth political environment that led to the adoption of the
1992 *National Mental Health Policy* and the first plan (Chapter 6), the *Second National Mental Health Plan* (Chapter 7) and the COAG *National Action Plan on Mental Health* (Chapter 8).

As described in Chapter 4, the thematic analysis undertaken of the published literature and Parliamentary records identified five themes that described the issues prominent in mental health:

1. Human rights and community attitudes
2. Community need
3. Service structure
4. Service quality and effectiveness
5. Resources

In Chapters 6, 7 and 8 these themes are used as headings to structure the discussion of the most prominent problem areas and policy responses described in the literature.
CHAPTER 6 – a national mental health policy for Australia

This chapter focuses on the years 1988 to 1996. In this chapter I describe the problems, the proposed solutions for these problems and the national political environment that led to the development and adoption of the 1992 National Mental Health Policy and the first plan for 1993-98 (Australian Health Ministers 1992a).

As described in Chapter 4, the thematic analysis undertaken of the published literature and Parliamentary records for these years identified five principal emergent themes relating to the issues in mental health: human rights and community attitudes; community need; service structure; service quality and effectiveness; and resources. I use these themes as an organising framework to discuss the most prominent problem areas and policy responses described in the literature.

1. Themes

1.1 Human Rights and Community Attitudes

Problem areas

I identified two main problem areas in the data sources from the literature review that coded to this theme: human rights abuses and stigma and discrimination.

(a) Human rights abuses

I found references to overt human rights abuses and neglect in a number of treatment settings, particularly in stand-alone psychiatric hospitals. As noted in Chapter 5, problems were becoming increasingly evident in the larger of these institutions. Several highly publicised inquiries into the care of residents with mental illness had found negligent, unsafe, unethical and unlawful treatment practices within these institutions (Carter 1991, Hoult and
Burchmore 1994, Slattery 1990, Tobin 1993). The literature provides an account of the public reaction to the disclosure of this abuse and neglect; specifically expression of feelings of guilt and a sense of obligation by members of the community to respond to the plight of individuals described in the intense publicity surrounding public inquiries. Such public reactions had often precipitated commissions or inquiries in one particular facility and local reformist activity; but these were usually short lived and often followed by further years of neglect (Hoult and Burchmore 1994, Lipton 1983).

However, over time the momentum for change built to a national level of support for a human rights approach to mental health policy. In June 1990 the first Federal Human Rights Commissioner of Australia Brian Burdekin announced a national inquiry into the human rights of people with mental illness which became known as the Burdekin Inquiry (HREOC 1993).

Public hearings commenced in April 1991 and were held over 15 months in all States and Territories with 456 witnesses appearing before the inquiry during the hearings. Private hearings, informal meetings and public forums for consumers and carers were also held. Over 820 written submissions from individuals affected by mental illness, carers, community organisations, clinicians, other mental health professionals and government authorities were received. The final report was released in October 1993 and provided a comprehensive description of the significant problems experienced by people with mental illness and their carers, not only in hospitals but also in the community (HREOC 1993).

(b) Stigma and discrimination
The second major problem identified in the literature was widespread ignorance regarding the nature and prevalence of mental illness in the community. Stigma and discrimination against people with mental illnesses was pervasive (HREOC 1993, Lea and Lowrey 1990, Raphael 1984). The discharge of psychiatric patients into the community without adequate support had reinforced pre-existing public concerns about the dangerousness of people with mental illness (Best 1985, Lipton 1983). A common public view was that there was a need for continued institutionalisation to ensure community safety. Stigmatising and discriminatory attitudes were also held by those providing services needed by people with mental illness. These attitudes were described as systemic across the health, housing, employment and welfare sectors (Lea and Lowrey 1990, Burdekin 1990, Burdekin 1992).

For decades the mental health consumer movement lagged behind other areas of health related activism to help overcome barriers of stigma and discrimination (HREOC 1993, 149-50, Tobin, Chen and Leathley 2002). Those in need of services were less organised and influential, compared with their counterparts in areas such as heart disease and cancer, and had commensurately less involvement in mental health policy and service planning. The stigma of mental illness contributed to the perception among other stakeholders, including health professionals and policy makers, that a person with a mental illness could not contribute to policy and service planning (Lea and Lowrey 1990).

**Policy Responses**

During the 1980s the Commonwealth government came under increasing pressure from stakeholders to support a national
approach, involving Commonwealth, State and Territory
governments, to mental health policy and service reform. There
were several mental health groups that took the role of 'issue
entrepreneurs' (Roberts et al. 2003) highlighting and promoting
mental health as a problem needing attention. The mental health
consumer movement began to grow in size and influence during
the 1980s (Epstein 2005). Along with professional bodies,
consumers began to advocate to become involved in developing
national mental health policy and services, areas from which they
had previously been excluded (Lea and Lowrey 1990, Beaumont
1990).

The Australian National Association for Mental Health
(ANAMH) and the Royal Australian and New Zealand College of
Psychiatrists (RANZCP) joined in an effort to increase the
influence of stakeholders. The coalition thus established between
a mental health NGO representing consumers, carers and services
providers (the ANAMH) led at that time by Professor Graham
Burrows and a professional organisation (the RANZCP), led by
Professor Beverley Raphael, acted along with others as issue
entrepreneurs between 1984 and 1989. In 1984 these two
organisations formally proposed a policy solution to the problems
of mental health in Australia in a submission to the
Commonwealth government. They proposed the development of a
national mental health policy so that the Commonwealth and all
State and Territory governments would commit to an agreed
policy direction to correct the problems caused by de-
institutionalisation (Raphael 1984, Whiteford 1992b) and the
considerable variation in service quality and capacity across
jurisdictions. Between 1984 and 1989 these organisations were
joined by individuals, other non-government bodies and
professional organisations to agitate for national policy action.

Addressing abuses of human rights was a prominent theme
in policy solutions proposed in the late 1980s and early 1990s. A
number of factors had coalesced: findings of substandard patient care by public inquiries into services, increasing advocacy by consumers and carers for attention to consumer rights as a way to improve mental health services (Lea and Lowrey 1990) and the June 1990 announcement of the National Inquiry into the Human Rights of People with Mental Illness (the Burdekin Inquiry).

The HREOC (renamed the Australian Human Rights Commission in 2008) was established in 1986 by legislation as an independent statutory authority charged with complaint handling as well as conducting inquiries and evaluating Australia’s human rights compliance with international instruments to which it is a signatory. Commissioner Burdekin’s powers did not include issuing enforceable undertakings, so he aimed at producing reports and mass media coverage potent enough to trigger political action.

For example, the Burdekin Report advocated for fairness in national consistency, on the argument that Australians should have similar rights and expectations of their mental health treatment regardless of which State they resided in (HREOC 1993, 896). Specific solutions were proposed to achieve this, on the grounds that State/ Territory mental health legislation should be consistent with Australia’s international human rights obligations (ANAMH 1984, ANAMH 1985, Raphael 1984, Burdekin 1990). In 1991 the United Nations General Assembly adopted Resolution 98B, for the ‘protection of persons with mental illness and the improvement of mental health care’ (United Nations 1991), providing further impetus for a human rights approach to mental health policy. Although not binding on United Nations member States, the resolution gave moral authority to the Commonwealth government to enter into consultation with the State and Territory governments about the rights of patients treated by their services (MHCA, BMRI and HREOC 2005, 33).

A number of the policy solutions discussed in relation to the
quality and effectiveness theme in 1.4, below, such as uniform standards for mental health services confirmed by independent accreditation agencies, and also in the structural reform of services such as the provision of treatment of people with mental illness within mainstream health facilities rather than separate psychiatric institutions, were seen as ways of safeguarding human rights as well as providing better quality care. Governments also established a mental health consumer outcomes taskforce which produced the National Mental Health Statement of Rights and Responsibilities, adopted by Australian Health Ministers in March 1991 (Australian Health Ministers 1991).

Policy responses to community stigma and discrimination were also proposed. These included recommendations for national public education and awareness programs with the goal of dispelling ignorance and misconceptions regarding mental illness (Lea and Lowrey 1990, Raphael 1984). It was also argued that a national advocacy body for mental health was needed (ANAMH 1985), especially to continue the advocacy started by the HREOC.

1.2 Community Need

Problem area
One problem area dominates the data sources from the literature review that coded to this theme – the burden of care on families and carers.

(a) Families of people with mental illness

Although the theme is called ‘community need’, the problem area most closely related to this theme was at the individual level rather than at the community level. De-institutionalisation had shifted much of the burden of care from hospital staff onto families, with consequent escalation in physical and mental health problems for family carers (Beaumont 1990, McQueenie 1992). Some
commentators suggested that without adequate community-based mental health services, deinstitutionalisation would increase the prevalence and severity of mental health problems rather than reduce them (Beaumont 1990). Advocates argued that the societal burden of mental illness meant it should receive a higher priority than that historically allocated by governments (HREOC 1993, 143, Raphael 1984).

There was little in the debate at the time about the mental health of the broader population. However, experts noted the lack of epidemiological data about the mental health of Australians, as well as poor information systems specific to mental illness in the Australian population (Andrews 1991, Eisen and Wolfenden 1988, Raphael 1984). A national survey of the prevalence or service utilisation of people with mental illness had never been undertaken in Australia.

Australian researchers were therefore reliant on overseas data to estimate local population need (Andrews 1991). Drawing upon these overseas studies they hypothesised that mental illness was prevalent in the community, causing significant disability and disruption to the family, personal and occupational functioning of those affected (Andrews 1991, Raphael 1984, Raphael 1993). Furthermore, experts suggested that there was a considerable unmet need for services, but that without national data, this was impossible to confirm (Eisen and Wolfenden 1988).

Some experts argued that Australia was falling behind with regard to promotion and prevention services (Raphael 1993, Tippett et al. 1993) although this problem area did not attract much attention at the time. They argued that unwillingness to accept and develop preventive
approaches as part of the service system was influenced by the view that since definitive ‘causes’ of many mental disorders had not been identified, prevention must be impossible (Tippett et al. 1993).

Policy responses

A shift was occurring in the policy agenda which had previously been dominated by concerns about the welfare of people discharged from psychiatric hospitals. The burden imposed on families of people with severe mental illness by deinstitutionalisation was becoming a priority for policy solutions. Advocates argued that existing State-based policies were outdated, unrelated to need, and failed to define either methods or responsibility for implementation. They rejected the piecemeal response to the social, economic and personal costs of mental illness as placing an unacceptable burden on families and argued a national response involving the Commonwealth government was needed (ANAMH 1984, Raphael 1984). Another argument used to make the case for Commonwealth involvement was that the human and social consequences of mental illness are matters of human rights and social welfare, policy areas that are the responsibility of the Commonwealth government.

Further, advocates proposed that a system of mental health indicators and/or a national mental health database should be developed which could collect and review morbidity data (Raphael 1984). Such a database was needed to monitor patients in treatment, especially in the community, and for the planning and evaluation of mental health services.

Although their proposals focused on responding to urgent and known unmet need, experts did also argue that the still speculative needs of the wider population should be planned for on the basis of epidemiological data (Andrews 1991, NATSIHC SHRG and AHMAC NMHWG 2004). Without this data, planning
would remain restricted to those already known to services or most likely to be in contact with a service, namely those individuals with more severe mental illness. In 1996 mental health was made one of the five National Health Priority areas reflecting the beginning of the recognition of the importance of population level mental health (AIHW and Department of Health and Family Services 1997).

1.3 Service Structure

Problem areas

Problems with service provision for those with severe mental illness dominated the academic literature and public debates about mental health care. The fundamental flaw in the policy of de-institutionalisation had been the failure to establish an adequate system of inpatient and community treatment, accommodation and support services for those leaving, or no longer able to be admitted to, psychiatric hospitals. Beverley Raphael (key informant interview) identified the main problem confronting governments at this time as being 'a systems failure' in the delivery of mental health care. Gardner (1997) summarises the prevailing view in these comments:

despite the rhetoric and the pharmaceutical advances, de-institutionalisation left a legacy of mistakes which saw many patients discharged from psychiatric hospitals without adequate clinical or support services available in the community. The second problem area related to those patients who remained in hospital. Concerns about the quality of their care escalated.

In terms of the structure of services, three main problem areas identified in the data sources from the literature review that coded to this theme were identified.

(a) Separation of mental health from general health services

One of the major problems identified was that mental
health services and general health service provision were mostly separate. True integration of these services was rare (Andrews 1991, Hoult and Burchmore 1994). Advocates argued that this separation reinforced stigma, denied mental health services access to the mechanisms for enhanced quality care existing in general healthcare and reduced equity of access to generic services (Mental Health Task Force 1991, 3, McQueenie 1992).

(b) Poor continuity of care between inpatient and community clinical services

The second major problem was that patients were often lost to follow up after discharge from hospital and did not connect with clinical community services. With this breakdown in care, the psychiatric condition of patients often deteriorated and relapsed, requiring their readmission. This placed great pressure on the remaining hospital beds (Burdekin 1991, Leonard 1994). These beds, already in high demand, were subject to increasing pressure from readmitted patients whose condition had deteriorated as a result of inadequate mental health care and/or the failure of accommodation services.

(c) Poor intersectoral linkages between clinical and other social services

The third major problem was the poor linkages between the sectors of health, housing, employment and income support (HREOC 1993, 555, 561, 909, Behan, Killick and Whiteford 1994). The failure to provide clinical and support services had resulted in responsibility for care being moved to another service sector. In facilities where adequate community and residential support services had not accompanied downsizing or closure of psychiatric beds,
common consequences were substandard accommodation, homelessness, incarceration and unnecessary admissions to hospitals (Hoult and Burchmore 1994, Raphael 1984). Commitment to implementing mental health service reform and willingness to expand community-based care varied enormously across jurisdictions (Beaumont 1990, McQueenie 1992)

Policy responses

The policy responses proposed during this period were almost exclusively focused on the service deficiencies arising from de-institutionalisation for those with severe mental illness. They echoed the policy challenges posed by the State based inquiries (Richmond 1983):

That as a matter of policy the highest priority in mental health services [must] be the community-based care and rehabilitation of the seriously mentally ill.

Scientific evidence supported the view that, with advances in treatments for severe mental illnesses, many individuals could indeed be cared for in community settings with only short inpatient admissions (Andrews 1991). However this required clinical services that could actually reach patients with the interventions and for community/social support services to deliver replacement accommodation and support services that had traditionally been provided in hospitals.

Experts and advocates proposed policy solutions in three major areas to improve mental health services in the community (Best 1985, Gardner 1997, Lipton 1983). The first was to change the way mental health services were administered. They suggested that mainstreaming mental health services within the general health sector would be necessary to ensure those with mental health problems were not treated differently to those with other health problems (Mental Health Task Force 1991, 3). They
saw bringing mental health services into mainstream health services as a policy solution.

The second policy solution was in response to the problem that patients had not been receiving continuity of clinical care between the inpatient and community arms of the mental health service. Service integration was the solution to better continuity of care between hospital and community services, so that hospital and community services would be administered as a single seamless service.

The third policy solution was in answer to the lack of housing and support services for patients in the community. It was in recognition of the reality that, in long stay hospitals, patients were provided with three types of interventions - clinical care, accommodation and support services, but when patients moved to the community these services became the responsibility of different government departments. Access to and coordination of the services was often poor. Advocates argued that the policy solution would require mainstream employment, housing and community services to assume responsibility for services their portfolios provided to people with disability, including those people with a psychiatric disability. At the time I argued (Whiteford 1994b):

No one service, in this case the mental health service, should have control over the majority of services needed by a person. One of the aims of institutional reform was to break this ‘whole of life control’ [over people with psychiatric disability].

Furthermore it was recognised that health professionals within the mental health services were trained to provide clinical diagnosis, treatment and rehabilitation. They did not necessarily have the training and skills to provide services such as disability support, housing or vocational training. Ian Hickie (key informant interview) noted that New South Wales had attempted to ‘run housing within mental health services’ but ‘this was spectacularly
unsuccessful’.

In principle the policy solution had a sound basis: it was discriminatory for people with psychiatric disability to be denied access to social and disability programs available to people with other forms of disability. Equity required people with psychiatric disability be treated on the same basis as people with physical, sensory or intellectual disability. Mainstreaming the provision of social and disability services could decrease the marginalisation and stigma which had been a barrier for people with mental illness living in the community. Broadening access to the services in the community available to other people would make the social environment for these individuals as normal as possible and promote social inclusion. However, as is discussed in the next two chapters, it was difficult to have this policy solution adopted and implemented, in part because it involved brokering agreement between multiple sectors on choosing a service model and resourcing it.

Some authors argued that long term inpatient facilities were still appropriate for those with disorders of a severe, unremitting and disabling nature (Andrews 1991, Eisen and Wolfenden 1988). A continuing role for hospitals as places of asylum as well as for the acute treatment and rehabilitation for those with severe mental illnesses was proposed for those who were too ill or disabled or dangerous to themselves or others to be adequately cared for in the community (Raphael 1984). These authors also highlighted, however, that these facilities would need to be upgraded in order to fulfil this function.

One area of policy work they undertook was to clarify and formalise Commonwealth government responsibilities in the area of mental health. This was not to include direct service provision but was in recognition of the financing provided by the Commonwealth government to mental health services now largely delivered outside the State-run psychiatric hospitals. Experts
argued it was no longer possible to maintain the view that the Commonwealth government had no role in public mental health services, following the movement of State and Territory mental health services into mainstream health and community support services (Mental Health Task Force 1991, 3).

Advocates argued for inclusion of other areas of mental health policy, for example mental health promotion and illness prevention strategies (Raphael 1993, Tippett et al. 1993) making the argument that preventing mental illness could help mitigate the human and economic costs. Despite their efforts policy makers did not see initiatives in these areas as a priority.

1.4 Service Quality and Effectiveness

Problem areas

Although they featured less prominently than service structure issues, I identified two main problem areas in the data sources from the literature review that coded to this theme. The poor quality of services both in the community and for those remaining in hospitals were identified by reference to a lack of national standards and a lack of information about the effectiveness of services.

(a) No national standards for mental health services

There were no national standards that defined the attributes needed in the delivery of mental health care. Mental health services were rarely accredited by an independent authority (HREOC 1993, 946, Raphael 1984).

(b) Lack of information on effectiveness

There was a lack of data on the cost effectiveness of service delivery. Service costs were being assembled but patient outcome information was needed to determine cost
Effectiveness:

Information necessary for effective management of services and for clinicians' evaluation of their activities is generally unavailable. Data collections focus excessively on service utilisation and resource in-puts. Within the limitations of these collections they are not sufficiently used as an information source ... (Eisen and Wolfenden 1988).

Policy Responses

While most of the policy solutions being proposed in respect of services were about structure and governance, some attention was being paid at this time to service quality to improve outcomes in mental health. National standards for mental health services were proposed with the expectation they would improve service quality and, from a rights perspective, engage consumers and carers in mental health service developments (ACHS, CHASP and AIMHS 1996, Whiteford 1996). Advocates argued investment in research into the causes of mental health was needed to develop better treatments, as well as evaluation of the effectiveness of different models of service delivery on patient outcomes (HREOC 1993, 821). They also suggested cost effectiveness studies of different providers of care and service models to define the optimal mix of providers at optimal cost (Raphael 1984).

Advocates proposed a system of mental health indicators and/or a national mental health database which would collect and review service data with the aim of improving the quality of Australian mental health services (Raphael 1984). The role of a well-trained and well-resourced workforce in improving the quality of care with better outcomes for patients was recognised as important not only in advocacy by professional organisations but in submissions to the Burdekin Inquiry and by the National Health Strategy review undertaken for the Commonwealth Health Minister (National Health Strategy 1993).
1.5 Resources

Problem Areas

I identified three main problem areas in the data sources from the literature review that coded to this theme. These related to inadequate financial and human resources and cost shifting between governments.

(a) Inadequate financial resources

The first resource problem I identified was the low overall expenditure on mental health and the inequity of the expenditure between hospital and community services. Experts considered that the distribution of funding for mental health services within the health budget was inequitable (Eisen and Wolfenden 1988, Raphael 1984). Even though the majority of people were being treated in the community, most State and Territory government mental health budgets were still spent on hospitals. It was estimated that, in 1992-93, 29% of State and Territory government mental health resources were directed towards community-based care and 73% of psychiatric beds were located in standalone hospitals that consumed half of the total mental health spending by the State and Territory governments. Less than 2% of resources were allocated to non-government programs that provided support services in the community (Whiteford, Buckingham and Manderscheid 2002). Community mental health services were under-resourced given the large number of patients they had to treat (Hoult and Burchmore 1994, HREOC 1993, 908, Beaumont 1990).

(b) Cost-shifting between jurisdictions

The complex arrangements between the Commonwealth,
State and Territory governments regarding the funding and administration of mental health services was cited as a major problem requiring a clear and coordinated national direction (Eisen and Wolfenden 1988, Raphael 1984). Specifically, the shift in emphasis away from State funded institutional services made existing Commonwealth/State monitoring of compliance with responsibilities increasingly ineffectual and outdated (Eisen and Wolfenden 1988, Mental Health Task Force 1991, 21). Public mental health services were regarded as a State and Territory government responsibility in terms of policy, financing and administration. However, most mainstream health and community support services were operated under mixed Commonwealth/State arrangements, and some (such as the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme) were solely a Commonwealth government responsibility. It was evident that since the State and Territory governments had shifted acute public mental health services to general hospitals and long term care away from State-funded psychiatric hospitals into the community, the Commonwealth government was now faced with increased expenditure in the sector for which they made a financial contribution (Mental Health Task Force 1991, 21).

The cost shifting from the State and Territory governments to the Commonwealth government became an increasing problem. Experts described the lack of policy integration between jurisdictions as a significant factor in a readily identifiable waste of resources and cost-shifting was endemic (Eisen and Wolfenden 1988).

The States have for various reasons shifted public services to general hospitals, into the community and away from State funded psychiatric hospitals. An efflux of psychiatrists, (and to a lesser extent other mental health professionals), from the public
to the private sector, has brought with it increased expenditure by the Commonwealth in the private sector. Overall expenditure trends in health are in the same direction.

(c) Human resources

The other resource problem was in the area of human resources. Workforce shortages existed in the specialised public mental health sector. Experts believed that, following de-institutionalisation and the increasing Commonwealth government subsidy of the private sector, many psychiatrists elected to limit their practises to urban private settings. This created a shortage of specialist medical services in community mental health care (Andrews 1991, Raphael 1984). The efflux of psychiatrists from the public to the private sector also brought with it increased expenditure by the Commonwealth government through the Medical Benefits Schedule (Eisen and Wolfenden 1988). There were concerns over whether the Commonwealth government’s medical benefits payments for psychiatrist services were being directed to the highest needs groups (Mental Health Task Force 1991, 38, NATSIHC SHRG and AHMAC NMHWG 2004)

There was a need to ensure the accountability of mental health professionals (HREOC 1993, 870). This became particularly salient following the highly publicised scandals involving the abuse and death of institutionalised patients, which occurred due to the idiosyncratic use of power by mental health professionals (Carter 1991, Slattery 1990, Tobin 1993). Experts considered training of community mental health professionals to be seriously deficient. Processes to ensure accountability of those professionals employed were found to be either non-existent or inadequate (Andrews 1991).
Policy responses

Most policy responses called for increased Commonwealth government expenditure in mental health, especially community mental health. While care in the community was proposed as being less costly for governments overall, compared with hospital care, there was an acceptance that more financial resources would be needed for mental health.

While it was considered undesirable for the Commonwealth government to administer services centrally, it was proposed that responsibility for national policies, national standards, workplace planning and training should be accepted by the Commonwealth government (Eisen and Wolfenden 1988). Attracting and retaining a skilled mental health workforce was expected to help ensure good practice and higher service standards (Andrews 1994, Solomon, Buckingham and Epstein 1993). Eisen and Wolfenden (1988) also argued that funding arrangements could not continue on an input resource model and needed to move to an outcome model in order to drive change.

2. The Political Response and the opening of the policy window

The Hawke Labor government was elected in March 1983. According to Brian Howe (key informant interview) the government had not been elected with a mandate to undertake mental health reform and the priority for the 1980s was reform of the Medicare health insurance system. The major problem areas identified in mental health (human rights abuses; the increasing burden on families of caring for relatives with mental illness; poor quality and organisation of mental health services; poor coordination of mental health with other social services; lack of funding and staff for mental health services; and cost-shifting from the State and Territory governments to the Commonwealth government) had been present for decades without a nationally coordinated policy response being seen as necessary. Mental health had
not been a politically attractive area and people with mental illness and their families had little political influence and limited capacity to advocate for themselves (Raphael 1984, iv). This began to change in the 1980s with professional groups, consumers and carers becoming increasingly organised and vocal.

When confronted with the 1984 submission by the RANZCP and the ANAMH, which argued for a national approach to mental health service delivery (Raphael 1984), the Commonwealth government was reluctant to assume the responsibility that might come with a national mental health policy. As noted in Chapter 5, this would have a budgetary impact, involve them in the criticisms about the public mental health services and increase the risk of cost-shifting from the State and Territory governments to the Commonwealth government.

In response to the RANZCP and ANAMH submission, the Commonwealth Health Minister, Neal Blewett, commissioned a review of the Australian mental health system by Dr Peter Eisen and Mr Kevin Wolfenden. Their report, handed to the Commonwealth government on 28 March 1988, identified a wide range of concerns about both service funding and organization (Eisen and Wolfenden 1988) and demonstrated a considerable Commonwealth government expenditure on services for people with mental illness. The report was presented to the Australian Health Ministers’ Conference on 22 October 1988 and then publically released. Media reports based on its key findings discredited the view that mental health was a State and Territory government responsibility. For example in December 1988 the *Sydney Morning Herald* reported (Williams 1988):

> the [Eisen and Wolfenden] report ... makes clear the [mental health] system is plagued by problems, inefficiency, wastage and a long-running feud between the Commonwealth and States over funding .... the Commonwealth bears two-thirds of the cost of mental health services - $1 billion in pensions to the mentally ill – yet does not monitor its spending and has no say in how the money is spent.

The report by Eisen and Wolfenden, while a complex document
that many policy makers found difficult to digest, did include specific recommendations for a national mental health policy and Commonwealth government involvement in the coordination of service developments (Bland 2002).

The momentum for a national policy response to the problems in the mental health sector increased. Some public figures started to make reference to the need for a national policy. For example, in 1989 the Governor-General of Australia, Bill Hayden, commented in his opening address to the ANAMH National Congress ‘Mental Health - Who Cares? The Foundation of a Nation’ (Hayden 1989):

It would be remiss if I did not say that I am also aware that one of the central issues you will be discussing is the need for a national policy on mental health. Such a policy to coordinate and integrate existing services for clients including those who suffer mental illness is one of the recommendations of the Eisen/Wolfenden consultants report last year... it does seem to me that this report marks something of a milestone in the assessment of the needs of mental health services in Australia... the report does represent a clear indication of the Commonwealth government’s concern about mental health services... what is important is that the opportunity created by the report should not be lost..

State and Territory government ministers conceded that the problems that arose from de-institutionalisation were in large part due to their failure to establish adequate community services for patients (1989):

While new treatments and new attitudes made it possible for more people to return more quickly to community life following a psychiatric admission, attempts at de-institutionalisation during the sixties and seventies were not backed up. There were few community services of sufficient quality or quantity needed to support former hospital residents and to ensure their quality of life. This meant higher rates of re-admission (Victorian Health Minister Caroline Hogg).

The Labor government was re-elected for a fourth term in March 1990, again without a specific mandate to undertake mental health reform. However the wider reform agenda was shifting toward social policy reform with continued use of the ‘super-departments’ introduced in 1987 to improve coordination and efficiency across related policy areas (Disney and Nethercote 1996, 35). Mike Codd, Secretary of the
Department of Prime Minister and Cabinet from 1986 to 1992 was identified by Brian Howe (key informant interview) as having argued that the Labor government focus during the 1980s on microeconomic reform should move to a focus on social policy reform and reforming Commonwealth/State relationships during the 1990s. These broad directions set the context within which mental health policy reform took place. Mr Howe became the Minister responsible for the relevant ‘super-department’; Community Services and Health in 1990 and then Health, Housing and Community Services from 1991 to 1993. His role was essentially that of an ‘issue entrepreneur’ within government and was critical to mental health reform being adopted by the government.

Earlier in 1986, as Minister for Social Security during the Parliamentary debate on the *Disability Services Bill*, he expressed a personal view, different to that of Senator Grimes the Minister for Community Services responsible for the Bill:

I refer particularly to the concern raised by the honourable member for Richmond (Mr Blunt), the shadow Minister for Social Security [about] the exclusion of people with long term psychiatric illnesses. I draw his attention to the statement made by Senator Grimes in the Senate. We are talking to some extent about a distinction in areas of responsibility between departments, but primarily between the Commonwealth and the States. Senator Grimes referred to this practice being traditionally, whether it is right or wrong, a State matter. I have always taken the personal view that the Commonwealth has to take more responsibility for psychiatric care. I believe that the tremendous problems associated with funding and the inequities that exist between psychiatric and overall health treatment may not have arisen if a different approach had been taken. I repeat that this is a personal view, but Senator Grimes was essentially saying that clearly there would be great cost implications for the Commonwealth (Parliament of Australia 1986a).

With this personal conviction regarding mental health and Commonwealth/State relations as a backdrop, Mr Howe undertook a review of Australia’s health system, called the *National Health Strategy*, led by one of his senior advisers, Jenny Macklin (at the time of this writing the Minister for Families, Community Services and Indigenous Affairs and Minister for Disability Reform in the Gillard Labor government). The *National Health Strategy* resulted in the publication of
a series of issues papers, one of which was on mental health, authored by myself and colleagues (National Health Strategy 1993). Our analysis confirmed there had been limited reallocation of resources from psychiatric institutions to the community during de-institutionalisation, and consequently community-based services were inadequate and fragmented. We also confirmed that the extent of the Commonwealth government expenditure on people with mental illness was $2.58 billion in 1991/1992 (e.g.; on sickness benefits, pensions, Medicare benefits and pharmaceutical benefits). By contrast, the combined expenditure of the public mental health services run by State and Territory governments was only $871 million in that year, demonstrating that spending on services for people with a mental illness was clearly not solely a State and Territory government responsibility.

This mental health issues paper developed under the National Health Strategy reinforced the findings of the Eisen-Wolfenden report, showing again the inconsistencies in the existing Commonwealth government policy frameworks. For example, the Commonwealth government spent $1.45 billion in 1991/1992 on income security for people with mental illness and psychiatric disability, but excluded them from the range of support and vocational programmes designed to decrease dependence on welfare payments and help disabled people back into the workplace (e.g. in the Commonwealth Rehabilitation Service). I believe this information provided tools for policy advocates and helped establish the need for a national approach to mental health (Whiteford 1994a). Ian Hickie (key informant interview) commented that it had become clear the Commonwealth was the ‘real payer’ in mental health and therefore needed a policy framework for this expenditure.

Mr Howe also oversaw changes to disability services, including psychiatric disability. The 1990-91 Commonwealth Budget introduced the Disability Reform Package which clarified the responsibility for service provision between jurisdictions with respect to disability services and made it clear that people with psychiatric disability were as eligible
as persons with any other kind of disability to participate in the programs. Under the 1991 *Commonwealth State Disability Agreement* the funding and administrative responsibilities for different types of services were rationalised with the Commonwealth government administering employment services and the State and Territory governments responsible for accommodation and community support services. Decisions on the allocation of specific services were to be decided by the type of service and not by the nature of the impairments of individual clients. This precipitated the following exchange in the Commonwealth Parliament (Parliament of Australia 1991):

Mr Mack asked the Minister for Health, Housing and Community Services, upon notice, on 9 September 1991:

Do persons with psychiatric disabilities receive a lower priority than those with other disabilities in claims for funding and services under the Disability Services Act; if so, why are they discriminated against?

Mr Howe — The answer to the honourable member's question is as follows:

Historically, most services for people with psychiatric illness have been the responsibility of State/Territory governments. It is appropriate that services for people while they are psychiatrically ill should continue to be the responsibility of State health agencies. People with stabilised psychiatric conditions who may be considered to retain a psychiatric disability, are a legitimate long term responsibility of the Disability Services Act (DSA). The involvement of the Commonwealth in meeting the needs of those with psychiatric disabilities was expanded in the 1990 Budget, with the establishment of special Commonwealth Rehabilitation Service (CRS) units in all capital cities, Alice Springs and Shepparton. These will have people with psychiatric disabilities as the major target group.

In addition, it should be noted that Commonwealth and States/Territories agreed at the recent Joint Meeting of Health and Social Welfare Ministers to have a National Mental Health Policy. The contents of the policy have yet to be agreed between the Commonwealth and the States/Territories.

These developments took place while the bureaucratic consideration of the Eisen-Wolfenden report was underway, with advice being formulated for each government and Commonwealth, State and Territory positions being negotiated. In 1989, the Commonwealth, State
and Territory governments established a working group of officials from each jurisdiction to develop a discussion paper on which consultations about the development of a national mental health policy could be undertaken (Howe 1990). I was the Queensland government representative on this and subsequent working groups. A mental health taskforce of Commonwealth, State and Territory officials produced a report for governments (Mental Health Task Force 1991) and arising out of recommendations contained in that report, the detail of a national mental health plan was drafted (Whiteford 1992b). A motivation for the State and Territory governments to be involved in the negotiations was to gain access to Commonwealth government funding (Lyster 1992). The State and Territory governments needed Commonwealth government funding to help provide their mental health services, especially given the need to increase the community-based services, since most patients with serious mental illness were living in the community following de-institutionalisation (Blackwood, Meldrum, Groves, Buckingham and Solomon, key informant interviews).

Governments also established a mental health consumer outcomes taskforce which produced the National Mental Health Statement of Rights and Responsibilities, adopted by Australian Health Ministers in March 1991 (Australian Health Ministers 1991). The endorsement of this document by governments coincided with the adoption by the United Nationals General Assembly of Resolution 98B, the 'protection of persons with mental illness and the improvement of mental health care’ (United Nations 1991) and raised expectations for a formal commitment to national mental health reform.

As noted earlier, Mr Howe had a personal perspective on mental health reform and this was embedded in the larger social policy reforms being advanced by the Hawke Labor government. For example, the Department of Housing and Regional Development’s Better Cities Program, a $816 million program aimed at urban and regional development, allocated $69 million from 1993-94 to 1995-96 to facilitate the process of downsizing psychiatric institutions and
redirecting resources, mainly land suitable for residential development, to alternative uses (Commonwealth of Australia 1994). It was Mr Howe's desire to include a social agenda in the program which led to the funding of de-institutionalisation initiatives under the 'Better Cities Program' (Neilson 2008). Under this initiative Victoria received funding $52 million of the $69 million allocation which provided the basis for that State to move ahead with a plan to redevelop mental health services that was stalled due to the lack of capital (Buckingham, key informant interview). Buckingham (key informant) was of the view that the injection of Commonwealth funding from the 'Better Cities Program' was a key reason why Victoria took the early lead in the national mental health reform process; this outcome being a good example of policy convergence.

The economic reforms were less evident given the 'distractions' of the Hawke-Keating leadership conflict that followed the 1990 Labor election victory. Mr Howe (key informant interview) stated that, on his move from the Department of Social Security to the Department of Health, the government wanted to use 'super portfolios' to foster cross-sectoral reform. Examples given by Mr Howe were child support, employment, disability reform, jobs, education and training and it was 'like the Blair government's joined-up government'. Mr Howe said he and Prime Minister Hawke saw potential in health and aged care for reform including constraining costs and creating efficiencies.

Mr Howe (key informant interview) commented:

mental health fitted nicely into cross portfolio reforms ... we wanted to become less dependent on tied grants ... focus more on outcomes. The national approach to mental health became one of the first moves towards transparent outcome driven social policy reform with clear benchmarks. It opened up a different way of working with the States ... it was part of the broader commonwealth State agreements [such as housing, disability and primary care].

The linking of the Kingdon's three streams occurred with adoption of the first National Mental Health Plan. From the problems stream the failures of deinstitutionalisation with human rights abuses, an increasing burden on families of caring for relatives with mental illness, low
resourcing and quality of mental health services, poor coordination of mental health with other social services and cost-shifting from the State and Territory governments to the Commonwealth government had repeatedly been identified. New research (especially the report by Eisen and Wolfenden) demonstrated the large financial exposure of the Commonwealth government in mental health. Policy solutions emerged in areas of Commonwealth responsibility, especially social services for people with psychiatric disability now living in the community. Politically, microeconomic reform was being pursued by the re-elected Labor government with a focus on social policy reform and reforming Commonwealth/State relationships during the 1990s. A reformist Minister (Brian Howe) had responsibility across the relevant policy areas (health, housing and community services) allowing him to coordinate intersectoral reform for people with psychiatric disability. Also from a political perspective the need to respond to the National Inquiry into the Human Rights of People with Mental Illness (the Burdekin Inquiry) helped galvanised the government to undertake mental health reform.

The National Mental Health Policy was adopted by Commonwealth, State and Territory health ministers in April 1992 and an implementation plan, which became the first National Mental Health Plan (Whiteford 1994a) was also adopted but never publically released. The content in the plan did however form Schedule F of the 1993-98 Commonwealth/State Medicare Agreements. The 1992/1993 Commonwealth Budget, with Mr Howe as Health Minister, announced $135 million for the implementation of the policy with most of this funding provided to the States and Territories through Schedule F of the Medicare Agreements. However not all the funds went to the States; a component was reserved for use by the Commonwealth for national initiatives. This was considered very important in giving the Commonwealth the means to embark on a range of nationally significant projects and other innovations, and to venture into areas that did not require State cooperation (Buckingham, key informant interview).
Schedule F of the 1993-98 Commonwealth/State Medicare Agreements stated that Commonwealth funding 'will also be available over the term of this agreement for demonstration projects of national significance that will encourage innovation and accelerate mental health reform'. The first National Mental Health Report released in March 1994 (Department of Human Services and Health 1994b, 115-6) and the second National Mental Health Report released in May 1995 (Department of Human Services and Health 1995, 19-20) describes the national initiatives funded by the Commonwealth with this allocation.

This was the first nationally agreed approach to mental health reform in Australia. A requirement of receiving the Commonwealth money was that each State and Territory 'maintain its effort', with respect to mental health, a requirement meant to prevent jurisdictions substituting the new Commonwealth money for their own previous commitments (thus not increasing the overall financial commitment to mental health). This became known as the 'quarantining' provision and I and other key informants (Buckingham and Blackwood) considered it had been successful.

In discussing the decision to have mental health placed on the national health agenda and included in the 1993-98 Medicare Agreements, Mr Howe (key informant interview) recalled the government agreeing there needed to be 'a more sophisticated way of doing government'. He went back to the influential Eisen-Wolfenden report which had recognised 'the money that the Commonwealth spent on mental health for which we received no recognition'. He recalled the Department of Finance being 'worried about cost shifting from State to the Commonwealth and the [Commonwealth] taking on more responsibility', but that the argument that the Commonwealth already had a large, existing financial commitment with no policy framework 'eventually won the day'.

As noted another political issue facing the Commonwealth government at this time, and identified by Mr Howe as influential in the decision to make a financial commitment, was the need to respond to
the forthcoming HREOC report of the Burdekin Inquiry. All key informants for this period (see Appendix 3) mentioned the HREOC Inquiry as influential on national policy and I also hold this view.

The Commission announced its Inquiry in June 1990, hearings commenced in April 1991 and the final report was released in October 1993. The criticisms made at the public hearings, reported in the media and later documented in the Commission’s report were shaped so as to place them in the context of a failure by Australia to uphold its international human rights obligations as well as emphasising the inconsistency with State/Territory mental health and other legal provisions (HREOC 1993, 895-6).

The issues identified by the hearings of the HREOC Inquiry were used by the Commonwealth Opposition to criticise the Commonwealth government, placing the issues firmly on the political agenda (Liberal Party and National Party of Australia 1992):

The Burdekin Enquiry into human rights and mental illness highlighted the harsh realities faced by people with mental illness. Yet mental health has not received the attention it deserves from the Federal Government.

Though Commissioner Burdekin publically ‘applauded the fact that since the inquiry began the Federal government has secured the States’ agreement to a national mental health policy’ (Burdekin 1993), on the release of the HREOC Report in October 1993 urgent government action was demanded (HREOC 1993, 15):

But the costs of our current neglect in terms of violations of the most fundamental rights of Australians affected by mental illness are clearly documented in this report. They demand an urgent, concerted and effective response.

Even though the National Mental Health Policy and the first plan had been announced with the $135 million committed in the May 1992 Commonwealth Budget, there was a political imperative to be seen to respond:

I intend to push as hard as I can, given I am not directly responsible for mental health policy – that is the responsibility of my colleague Brian Howe – to get these services out of the cities and into the bush. That raises another question: there are not
enough services in the cities either. The Burdekin Report shows that there is a paucity of services right across the nation. That is something we will have to address with every State and Territory (Parliament of Australia 1993a).

Clearly from listening to the comments this morning of State ministers around the country of both political persuasions, there remains much more to be done. Clearly governments of all political persuasions have used some sections of the Richmond Report from the 1980s to save a lot of money by closing institutions, but have never observed the second part of the Richmond Report to spend that money in creating more opportunities for community care, and that is sad (Parliament of Australia 1993b).

There was initial confusion over whether there would be additional funding following the release of the HREOC report. Senator Graham Richardson had become Commonwealth Health Minister on 24 March 1993, though Brian Howe, still Deputy Prime Minister, retained responsibility for mental health in his portfolio of Housing, Local Government and Community Services. The position of Mr Howe was that the government had pre-empted the HREOC report by releasing the National Mental Health Policy and the first plan with a $135 million commitment in the 1992/1993 Commonwealth Budget. Mr Howe and Senator Richardson made conflicting comments (Meade and Hole 1993):

The Federal Government appears split over its response to the critical Burdekin report on mental health with the Deputy Prime Minister, Mr Howe, ruling out more funding and the Minister for Health, Senator Richardson, guaranteeing more.

The Government would not allocate any more money for mental health because the Burdekin report reinforced the policy directions of the National Mental Health Strategy ... Mr Howe said money was not the answer because an extra $135 million had already been allocated by the Federal Government for the national strategy .... “We don’t actually think – and I think this is an important point – that funding is so much the issue,” Mr Howe said. “But we do think that we need to develop a different, more sophisticated approach to the way we manage the funds.”

Senator Richardson told the Senate earlier yesterday, however, that the Federal Government would undoubtedly need to spend more on mental health. “I think it would be very difficult for any government, State or Federal, to look at the Burdekin report and not realise that more money has to be spent,” he said. “In my view, the possibility of offering no extra funds in the light of the Burdekin report would be nil.”
As preparations were made for the May 1994 Commonwealth Budget the government came under increasing political pressure to respond with a budgetary allocation but in February 1994 Mr Howe was maintaining the position he held during 1993 (Meade 1994):

The Federal Government will not increase spending on mental health significantly in the May Budget despite last year's damning report by the Federal Human Rights Commissioner ...... the Government's first considered response to the Burdekin Report, released as a discussion paper yesterday, contained no promises of more funding in the area. Instead, the paper detailed what the Commonwealth was already providing in mental health services through the five year National Mental Health Strategy implemented in 1992. Last night, a spokeswoman for Mr Howe said the Budget would not contain a big increase in spending. Many of the areas were the responsibility of the States and Territories ... The Minister for Health, Senator Richardson, who embarrassed Mr Howe last year by saying the Government would need to spend more on mental health, will address a Burdekin Report conference in Sydney on Thursday.

Senator Richardson announced, days later, that he and Mr Howe would take a submission to Cabinet for additional funding (Larriera 1994):

The Minister for Health, Senator Richardson, although not directly responsible for the mental health portfolio, said yesterday that he would join the Minister for Housing, Local Government and Community Services, Mr Howe, in taking a joint submission to Cabinet for additional funding.

The submission in fact secured substantial funding in the May 1994 budget sufficient to almost double the Commonwealth government commitment (Commonwealth of Australia 1994) although by the time of the Budget Senator Richardson was no longer the Health Minister, having resigned on 25 March 1994 (and retired from Parliament) to be replaced as Health Minister by Carmen Lawrence (Middleton 1994):

Services for the mentally ill will receive an extra $169 million over the next four years as the Federal Government's response to the Human Rights Commission's damning report on mental health. The Health Minister, Dr Lawrence, announced last night that the National Mental Health Strategy would receive $133.6 million of the new money, which represents a doubling of existing funding to a total of $250 million over the next four years. Dr Lawrence said the extra mental health funding would be used to address Mr Burdekin's primary areas of concern.

The content of the *National Mental Health Policy* (and first plan contained in Schedule F of the Medicare Agreements) reflected closely the policy solutions that had been proposed by the policy community. The multilateral agreement to the policy and plan heralded a period of unprecedented Commonwealth/State collaboration and co-operation in mental health reform in Australia. To oversee the implementation of the *National Mental Health Policy* and plan the National Mental Health Working Group (NMHWG) was created (Whiteford 1994a). This group reported to the Australian Health Ministers' Advisory Council (AHMAC) and had twelve members, one representative from each State and Territory health department, two representatives from the Commonwealth department of health (one of whom provided secretariat services) and the chair and deputy chair of the newly created National Community Advisory Group (NCAG) which comprised mental health consumers and carers. The appointment of community members to a Commonwealth/State body made up of government officials was unusual for the time, especially as it meant that individuals with a mental illness would have direct input into, and the ability to observe, intergovernmental processes (Behan, Killick and Whiteford 1994). At a broader level, support was provided to consumers and carers in all jurisdictions to develop the capacity to advocate and to engage in service planning and development (SPICE Consulting 1998), with Schedule F of the 1993-98 *Commonwealth/State Medicare Agreements* specifically requiring the establishment of State and Territory community advisory groups.

The AHMAC NMHWG established a set of national policy indicators in July 1993. There were 49 indicators drawn directly from the national policy and agreed upon in order to monitor progress towards the implementation of the policy (AHMAC Mental Health Drafting Group on Performance Indicators 1993). The indicators were collected for the 1992/93 year and progress on implementation was published annually in national reports made available to the public. The first *National Mental
Health Report was released in 1994 (Department of Human Services and Health 1994b).

A major effort was launched to gather and assemble data to give as accurate a picture as possible of Australia’s mental health services. There were no agreed data sets or even common definitions for describing expenditure and activity at the outset and emphasis was placed on establishing standard definitions and ensuring the comparability of data collected from the States and Territories. The AHMAC NMHWG established a Mental Health Information Strategy Committee which is still in existence at the time of this writing. The membership included all State and Territory health departments, the Commonwealth Department of Health, the NCAG, the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW) and the Australian Private Hospitals’ Association. This group developed a National Mental Health Data Dictionary and Minimum Data Set for Australia, and laid the foundations for the future national mental health information development strategy.

Legislative and services reform for those patients with severe mental illness were prioritised. The policy and plan required the mainstreaming of mental health services to bring them under the same administrative umbrella as other health services (Singh 1992, Whiteford, Macleod and Leitch 1993); the integration of hospital (inpatient) mental health services with community mental health services (Rosen, Miller and Parker 1989, Whiteford, Macleod and Leitch 1993); and intersectoral linkages requiring access to housing and community services (mostly operated outside of health departments) for individuals with mental illness and psychiatric disability living in the community (Whiteford 1992a, 1992b).

Whilst the responsibility for mainstreaming required mental health services to be delivered within the same administrative structure as other health services and for acute psychiatric care to be delivered in general hospitals alongside other acute health care services (Singh 1992), integration required hospital and community components of the
mental health service to become a single, functionally integrated service to provide continuity of care for people with long-term mental illness (Singh 1992, Whiteford, Macleod and Leitch 1993).

The third services policy direction, that of intersectoral linkages reform, was more complicated as it required the support and action of sectors other than health. As noted in Chapter 5 the Commonwealth Disability Services Act 1986 recognised psychiatric disability but afforded it a low priority (Whiteford 1994b). This was changed with the Commonwealth State Disability Agreement 1991. Under that Agreement the Commonwealth government had administrative responsibility for employment related services, the State and Territory governments had responsibility for accommodation and support services (including accommodation support, respite, recreation, independent living skills training and community access services, information and print disability services), and advocacy services and research and development were to be a joint responsibility. The State and Territory governments received responsibility for administering the bulk of the non-employment related disability services at a time where major implications for these services were surfacing as a result of the mental health and psychiatric disability reforms. The Commonwealth Disability Discrimination Act 1992 made it unlawful to discriminate against people with disability including those with psychiatric disability.

An attempt was made to align the policies and programs of health, housing and community services departments in all jurisdictions when relevant Ministers in all jurisdictions endorsed findings of a Mental Health Forum on Intersectoral Linkages (Mental Health Forum on Intersectoral Linkages 1995). Nevertheless there remained a substantial problem in providing equitable access to people with psychiatric disability, given the relatively small growth in expenditure in that program in the 1990s, a problem which proved very serious as discussed in Chapter 8.

After several years in development, national standards for mental health services were adopted by all governments in January 1997
(ACHS, CHASP and AIMHS 1996) and mechanisms put in place to assess whether services were meeting these standards. The standards were developed by a consortium comprising the Australian Council on Healthcare Standards, the Community Health Accreditation Standards Program of the Australian Community Health Association and the Area Integrated Mental Health Service Standards. They consisted of eleven major criteria, organised in three categories. Standards 1 to 7 relate to human rights, dignity and community acceptance. Standards 8 to 10 address mental health service organisational structures and links between parts of the mental health sector. Standard 11 describes the process of delivering care on a continuum and the types of treatment and support that should be available to consumers. These standards were included in the 1998 – 2003 Australian Health Care Agreements and in the Commonwealth/State Mental Health Information Development Plans (Department of Health and Ageing 2004). Consumers and carers were expected to use the standards to legitimise participation in service planning, development and evaluation, thus facilitating quality improvement through the development of a more consumer/ carer focused system (Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997). The government also encouraged professional bodies to develop protocols for clinical treatment.

The Commonwealth, State and Territory governments agreed there should be nationally consistent State/Territory mental health legislation (Australian Health Ministers 1992b, 3, Department of Human Services and Health 1994c). Furthermore, it was accepted that all relevant legislation should be consistent with Australia’s international human rights obligations as outlined in United Nations Resolution 98B, the ‘protection of persons with mental illness and the improvement of mental health care’ (Department of Human Services and Health 1994c). The Commonwealth government developed model mental health legislation and also a Rights Analysis Instrument which was applied to all State and Territory mental health legislation in order to facilitate the process of achieving consistency across jurisdictions and nation-wide
compliance with the UN principles and the *National Mental Health Statement of Rights and Responsibilities* (Watchirs and Heesom 1996).


In 1994 the Australian Health Ministers’ Conference agreed that one of the key goals for the improvement of mental health up to the year 2000 was to reduce the rate of youth suicide (Department of Human Services and Health 1994a). In July 1995 the National Advisory Council on Youth Suicide Prevention was formed, comprising seventeen members representing government, the community, consumers, young people, service providers and researchers. The National Youth Suicide Prevention Strategy was the Commonwealth government’s response to a series of national and international events that drew attention to the need for a concerted and coordinated approach to the prevention of suicide among young people (Mitchell 2000a). It was launched in July 1995 and ran until June 1999 with $31 million allocated over four years.

The Commonwealth, State and Territory governments endorsed actions in many other areas including the development of national public education and awareness programs to decrease stigma regarding mental illness, getting epidemiological information about mental illness in the population to assist service planning, promoting research into the causes of mental illness, developing programs for special needs groups and the evaluation of the effectiveness of different models of service delivery. It is beyond the scope of the thesis to discuss all of these and the many other initiatives during the life of the first plan.

4. **Conclusion**

The opening of the policy window in 1992 can be seen to be the
result of converging factors. There were escalating clinical and social problems for patients in the aftermath of psychiatric de-institutionalisation. The services in the community for these patients was under resourced and often of poor quality. There was an increasing burden on families caring for relatives with mental illness. Community advocacy was becoming more vocal in proposing policy solutions. There was a high profile public inquiry underway that resulted in prominent media reporting of human rights abuses and service deficiencies. The Commonwealth government commissioned an influential report (the Eisen-Wolfenden report) which provided evidence of the previously underacknowledged high cost of mental illness to the Commonwealth Budget and unregulated cost-shifting from the State and Territory governments to the Commonwealth government.

At a political level there was a socially reformist government Minister, Brian Howe, in a position of influence at a time when cross portfolio social policy reform was an emerging priority for his government. In addition there was a political necessity for the government to respond to the intense publicity generated by the Burdekin Report.

The opening of this policy window differed from the next two windows (discussed in Chapters 7 and 8) because there was no pre-existing national mental health reform process. Once the National Mental Health Strategy commenced with the adoption of the *National Mental Health Policy* and first plan, the Commonwealth government was required to consider its position on involvement in national reform at the conclusion of each five year national mental health plan. The need for the consideration of its position necessitated the issue of mental health being placed on the Commonwealth political agenda.

The *National Mental Health Policy* and first plan (and Schedule F of the Medicare Agreements), responded to the problems identified and contained many of the policy solutions that had been proposed by the policy community. A major period of national mental health reform was launched in Australia with the implementation of the policy and plan
focussing primarily on the needs of those individuals with severe mental health illness, problem areas that had dominated the policy debate in the decades prior to 1992.
CHAPTER 7 – the renewal of the National Mental Health Strategy by the Coalition government in 1998

This chapter focuses on the years 1996 to 2003, a period that begins with the election of the Howard Liberal-National Coalition government in 1996, continues after the newly elected Commonwealth government considered its position at the conclusion of the first National Mental Health Plan in 1998, and concludes with the end of the Second National Mental Health Plan in 2003. The first plan focussed on services for individuals with severe mental illness for which State and Territory governments were primarily responsible. The first plan was oriented towards the needs of State and Territory governments as providers of community-based treatment and care for patients who had either been discharged from long stay hospitals or who could not be admitted because of bed closures.

Between 1992 and 1998 when the first plan ended, the political orientation of the Commonwealth and most State and Territory governments changed. These changes of government occurred in the following sequence: Victoria, October 1992 (the Labor Kirner government was replaced by the Liberal-National Kennett government), Western Australia, February 1993 (the Labor Lawrence government was replaced by the Liberal-National Court government), South Australia, December 1993 (the Labor Arnold government was replaced by the Liberal Brown government), Australian Capital Territory (ACT), March 1995 (the Labor Follett government was replaced by the Liberal Carnell government), New South Wales, April 1995 (the Liberal Fahey government was replaced by the Labor Carr government), Queensland, February 1996 (the Labor Goss government was replaced by the Liberal-National Borbridge government) and, at the Commonwealth level, in March 1996 (the Labor Keating government was replaced by the Liberal-National Coalition Howard government). However, the first Plan continued essentially unchanged until June, 1998. In part, this was because substantial public expectation for reform had been raised,
reinforced by annual reports issued by the Commonwealth Department of Human Services and Health/Health and Family Services which demonstrated progress in achieving this reform. Governments, with some short-lived exceptions, felt obliged to maintain the reform momentum. Another reason was that Commonwealth funding to the States and Territories for policy implementation was bound up with the five-year Commonwealth/State Medicare funding agreement. Over time, this apparent acceptance led to the perception that the National Mental Health Policy had bipartisan political support, further legitimising and reinforcing support for the reforms.

By March 1996, when the Howard Coalition government was elected and Michael Wooldridge became the Commonwealth Health Minister, the mental health policy making capacity of the Department had made significant advances since the commencement of the first plan in 1992. No identifiable unit dedicated to working on mental health policy had existed in the Department of Health before 1990 and the first mental health policy section was not established until 1992. At the meetings held with the Commonwealth to develop the first plan, State and Territory representatives provided most of the technical knowledge and expertise (Buckingham, key informant interview); consequently they were able to exert considerable influence over the content. However, by the time the Coalition government was elected in 1996, the Commonwealth Department of Health and Family Services, as the Department of Health and Ageing was then called, had an established mental health branch responsible for policy, had accumulated more technical expertise in mental health and had acquired much greater awareness of the Commonwealth government’s responsibilities and commitments in the area of mental health. The bureaucrats in the mental health branch had translated the National Mental Health Strategy documents into a defined work program and the Commonwealth instrumentality was able to assert more influence in assessing and proposing national mental health policy to areas for which the Commonwealth government was responsible.
Despite this evidence of bureaucratic commitment there was uncertainty as to whether the Commonwealth government would continue with the National Mental Health Strategy. No funding had been allocated in the Commonwealth forward estimates after 1997/98 and the uncertainty intensified over the first two budget cycles of the Howard government, given the focus on achieving savings. With the Commonwealth/State Medicare funding agreements coming to an end in June 1998, the new Liberal-National government had to decide whether to withdraw from, modify or maintain unchanged the national mental health reform initiated by the previous Labor government (James, key informant interview).

As I did in Chapter 6, I used the themes identified in Chapter 4, human rights and community attitudes; community need; service structure; service quality and effectiveness; and resources as an organising framework to analyse the problems described in the literature and policy responses proposed in the lead up to 1998.

1. Themes

1.1 Human rights and community attitudes

Problem areas

I identified a key problem area in the data sources from the literature review that coded to this theme – community attitudes toward mental illness.

(a) Community attitudes toward mental illness

The sources indicate a shift in focus during 1996-03 with individual human rights becoming much less prominent, although concerns about community attitudes and stigma persisted as evidenced by demands to provide public education to improve the attitudes and knowledge about mental illness. Sensationalised media reporting continued to fuel fear and ignorance (Martin 1997, Singh and McGorry...
1998) and this was targeted for policy attention.

I also found a continued emphasis on the importance of consumer and carer involvement in mental health service delivery and planning at a local level with the extent of this involvement being monitored annually (Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997, 7,8,45). Carers and consumer advocates were worried that the NCAG, whose term was concurrent with the five years of the first National Mental Health Plan, would be disbanded in 1998 and the mental health sector would no longer have a peak consumer and carer national body.

Policy responses

As noted in Chapter 6, policy makers and bureaucrats were revising State and Territory mental health legislation to make it consistent with the United Nations principles and the National Mental Health Statement of Rights and Responsibilities (Watchirs and Heesom 1996). National standards for mental health services were adopted in January 1997 in order to improve service quality as well as instilling a rights perspective (ACHS, CHASP and AIMHS 1996, Whiteford 1996). Whilst Burdekin (1995) acknowledged that tolerance cannot be legislated, he advocated for changes to the law as a necessary precondition to bring about greater community understanding.

In conjunction with these legislative changes there were initiatives to increase community awareness of suicide and mental illnesses (Clausen 1999). National media campaigns were designed to increase understanding of mental health issues and reduce stigma (National Mental Health Strategy Evaluation Steering Committee 1997, 11). However policy advocates considered this area needed further action and investment to maintain progress.

1.2 Community Need
Problem areas

I identified two key problem areas in the data sources from the literature review that coded to this theme – lack of focus on common mental disorders and on suicide prevention.

(a) Lack of focus on the most common mental disorders

As noted, the policy directions of the first plan were in response to the legacy of 30 years of uncoordinated de-institutionalisation. While the evaluation of the first plan established that a number of important reforms had been achieved, (Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997, National Mental Health Strategy Evaluation Steering Committee 1997, Singh and McGorry 1998), during the five year life of the plan experts and advocates increasingly criticised it on the grounds that the patient focus of the first plan was too narrow, the threshold for access too high and desirable elements such as prevention and early intervention had been ignored (Ash et al. 2007; Raphael, key informant interview).

Many stakeholders expressed the opinion that State and Territory services focused on those diagnosed with severe mental illnesses to the neglect of others with a mental disorder deemed less severe (National Mental Health Strategy Evaluation Steering Committee 1997, Singh and McGorry 1998). The stakeholder community began to argue that a broader range of diagnostic groups should be seen as within the purview of public mental health services. Barrand (1997, 147) summarised the argument as follows:

The NCAG [National Community Advisory Group] response stemmed from community consultation workshops and highlighted the importance of the redefining of the emphasis of the strategy to encompass not only ‘serious mental illness’ but,
more appropriately, ‘seriously mental health care problems’ on the premise that mental health services should flow from the level of illness and the corresponding level of disruption to the life of the person and his or her carers, and not solely on a clinical diagnosis and treatment regime.

A more radical argument was to broaden the policy scope even further, taking a whole of population approach so that people without mental disorders would be included. The argument in support was that mental health promotion and illness prevention for the whole population should be included for the policy to be as effective as possible. (Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997, Baume 1995, Hunter 1997, Martin 1997).

Even those treatment providers responsible for State and Territory mental health services, whose client group comprised those patients with more severe disorders, argued for an expanded scope for services. For example, as early as 1994 the New South Wales Director of Mental Health, Dr Noel Wilton commented (Wilton 1994):

Priorities for mental health services have to date been mainly for treatment intervention after onset of illness with some increasing emphasis on rehabilitation services of latter years. Prevention and promotion in the field have been sadly neglected.

Despite the persistent problems facing those with severe mental illness, advocacy to make the needs of this group a priority diminished, whilst stakeholders, including professionals, intensified their advocacy efforts in support of expanding the scope of mental health reform to include common mental disorders. Several influential studies were conducted around this time and new findings were published that helped define this problem area.

As one of six national priorities for mental health information development in the 1992 National Health Information Agreements, and as required by Schedule F of
the 1993-98 Commonwealth/State Medicare Agreement, in 1997 the ABS conducted the first nationally representative survey of mental disorders in Australia, the National Survey of Mental Health and Wellbeing (NSMHWB), using a household sample (ABS 1998). The NSMHWB was used to construct findings for advocacy purposes even before its official release in 1998, as the planning, undertaking and early advice to the Commonwealth on the likely findings of the survey influenced the thinking amongst the bureaucracy and its advisors (D. Casey, Buckingham, key informant interviews). Survey data indicated that depression, anxiety and substance misuse were the most common mental disorders in the Australian population. These disorders were less common in the population treated by public specialised mental health services, which the first plan had focused on reforming. Of those surveyed who met the diagnostic criteria for a mental or substance use disorder and who had accessed treatment, most were treated in primary care, the part of the health sector subsidised by the Commonwealth.

Another study published just before the NSMHWB had shown that around one third of people seen by general practitioners have a diagnosable mental disorder. A further one third of those seen suffer from significant psychological symptoms that do not meet the criteria for any specific disorder. Of those with a mental disorder, only half receive a diagnosis and, of these, only half receive specific drug treatment (Harris et al. 1996). In the NSMHWB, 65% of those with a disorder had not used any form of health service in the previous 12 months. This bought into sharp policy focus the role of primary health care, specifically general practitioners, and also those who were not accessing care, a population that had not been considered
In 1996, the first volume of final results and methods (Murray and Lopez 1996b) from the Global Burden of Disease (GBD) Study was published by Harvard University Press. In 1992, the GBD study was commissioned by the World Bank, with the 'early and full participation' of WHO, to 'quantify and project the health problems of populations to guide public health planning' (Murray and Lopez 1996a). In 1993 preliminary results from the GBD were published in the World Development Report, marking the introduction of a new metric that combined premature mortality and years lived with a disability, the Disability Adjusted Life Year (DALY). This metric allowed comparison of mortality and morbidity between disorders and was used to demonstrate that mental disorders were the leading causes of health-related disability in most countries, causing more impairment than prominent disorders such as cancer and heart disease (Murray and Lopez 1996b). This study, which revolutionised the measurement of disease impact internationally, was also influential with the Commonwealth bureaucracy. In 1998 an Australian (national) Burden of Disease Study was conducted at the AIHW that drew upon information about mental disorders in Australia from the NSMHWB and used the DALY summary measure. The AIHW report on the Burden of disease and injury in Australia found that mental disorders, predominantly anxiety, depression and substance misuse accounted for nearly 30% of all health-related disability, and that depression was the leading cause of disability among all health conditions for both sexes (Mathers, Vos and Stevenson 1999). This report reinforced the public health implications of the NSMHWB that common mental disorders were, at a population level,
very important because of their prevalence. The fact that most people with these disorders received no treatment and those that were treated received it from primary health care services helped change the thinking about priority setting amongst the Commonwealth bureaucrats (Buckingham, D. Casey, key informant interviews).

(b) Lack of attention to suicide prevention

The neglected problem of suicide prevention gained greater policy attention during this period. Nearly ninety% of people who die by suicide have a mental disorder, the most common disorder being depression. Rising rates of suicide were of concern, particularly among young males (AIHW and Department of Health and Family Services 1997, Baume 1995, De Vaus 1996, Taylor 1996, White 1995). This attracted media attention which increased following reports that in 1991, deaths from suicide in Australia had overtaken deaths from motor vehicle accidents (Baume 1995, White 1995) for the first time since 1930 (ABS 1994). Baume commented:

Alarmingly, in Australia suicide claims more young lives than motor vehicle accidents. Of all external causes of death in 1991 suicide accounted for 31% of those deaths, followed by motor vehicle accidents (Baume 1995).

Some advocates provided data suggesting Australia had one of the highest rates of youth suicide in the industrialised world (Taylor 1996).

Policy responses

One of the most consistent policy responses was to increase treatment rates amongst the high prevalence mental disorder groups (Singh and McGorry 1998) by targeting primary care, the
part of the health sector where most of the people with those disorders in treatment could be found. This led to a focus on primary health care reform, which is discussed under the theme service structure. Experts recognised that such strategies could be at the expense of those with severe, lower prevalence mental illnesses (McGorry 1998).

As also noted in the discussion regarding, service structure, a second policy response was to develop and implement strategies to prevent the onset of mental illness and suicide, although it was recognised that these should be grounded in an understanding of risk factors and protective factors (Mental Health and Special Programs Branch 2000a, 2000b, 2000c, 2000e, Buist 2002).

Preventative activities targeting at-risk population groups were also proposed as potentially useful strategies in addressing the significant burden of mental disorders (AIHW and Department of Health and Family Services 1997). Pregnancy was identified as an opportunity for prevention because virtually all pregnant women have contact with a health professional and there is a higher risk of mental illness during the perinatal period (Buist and Bilszta 2006, Wooldridge 2001, Buist 2002, Kennett 2005, 2006). Children of parents with a mental illness were identified as another high-risk group that could benefit from targeted promotion and prevention initiatives (AICAFMHA 2001, 2004).

1.3 Service structure

Problem areas

I identified two key problem areas in the data sources from the literature review that coded to this theme – lack of attention to mental health promotion and prevention activities and primary care services.

(a) Lack of mental health promotion and prevention activities
The release of the report *Goals and Targets for Australia’s Health in the Year 2000* (Nutbeam et al. 1993) contributed to a shift in the focus of mental health reform to the population as a whole, including those individuals with a mental disorder who were not in contact with the mental health system. However, in the period before the NSMHWB published its findings (ABS 1998), the lack of population information hampered this effort (Whiteford 1994a).

Professor Beverly Raphael was a strong advocate for the introduction of mental health promotion and illness prevention. As early as 1993 Raphael was making the case for a population health approach to the *National Mental Health Strategy* (Raphael 1993). The need for attention to mental health promotion and illness prevention was also advocated at the State and Territory level.

(b) Primary Care had been ignored

While progress was made in the structural reform of specialist mental health services during the life of the first plan (Australian Health Ministers 1998, Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997, National Mental Health Strategy Evaluation Steering Committee 1997, Singh and McGorry 1998), problems remained. Insufficient clinical resources were still being deployed to community care and there was a failure to improve access to housing and disability services as their capacity was insufficient for the large number of individuals with psychiatric disability (Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997, Thornicroft and Betts 2002). The evaluation of the first plan (National Mental Health Strategy Evaluation Steering Committee 1997) noted:

> 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 the apparent escalation of demands on their limited resources.

However, as noted earlier, the focus of service reform was shifting to primary health care and the role of general practitioners who were subsidised by the Medicare Benefits Schedule, a Commonwealth government program. Primary care medical practitioners complained that whilst they provided a large proportion of mental health care and were central to recognition and accurate diagnosis, little support was available to them in the management of mental health problems (Andrews 1994, National Mental Health Strategy Evaluation Steering Committee 1997, Henderson 1995). Evidence of problems in primary care was beginning to surface, for example that general practitioners were failing to recognise and therefore treat many patients who presented with mental disorders (Henderson 1995). The Joint Consultative Committee in Psychiatry of the Royal Australian College of General Practitioners (RACGP) and the RANZCP commented that while public psychiatry has received a lot of attention, another very active sphere of psychiatric service delivery – primary – has remained largely in the background. In some ways, primary care psychiatry could be regarded as the last frontier of mainstreaming (Joint Consultative Committee in Psychiatry 1997).

**Policy responses**

Advocates and experts argued that in a population-focused system, promotion, prevention and early intervention strategies should be greatly expanded to reduce suicide rates and the burden of mental disorders (Baume 1995, McGorry 1998, Taylor
The concepts of 'indicated prevention' and 'early intervention' emerged as potentially useful constructs for designing and planning services (Singh and McGorry 1998). Policy responses argued for changes in services operating beyond the boundaries of the traditional mental health sector to areas which had contact with populations likely to be at risk of mental disorder, such as child welfare, education, police and corrective services and non-government service providers.

However the importance of primary health care dominated the debate. Fostering partnerships between specialist mental health and the primary care sector was emphasised (Harris 1994). This needed a change in direction as little attention was given to the private sector (primary or specialist services), subsidised by the Commonwealth government during the first plan (Whiteford, Buckingham and Manderscheid 2002).

The Joint Consultative Committee in Psychiatry of the RACGP and RANZCP (Joint Consultative Committee in Psychiatry 1997) commented that

Australian general practitioners see three quarters of people who seek help for mental health problems and mental disorders, yet they are overlooked as mental health service providers. They have few tools to use, limited training for their broad roles and often receive little or no support from specialist services.

The report from the Joint Consultative Committee examined the roles of Australian general practitioners and service linkages with specialist mental health services. In this report the Committee concluded that primary care psychiatry was underdeveloped in terms of skills, tools and resources, and made recommendations regarding general practitioner education and training in mental health. Recommendations for better links between mental health professionals, general practitioners and non-government service providers were made with action to assist general practitioners based on the RACGP and RANZCP report (Whiteford 1998) and various collaborative care models of
1.4 Service quality and effectiveness

Problem areas

I identified two key problem areas in the data sources from the literature review that coded to this theme – lack of standards for the clinical workforce and lack of measures which monitored patient outcomes.

(a) No standards for clinical workforce

The National Mental Health Service Standards, developed under the first plan, described what was needed for a service to be accredited as a mental health service. However it was argued that standards were needed for clinicians working in the mental health services to improve the quality of clinical treatment being given to patients (Buckingham et al. 1998, 273).

(b) No routine measuring of patient outcomes

While regular review of consumer outcomes was one of the original thirty-eight objectives in the 1992 National Mental Health Policy, action in this area was not commenced until the 1996-2003 period. Most of the attention was towards process and structure rather than outcomes and achievements (Steering Committee for the Evaluation of the Second Plan 2003, Leonard 1994). Experts regarded the emphasis on inputs and counting activity rather than a system focusing on patient outcomes as a significant impediment to better quality care (AIHW and Department of Health and Family Services 1997, Singh and McGorry 1998). A summary of progress in information development made over the period 1993-1998 under the first National
Mental Health Plan can be found in the report prepared by of the National Mental Health Information Committee (Mental Health Branch 1999).

**Policy responses**

One policy response was to describe National Mental Health Practice Standards - the key professional competencies that clinicians needed to have to work in a mental health services (KPMG Consulting and AHMAC NMHWG Education and Training Steering Group 1994). It was also argued that clinical competencies which describe the attributes of clinicians in areas such as knowledge and skills be augmented by developing clinical treatment guidelines for the disorders being treated in the services (Grimshaw and Russell 1993).

Further it was proposed that Commonwealth, State and Territory mental health services embed the collection of routine consumer outcome monitoring within everyday clinical practice and ensure their information systems capture these data, in addition to the existing data on inputs (financial, human and capital resources) and processes (e.g. occupied bed days and occasions of service). It was proposed that consumer outcome data should be routinely collected to complete a national picture of service quality (Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997, Morris-Yates and Strategic Planning Group for Private Psychiatric Services 2000, Stedman et al. 1997, Henderson 1995).

The potential cost savings of effective promotion, prevention and early intervention strategies also began to be promoted to policy makers (McGorry 1998, Singh and McGorry 1998).

1.5 **Resources**

**Problem areas**
One key problem area was identified in the data sources from the literature review that coded to this theme – lack of resources for primary mental health care.

(a) Poor resourcing of primary mental health care

Experts considered it was problematic that economic resources for mental health care were not distributed equitably within the total health budget (Andrews et al. 1999). Historical funding arrangements based on advocacy and tradition were becoming increasingly outdated (Andrews 1997). There was concern that resources were being spent inefficiently, for example, where private psychiatrists were engaging in long-term psychodynamic therapy for individuals who did not meet the criteria for a mental disorder (Andrews 1994, Solomon, Buckingham and Epstein 1993, Morstyn 1995).

As noted earlier, general practitioners complained that whilst they provided a large proportion of mental health care and were central to recognition and accurate diagnosis, they were not resourced, and the structure of the Medicare Benefits table did not allow adequate time for management of mental health problems (Andrews 1994, Joint Consultative Committee in Psychiatry 1997, National Mental Health Strategy Evaluation Steering Committee 1997, Henderson 1995).

Policy responses

In addition to the usual demand for increased financial allocation to mental health, strategies were proposed to improve the targeting of scarce resources (Manderscheid, Pirkis and Purdon Associates Pty Ltd 1997, Andrews 1997, Leonard 1994). It was suggested that a more equitable framework for resourcing mental health services could be based on disease burden and efficacy of

2. The Political Response and the opening of the policy window

On 2 March 1996 the Howard Coalition government was elected and Michael Wooldridge became Commonwealth Health Minister. There was no specific mention of action to address mental health in the Coalition’s health policy (Liberal Party and National Party of Australia 1996) and no clear electoral commitment for mental health reform (James, key informant interview). The five year first National Mental Health Plan ended on 30 June 1998 and this required the Coalition government to formally consider ongoing Commonwealth support for the national mental health reform agenda, an initiative of the previous Labor government. Financial commitment from the Commonwealth government to the State and Territory governments would require allocations to be made in the forward estimates of the Commonwealth budgetary process (Podger, key informant interview). Furthermore, to undertake reform in areas of mental health service provision identified as a Commonwealth government responsibility (e.g. the common mental disorders treated in primary care) would require funding to be redirected from State and Territory governments or additional funding to be secured.

The reform challenge was made more difficult as the first budget of the newly elected Coalition government, delivered on 20 August 1996, was one in which public spending was reduced (Song and Freebairn 2006, Wanna, Kelly and Forster 2000, 240-69). The 1996 and 1997 Commonwealth budgets were ‘savings budgets’ (Podger, key informant interview); whereas within the 1998 budget there was some room for new provisions, especially as this budget would provide the
funding for the new Health Care Agreements which would cover the five year period 1998 to 2003. Continued Commonwealth government spending on mental health under the 1998-2003 agreement required a political imperative, as well as clearly defined solutions to the problems being identified.

Dr Wooldridge took the view that the Commonwealth government should remain involved in mental health reform and made the case for expanding the role of the Commonwealth government in mental health. His role as an ‘issue entrepreneur’ within government was critical to the Commonwealth government continuing to be involved in, and driving, mental health reform. The reasons for this included his view that the State and Territory governments had not handled mental health well (Podger, key informant interview) and there was a role for the Commonwealth government to continue to be involved. Personal interest played a role, as Rebecca James, an adviser to Dr Wooldridge, had a member of her extended family experience a mental health problem. She believed that Dr Wooldridge also had a personal commitment to reform in this area, having observed the Victorian mental health reforms while working as a general practitioner in that State. She believed there was still a need to respond to the issues raised in the Burdekin Report and in the public debate around de-institutionalisation and the poor care provided to people with severe mental illness living in the community.

However mental health was not considered a politically attractive area (James, key informant interview). From discussions at the time I am aware there was not strong support within the government, given the budgetary constraints, to continue national mental health reforms using Commonwealth funding. I understood the members of the Expenditure Review Committee in their deliberations prior to the 2008 budget were not unanimously in support of continued Commonwealth government involvement in mental health reform. Two external issues influenced the political decision making process.

The first was the Port Arthur shootings. Eight weeks after the
Coalition government was elected a tragic event gained extensive public and media attention and influenced the response of government to mental health. On 28 April 1996, a lone gunman, Martin Bryant murdered 35 people and wounded 21 others at Port Arthur in Tasmania. Following the Port Arthur shootings, media reports suggested Martin Bryant had a mental illness, a claim later found to be incorrect (Mullen 1996). Nevertheless debate occurred in both political and media circles for several days as to whether the problem that caused the tragedy, and therefore needed a policy response, was a dangerous mentally ill individual in the community (rather than in hospital) or the availability of guns (The Age (Melbourne) 1996, Barker 1996, Whiteford 2005).

New Zealand gun control researcher Philip Alpers presented publicly available data to a Melbourne conference (Alpers 1996) that showed that the majority of mass civil homicides are not committed by persons with known mental illness discharged from hospital and that most perpetrators held a license for their firearm (Cantor, Mullen and Alpers 2000). Media coverage and government consideration of this data were successful in helping turn the debate toward gun control (Whiteford 2005). The Australasian Police Ministers’ Council convened a special meeting on 10 May 1996 and agreed to a national plan for the regulation of firearms—the Nationwide Agreement on Firearms. This agreement banned self-loading rifles and self-loading and pump-action shotguns, introduced a nationwide registration of firearms along with limitations to firearm ownership, and led to the Australian firearms buyback scheme.

Ironically, at the same time, the Commonwealth health department was developing a strategy to address the negative publicity associated with a spate of fatal shootings of people with mental illness by police. A taskforce of police and mental health officials had been established by the former Labor government in 1996 to develop strategies for improving mental health crisis intervention. The final report of the taskforce, including recommendations for crisis intervention reform, was finalised and implemented under the Howard
Coalition government in 1998 (see Appendix 1).

I observed the significance of the political impact of the Port Arthur shootings on mental health policy at the time, and this view was also expressed by key informants (James, D. Casey) even though the debate had turned to gun control. There was still said to be concern amongst some senior politicians that Martin Bryant must have had some form of mental illness to have committed such a horrendous crime and that mental health services, especially for individuals in the community, were necessary. I was told at the time by more than one source that the Prime Minister had been ‘spooked by Port Arthur’ and withdrawal of Commonwealth government support from national mental health reform in the budget following the Port Arthur shootings was not considered to be politically defensible.

The second issue I and key informants (D. Casey, Raphael and James) identified as influencing the Coalition to support mental health was suicide prevention. This was an area of particular importance to the Prime Minister. One key informant (D. Casey) recalled being told by someone who attended a meeting where the Prime Minister spoke to parents who had lost children from suicide that the Prime Minister ‘had tears in his eyes’. He also noted that all Commonwealth funding at the time for suicide prevention projects had to be approved through the Prime Minister’s office.

The linking of the Kingdon’s three streams occurred with the first National Mental Health Plan ending in June 1998 and the Coalition government needing to formally consider any ongoing Commonwealth involvement in national mental health reform. From the problems stream, research had shown common mental disorders caused the most health burden (as measured by premature mortality and disability), were often not treated and when treated it was in primary health care, a Commonwealth government responsibility. Policy solutions in the area of general practice reform were being promoted and the Minister responsible, Dr Wooldridge (a former general practitioner) took the view, for pragmatic reasons and with a personal interest, that the
Commonwealth government should remain involved. From a political perspective, after two ‘saving budgets’ (1996 and 1997) the 1998 budget was an opportunity for new provisions, with an election due (subsequently occurring October 1998). Also from a political perspective external events (the Port Arthur shootings, a spate of fatal shootings of people with mental illness by police and the Prime Minister’s interest in suicide prevention) galvanised the government to support the Health Minister.

While it was decided that the Coalition government would support national mental health reform through a commitment to a second National Mental Health Plan, politically it needed to ‘brand’ the second plan so it could be distinguished from the reform agenda initiated by the previous Labor government. Dr Wooldridge developed a strategy for this which was consistent with his view about the limitations of the first Plan (and essentially served as an alignment of Kingdon’s politics stream with the problem and policy streams). There was a change in the focus of Commonwealth activities from severe mental illness toward more common mental disorders such as anxiety and depression, in response to the evidence showing the high prevalence and burden of this group of disorders. The focus also shifted from specialist mental health services (a State and Territory government responsibility) to primary mental health care (general practice), an area of Commonwealth government responsibility where the more prevalent mental disorders were treated. Ian Hickie (key informant interview) saw the Commonwealth focus on general practice and primary care as complementing the State and Territory focus on community mental health services.

Dermot Casey (key informant interview) recalled Dr Wooldridge started using the phrase ‘mental illness is not them, it is us’ which received wide media coverage. This phrase was seen to symbolise the change in focus from severe mental illness (e.g. psychosis) which were difficult for the general population to understand to anxiety and depression, common disorders with which the community could more easily identify. This change, and the emphasis on mental health
promotion, illness prevention and suicide prevention, was used to distinguish Coalition mental health policy from the previous Labor mental health policy. Prominent NGOs were becoming more active and supportive of mental health, including mainstream organisations which would not have previously aligned themselves with mental health; an example of this is Rotary Health Research which adopted mental health as a key area to support from 1995 (D. Casey, key informant interview).

In the 1997-98 Commonwealth Budget, funding was provided to:

- maintain the momentum of mental health reform under the National Mental Health Strategy (NMHS) ... while the current NMHS does not cease until June 1998, the Federal Government has allocated funds in the 1997-98 financial year to enable developmental work to precede implementation of the Commonwealth's continued participation in the NMHS (Department of Health and Family Services 1997a)

On 30 July 1998 Commonwealth, State and Territory health ministers formally endorsed the Second National Mental Health Plan 1998–2003. As noted above, the stated intention was to continue the reforms of the first plan and to broaden the reform context in three further priority areas for reform, promotion/prevention; the development of partnerships in service reform; and the quality and effectiveness of service delivery (Australian Health Ministers 1998, 6). Mental health was included as part of the Australian Healthcare Agreements 1998-2003 with specific funding provided (in Schedule G) to implement the second plan as it applied to the relevant State or Territory. However the areas specified for action were very general and there was no requirement that each State and Territory maintain its own financial effort in mental health, as there had been in the previous Medicare Agreements. Each State and Territory was required to provide data to the Commonwealth on its mental health programs for national reporting purposes. My view generally considered to be correct by stakeholders in the mental health sector and several key informants (Buckingham, D. Casey, Hickie) was that the Australian Healthcare Agreements 1998-2003 greatly reduced the capacity of the Commonwealth to influence State and Territory reforms, resulting loss...
of national focus within the activities undertaken by each State and Territory.


Although the stated intention was to continue the reforms of the first plan while broadening the reform to encompass the three priority areas of mental health promotion and illness prevention, development of partnerships in service reform and service quality and effectiveness was different in reality. Much more of the Commonwealth effort focussed on areas related to its jurisdictional health responsibilities than had been the case with the first plan. The States and Territories attempted to broaden the scope of their areas of mental health activity as required by the second plan.

Under the first plan, there was some attention to community education, focused largely on increasing public awareness of the extent of mental illness and promoting destigmatisation. This was greatly expanded under the second plan (Australian Health Ministers 1998, 12). One of the policy initiatives of the Commonwealth and Victorian governments, later supported by other State and Territory governments, was to establish the organisation beyondblue: the national depression initiative (beyondblue The National Depression Initiative 2013, Hickie 2002). It was founded in October 2000 with initial support from the Commonwealth and Victorian governments, with other State and Territory governments providing financial support in the years after its establishment. One of the aims of beyondblue was to increase the community awareness of depression and to promote a reduction in stigma associated with depression and related disorders. With prominent former Victorian premier Jeff Kennett as Chairman the organisation achieved a high profile and there is good evidence for its effectiveness in its work for advocacy and promoting policy solutions (Highet et al. 2006, Jorm, Christensen and Griffiths 2006). There were many other initiatives in this area, for example StigmaWatch, launched by the non-government organisation SANE Australia (SANE Australia n.d.) to
monitor and report on inaccurate or discriminatory references to mental illness in the Australian media. The increasing willingness of public figures including former politicians, sporting identities, media, film and television personalities to identify with and advocate for mental health issues both represented and facilitated progress in reducing the stigma associated with mental illness.

The Commonwealth government responded to the concern among the consumer and carer community that, with the first plan and the term of the NCAG ending in 1998, that the mental health sector would not have a peak national organisation. In 1997 the Commonwealth government replaced NCAG with the MHCA (MHCA 2013) which had the remit of providing a national voice for a larger number of stakeholders with experience of, or an interest in, mental health issues (Department of Health and Family Services 1997b, Wooldridge 1997, Graham 1999). Michael Wooldridge specifically requested that the council be created with a membership representing not only consumers and carers but also professional organisations active in mental health. The intent was to have a body which could speak with one voice in areas related to mental health policy. Despite initial scepticism, including from myself, that the sector would be able to come to an agreed policy position on the topics being considered, the council did become an effective advocacy and advice body for mental health in Australia.

The first meeting of the interim council board was held on 26 November 1997. The first chair of the MHCA was John McGrath, the former Victorian State Member for Warrnambool who is widely acknowledged today as being responsible for the MHCA being able to function as an effective body. There were two consumer and two carer representatives from each State/Territory community mental health advisory group and two from the National Mental Health Consumer Network. In addition there were individuals representing psychiatry, psychology, general practice, occupational therapy, mental health nursing and social work, plus representatives from non-government service providers and special needs groups including Indigenous and
culturally diverse communities. Another ex-politician, the former Western Australian Health Minister, Keith Wilson, became the chair of the MHCA, replacing Mr McGrath in November 2002.

Consumer and carer representation continued in State and Territory mental health services, as required under the first plan and by 2002, 77% of service delivery organisations had a formal mechanism for consumer representation on local decision making and advisory bodies. Progress had been slower than expected and all jurisdictions re-committed to implementing this reform during the period of the Australian Health Care Agreements 2003-08 (Department of Health and Ageing 2004, 33).

Suicide continued to be a high profile public issue due in part to annual documentation by the ABS of the rise in suicides (ABS 2000). Commonwealth Health Minister Michael Wooldridge released the National Action Plan for Suicide Prevention in 1999 (Wooldridge 1999) which expanded the 1995 National Youth Suicide Prevention Plan into a National Suicide Prevention Strategy covering all age groups (Martin and Page 2009, 28-9).

As noted earlier, all governments were required to expand the scope of mental health reform. There was no specific national action on Indigenous mental health issues arising from the first National Mental Health Plan. Following the Royal Commission into Aboriginal Deaths in Custody (1991), the Burdekin Report (HREOC 1993) and Ways Forward, the landmark report by Swan and Raphael in 1995 (Swan and Raphael 1995) Indigenous mental health began to receive more policy attention. The Commonwealth government developed an Emotional and Social Wellbeing (Mental Health) Action Plan (Department of Health and Family Services Social Health Reference Group 1996) which was launched by Michael Wooldridge, in October 1996, during Mental Health Week with $20 million allocated to improve the mental health status of Indigenous Australians (NATSIHC 2003, NATSIHC SHRG and AHMAC NMHWG 2004).

Attention was also paid to services for people from a non-English speaking background, with the Commonwealth government establishing
the Australian Transcultural Mental Health Network (now called Multicultural Mental Health Australia) in 1995. The aim of the network was to provide support for State and Territory transcultural mental health centres and improve mental health outcomes for people using those services. Multicultural Mental Health Australia now links a wide range of State and Territory mental health specialists and services, advocacy groups and tertiary institutions to promote the mental health and wellbeing of Australia's diverse communities (Mental Health in Multicultural Australia 2012).

In line with the emphasis on promotion, prevention and early intervention, there were many initiatives including support for the Early Psychosis Prevention and Intervention Centre, with the launch of the Australian clinical guidelines for early psychosis (EPPIC n.d.) and the establishment of a national early intervention initiative, AusEInet (Australian Network for Promotion Prevention and Early Intervention for Mental Health n.d.).

The Commonwealth government co-funded the Strategic Planning Group on Private Psychiatric Services in 1996 (in 2007 renamed the Private Mental Health Alliance) which became the vehicle to coordinate private sector reform (Whiteford, Buckingham and Manderscheid 2002). The secretariat for the Group was provided by the AMA and, in addition to the AMA, the members were the RANZCP, Australian Private Hospitals Association, Australian Health Insurance Association, Commonwealth Department of Health and Ageing, Department of Veterans' Affairs and the Private Mental Health Consumer and Carer Network. The aim was to address issues related to funding, classification, quality of care, outcome measurement, consumer and carer participation, and related topics as they affected the private mental health sector.

In June 1999, the Commonwealth government established a national primary mental health care initiative to provide education and skills-based training in mental health for general practitioners (Whiteford 2008). The first major reform under this initiative came when the Commonwealth government provided $120.4 million over four years in
the 2001-02 Budget for the 'Better Outcomes in Mental Health Care' program (Department of Health and Ageing 2011, Hickie and Groom 2002). Its key components included a network of State-based mental health development and liaison officers supported by a national coordinator based at the headquarters of the Australian Divisions of General Practice (ADGP) in Canberra and a resource centre at Flinders University in South Australia. The network supported mental health programs in divisions of general practice including education and training programs. Financial incentives for general practitioners were introduced in the 2001-02 Commonwealth Budget. These were in response to complaints commonly expressed by general practitioners, such as the unmet need for relevant training, access to allied and specialist support and improved remuneration for the time spent on mental health consultations. The 2005-06 Commonwealth Budget continued this program, and included new funding of $42.6 million over five years to expand it. The key components of the initiative (Australian Divisions of General Practice 2005, Pirkis et al. 2006) were education and training for general practitioners; remuneration for a specific (3 Step Mental Health Process) of assessment, planning and review; remuneration for general practitioners to provide psychological therapies; increased access to Allied Health Services; and increased access to psychiatrist advice. Formal structures were established between groups such as ADGP, beyondblue, MHCA, RACGP, RANZCP, the Australian Psychological Society, the Rural Doctors' Association of Australia, AMA, and the Commonwealth Department of Health and Aged Care (Hickie and Groom 2002) to progress these reforms.

In November 2000 the National Mental Health Promotion, Prevention and Early Intervention Action Plan was launched (Department of Health and Aged Care 2000) which provided the strategic framework agreed by the Commonwealth, State and Territory governments for action in mental health promotion, illness prevention and early recognition and intervention.

National practice standards for mental health clinicians were
developed under the second plan (NMHETAG, NETINMHT and National Mental Health Strategy 2002). In February 1999 the Commonwealth government released a report identifying mental health nursing, occupational therapy, psychiatry, psychology and social work as the key mental health professional groups. During a series of workshops involving these professions, common ground between all five disciplines working in the mental health sector was established and collaboration proposed between the higher education sector, the Commonwealth, State and Territory governments and the professional associations to train clinicians to agreed standards (Deakin Human Services 1999). These standards, released in 2002, identified the attitudes, knowledge and skills needed by the key mental health professional groups (NMHETAG, NETINMHT and National Mental Health Strategy 2002).

The RANZCP was commissioned to develop clinical practice guidelines that described the optimal treatment for six major mental disorders: anorexia nervosa, bipolar disorder, depression, panic disorder and agoraphobia, and schizophrenia; deliberate self-harm was also included. For each disorder or condition, two guidelines were developed, one for consumers and carers, and another for clinicians; these were released in 2003 (RANZCP n.d.). There is some indication that both versions were found to be useful (Codyre et al. 2008, Killackey 2008).

The establishment of a mental health work program within the AIHW in 1995 was considered an important initiative in mental health data development. Through its national role in health information management, the AIHW had the capacity to coordinate the development and implementation of a national minimum data set (NMDS) for mental health care in both institutional and community settings (Briggs 1999).

In 1999 all State and Territory governments agreed to implement a mental health information development agenda (Eagar, Burgess and Buckingham 2000). That agenda was outlined with the publication of the document, Mental Health Information Development: National Information Priorities and Strategies under the second plan (Briggs 1999). It committed all State and Territory governments to collect
information about the cost, quality and outcomes of Australia’s mental health services. Outcomes, accountability and key performance indicators were considered important to the process of monitoring and improving the quality of mental health services (MHCA 2006, Performance Indicator Drafting Group 2005, Burgess, Pirkis and Coombs 2006). $38 million was offered to the State and Territory governments by the Commonwealth government through Information Development Agreements. These agreements acted as sub-agreements under the Australian Health Care Agreements, but provided much greater attention to detailing the specific requirements of States and Territories (Buckingham, key informant interview).

A key element of the Commonwealth/State Information Development Agreements was development of information infrastructure and workforce skills to support consumer outcome measurement. The National Outcomes and Casemix Collection was established in 2003 (Pirkis et al. 2005) to measure changes over time in the health status of a consumer of a mental health service. This included both clinician and consumer-rated measures. The collection was introduced across all public mental health services in Australia in the 2003/04 year and is a key performance indicator based on the National Health Performance Framework which became linked to the strategic directions of the third plan. Australia’s steps to implement routine outcome measurement in mental health services became recognised internationally as leading developments in this area (Buckingham, key informant interview).

With respect to service reform the Commonwealth government trialled mental health integration projects as a way of integrating private psychiatry and public sector mental health services to create a more flexible integrated framework in which mental health care could be delivered (Eagar et al. 1999). These trials did not lead to any long term change to mental health service delivery between the private and public sectors.

There were very few Commonwealth government initiatives targeting those people with severe mental illness who had been the
focus of the first plan. One exception was attention to people with mental illness who had been involved with the criminal justice system and treated in forensic mental health services. Patients of these services were highly visible in the media, and this was one area where the public saw the provision of services as a means of enhancing public safety. The Commonwealth government funded the development of a national approach to forensic mental health which was released early in 2000 and essentially served as a tool for discussion and planning for good practice (Briggs 1999). No resources were allocated.

4. Conclusion

The opening of the policy window in 1998 was the result of a convergence of factors. Unlike the 1992 policy window, the ending of the first Plan required the Commonwealth government to formally consider its position on involvement in the reform process. There was a growing backlash among stakeholders regarding the narrow focus of the first plan on severe mental illness. They were advocating for a broader focus on a wider range of mental disorders and a move to mental health promotion, illness prevention and early intervention.

New information became available from epidemiology and related research confirming the high prevalence and high burden (premature mortality and disability) from common mental disorders which supported the need for a broadening of the policy scope. Further, evidence emerged at this time about the low treatment rates of common mental disorders. Most of these disorders were treated in general practice (primary mental health care), an area for which the Commonwealth had policy responsibility. There was evidence suggesting a need for improving the capacity of general practitioners in the diagnosis and treatment of mental disorders.

While in the 1996 and 1997 Commonwealth budgets expenditure on programs was reduced, the 1998 budget provided the funding for the new Health Care Agreements which would cover the five year period 1998 to 2003. Continued Commonwealth government spending on
mental health for this period was achieved with the efforts of the Health Minister Michael Wooldridge who, for technical and personal reasons, took the view that the Commonwealth government should remain involved in mental health reform and made the case to his colleagues.

External factors were also crucial in securing political support within government. Responding to the tragedy of suicide was an issue strongly supported by the Prime Minister. The Port Arthur shootings, although resulting in a policy response based on gun control, was seen to have implications for mental health services, given the perception that violence in the community and mental illness were related. Withdrawing government support from national mental health reform following the Port Arthur shootings was not considered to be politically defensible.

Dr Wooldridge developed a policy direction within mental health that encompassed a broader population health focus and emphasised the role of primary care. This approach was supported by stakeholder advocacy and scientific evidence and also allowed the Coalition government an approach that distinguished it from that of the previous Labor government.

Despite the rhetoric that the Second National Mental Health Plan would also continue to drive the reforms started during the first Plan (the treatment and care of those with severe mental illness), the momentum in this area waned. The emphasis shifted to primary mental health care and promotion and illness prevention, areas for which the Commonwealth had jurisdictional health responsibilities. The States and Territories for their part attempted to broaden the scope of their areas of mental health activity as required by the Second plan with varying degrees of enthusiasm.
CHAPTER 8 - the COAG national mental health action plan in 2006

In this chapter I focus on the years 2003 to 2008 and identify the issues that led the Howard Coalition government to adopt the Council of Australian Governments’ (COAG) *National Action Plan on Mental Health* in 2006, two years before the end of the third National Mental Health Plan (2003-08) endorsed by Australian Health Ministers.

Policy cycles in a particular area are characterised by repeated attempts to resolve a particular problem that remains at best, only partially resolved. These attempts are often accompanied by a change in the way the problem is conceptualised, as justification for novel policy solutions. As policy windows open and close over time the costs of adopting innovative solutions can contribute to a corresponding if inadvertent neglect of those areas that had been the focus of earlier efforts. In chronically underfunded systems maintaining a delicate fiscal balance, reformist planning is vulnerable to being overtaken by events, triggering another cyclical return to crisis management that policy was meant to forestall, thus demonstrating the need for the next policy cycle to refocus on neglected fundamentals. This is what happened in mental health.

Before 2006, mental health reform had been progressed through the national meetings of Health Ministers and their subordinate committees. The Australian Health Minister’s Conferences endorsed the National Mental Health Policies and Plans ‘subject to Commonwealth financial contribution’ in 1992, 1998 and 2003. Meanwhile, the meetings held by first Ministers (the Prime Minister, Premiers and Chief Ministers) from 1992 onward had become known as the Council of Australian Governments (COAG). COAG meetings superseded the series of ad hoc Special Premiers’ Conferences that began in October 1990. In the early years of the Howard Liberal-National Coalition government (1996-2007), COAG was little used as a mechanism for intergovernmental action, perhaps because of its association with Keating and Labor, as well as its
acceptance of the States as collaborative participants (Parkin and Anderson 2007). In the later years of the Howard government, COAG was increasingly used to address and manage a number of national issues, including counter-terrorism, water trading and management, energy regulation and a range of health issues. By 2006, the exigencies of events dictated that mental health policy reform could no longer be left solely with Health Ministers, but must become a matter for COAG, leading to the adoption of the COAG National Action Plan on Mental Health in 2006, two years before the end of the third plan.

The evaluation of the second National Mental Health Plan (1998 to 2003) noted that the broadening of the reform agenda to a wider spectrum of interventions including mental health promotion, illness prevention, early intervention and primary mental health care had lost the focus on services for those with more severe illnesses (Thornicroft and Betts 2002). Community consultations in particular revealed a high level of dissatisfaction with services for these patients. Progress on the reform areas started during the first plan had stalled, constrained by the low level of resources available and variability in degrees of commitment to ongoing reform among the State and Territory governments. This loss of momentum resulted in a provider and community backlash.

In the eighth year of the Howard Coalition government at the Commonwealth level, Health Ministers adopted the third National Mental Health Plan (2003–08). The content of this plan was essentially to continue the promotion, prevention and primary mental health care reform agenda of the second plan while emphasising the need to address the unfinished reform agenda of the first plan. In my analysis I found that the adoption of the third plan by Health Ministers did not meet the definition of a ‘policy window’ in the thesis, that is, an opportunity to make a case for change. The decision to consider ongoing reform was mandated by the end of the second plan and there was a consensus among governments that a third plan was needed. The content of the third plan was largely a continuation of the reform progressed in the second plan.
However just as the third plan was starting, issues were emerging that coalesced and developed political momentum to the extent that mental health became an issue of vital concern to heads of governments, to be considered at the COAG meeting of 14 July 2006. This chapter describes the issues and circumstances that led to mental health reaching the threshold of political necessity required to attain a place on the COAG agenda, and then to the development of the COAG National Action Plan on Mental Health which ultimately superseded the third plan.

As in Chapter 6 and Chapter 7, I use the themes identified in Chapter 4, human rights and community attitudes; community need; service structure; service quality and effectiveness; and resources as an organising framework to assemble the problems described in the literature and policy responses proposed in the lead up to 2003.

1. Themes

1.1 Human rights and community attitudes

Problem areas

I identified two main problem areas in the data sources from the literature review that coded to this theme – a re-emergence of human rights concerns and the need for involvement of consumers and carers in service delivery.

(a) Re-emergence of human rights

Despite years of reform, problems in the area of human rights continued to be reported in Australia’s mental health system. Whilst human rights had been a major focus of the first plan, it had not been a prominent issue during the second plan. However, stigma and discrimination, along with insufficient resources and inadequate facilities, were still causing concern 13 years after they were identified in the Burdekin HREOC report (MHCA, BMRI and HREOC 2005,


Systemic failures to protect the rights of people with mental illness were reported, and attributed not only to the health sector but also to sectors such as employment, education, housing welfare and immigration (Senate Select Committee on Mental Health 2006b). The immigration system came to represent a particular problem area. People detained within the immigration system were considered to have been denied rights provided to other incarcerated individuals such as those convicted of crimes and serving custodial sentences (Freckelton 2005, McSherry 2005, Ozdowski 2004). Children in immigration detention were found to be at particularly high risk of serious mental harm.

(b) Consumer and Carer involvement in services


Policy responses

The Human Rights and Equal Opportunity Commission (HREOC), which had been less involved in mental health after the 1992 Burdekin Report on the national inquiry into the human rights of people with mental illness (HREOC 1993), became active in the area again. Dr Sev Ozdowski was the Australian Human Rights Commissioner and Disability Discrimination Commissioner from 2000 to 2005. In May 2004 he released the nine hundred page report *A Last Resort? National Inquiry into Children in Immigration Detention* (HREOC 2004). The MHCA, with the assistance of Dr Ozdowski, undertook a review of mental health services and related social supports (Hickie et al. 2005). The resulting thousand page report, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia* (MHCA, BMRI and HREOC 2005), urged a renewed focus on the human rights of people with mental illness. While the application of the
Rights Analysis Instrument described in Chapter 6 to all Australian mental health legislation had taken an important step towards quality assurance in mental health services by identifying gaps and best practices (Watchirs 2000, Watchirs 2005), The Human Rights Commissioner found that further progress, especially a change in attitudes and culture in human services, would be necessary in order to prevent breaches of human rights of persons with mental illness (Ozdowski 2004).

Activists and experts proposed that stigma and discrimination be addressed by encouraging more responsible media reporting of mental illness and population-based mental health promotion via established organisations such as beyondblue and SANE (Carr, Halpin and Low Prevalence Disorders Study Group 2002, Francis et al. 2001, Groom, Hickie and Davenport 2003, MHCA, BMRI and HREOC 2005, SANE Australia 2003, Chiroiu 2003, Haikerwal et al. 2005, Hickie 2000, 2004, Hickie et al. 2005, Jorm, Christensen and Griffths 2005, Kennett 2005, Stacey and Herron 2002). They suggested that community education campaigns should focus on reducing the disparity between public and political perceptions of ‘health’ and ‘mental health’ (Hickie and Groom 2002, Kennett 2006), and recommended that governments increase their commitment to consumer and carer participation through implementation of formal mechanisms to ensure their role in matters of service planning, delivery and policy (McGrath 2002, Townsend et al. 2006).

1.2 Community Need

Problem areas

I identified two main problem areas in the data sources from the literature review that coded to this theme – economic and social needs of consumers and the need for priority to be given to people with severe mental illness.
(a) Economic and social needs

Epidemiological studies such as the adult, children and adolescents, and people with 'low prevalence' (psychotic) disorders components of the 1997-98 National Survey of Mental Health and Wellbeing demonstrated the high prevalence and low treatment rates for mental disorders (ABS 1998, Jablensky et al. 1999, Sawyer et al. 2001) while the Australian Burden of Disease Study (Mathers, Vos and Stevenson 1999) confirmed the high level of disability caused by mental disorders. Researchers and advocates continued to emphasise the high prevalence and significant disability caused by mental disorders. They reported on the economic and social costs of mental illness as well (Andrews and Tolkien II Team 2006, Burgess et al. 2002, Butterworth and Berry 2004, McGorry 2005, Pirkis et al. 2006, Sanderson et al. 2003, Vos and Mathers 2000), and advocates used their findings, especially the data on suicide, high rates of homelessness, prolonged unemployment, incarceration or increased financial burden and poverty (MHCA 2006, MHCA, BMRI and HREOC 2005, SANE Australia 2003, 2004).

The impact of the high prevalence of mental disorders in terms of labour productivity was at the forefront of these discussions (MHCA 2006, Butterworth and Berry 2004, McGorry 2005, Waghorn and Lloyd 2005) and the increasing recognition that the economic burden of mental illness, in terms of lost productivity, had been a key factor in spurring action in a number of countries (Saxena et al. 2007). The case for investment was made stronger by evidence (Wang et al. 2007) for a positive economic return on investing in treatment of mental disorders (Rosenberg, Hickie and Mendoza 2009):
The 2006 [Australian] National Action Plan on Mental Health was inspired not merely by health concerns but also by economic factors. Numerous reports have detailed the negative impact on the Australian economy wrought by mental illness.

(b) Focus on people with severe disorders and social disadvantage

One of the main targets of the second plan, low population treatment rates for common mental disorders, remained of concern. Unmet need in primary care due to failure to recognise and treat mental disorders continued to be reported as problematic (Caldwell et al. 2004, Hickie et al. 2001). However, along with the refocus of attention on human rights, there re-emerged a focus on the significant disability and unmet needs of those with more severe disorders who were the most socially disadvantaged (Harvey et al. 2002). Even the best services were shown to fail to meet the needs of those with complex problems unless there was close cooperation with housing, welfare and disability support services (Harvey et al. 2002). The mental health needs of sub-populations, such as asylum seeker detainees, particularly children and adolescents, was becoming a prominent issue (HREOC 2004, Palmer 2005, Ozdowski 2004).

Policy responses

Policy responses were to refocus attention in the areas of service reform, especially to those with more severe illness as described in the service structure theme 1.3 below, but also to those being treated in primary care.

In the area of primary care, where most people with common mental disorders were treated, many including myself argued for improving access to services by to enhancing the successful Better Outcomes in Mental Health Care initiative
(Haikerwal et al. 2005, Harrison and Britt 2004, McCormack and Thomas 2004). It was proposed that short term psychological therapies that had been shown to be cost effective (Mihalopoulos et al. 2005) be expanded and subsidised in the Medicare Benefits Schedule. This policy proposal was recommended by mid-term reviewers of the second plan (Betts and Thornicroft 2001, 5-6), professional organisations (Senate Select Committee on Mental Health 2006b, 57,58,98-100,125,137), advocacy groups (MHCA 2006, 8, MHCA, BMRI and HREOC 2005, 177,342,802, SANE Australia 2004, 1), and the Senate Select Committee on Mental Health (Senate Select Committee on Mental Health 2006b, 6).

New service models that did not require face to face contact with a health professional were also proposed to improve access in a cost-effective way. Both e-health and tele-health initiatives represented potentially cost-effective vehicles for prevention, and could extend mental health services to difficult to reach populations e.g. people living in rural and remote areas (Andrews and Tolkien II Team 2006, Betts and Thornicroft 2001:13, Christensen, Griffiths and Evans 2002, Griffiths, Blomberg and Christensen 2003, Urbis Keys Young 2002, Hickie, Davenport and Luscombe 2006).


1.3 Service structure

Problem areas

I identified two main problem areas in the data sources from the literature review that coded to this theme – a lack of access to
services and the need to better coordinate services across sectors.

(a) Lack of access to services

Mental health services were characterised as functioning in ‘crisis mode’. Lack of access was identified as a major problem for both people with common mental disorders such as anxiety and depression as well as those with severe mental illness, such as psychoses, who were unable to find hospital beds when requiring emergency treatment (although the latter was rarely clearly quantified). What was quantified however was that acute hospital units were overburdened with people suffering from chronic disorders who could not be discharged because community services were unavailable (Andrews and Tolkien II Team 2006, Betts and Thornicroft 2001:17, SANE Australia 2003, Andrews 2005, Griffiths 2006, Newman 2005, Rey, Walter and Giuffrida 2004, Townsend et al. 2006, Woodruff 2006). Community treatment options, particularly residential services with links to clinical support were inadequate in the wake of de-institutionalisation (Betts and Thornicroft 2001:12, Groom, Hickie and Davenport 2003, MHCA, BMRI and HREOC 2005, Steering Committee for the Evaluation of the Second Plan 2003, Newman 2005, Ozdowski 2005, Savy 2005, Smith and Gridley 2006, Woodruff 2006).

The same problems that had been the target of the 1992 policy response in the first plan - de-institutionalisation without adequate community care resulting in a new form of institutionalisation, homelessness and imprisonment – were again becoming prominent (New South Wales Legislative Council Select Committee on Mental Health 2002, xv, Griffiths 2006, Hickie et al. 2005, Savy 2005, White and Whiteford 2006). Many including
myself were concerned that prisons were becoming de facto psychiatric institutions (Griffiths 2006, Hickie et al. 2005, Ozdowski 2005, Savy 2005, White and Whiteford 2006).

Crisis response services were only sufficient to intervene in the most severe situations, and were not able to respond to those needing early relapse response or ongoing treatment and support (Betts and Thornicroft 2001:17). There were no coherent national strategies covering key issues such as dual diagnosis, rehabilitation, supported accommodation, and education and training for families and carers (Teesson and Byrnes 2001).

(b) Intersectoral service coordination

Whilst some advances had been made in forming intersectoral partnerships to address consumers' needs, the complexity of the system continued to create barriers to continuity of care, and intersectoral collaboration had not developed in a systematic or coordinated fashion (AICAFMHA 2001, AICAFMHA 2004, Steering Committee for the Evaluation of the Second Plan 2003, Townsend et al. 2006, Waghorn and Lloyd 2005, Waghorn et al. 2004).

There continued to be concerns about integration within health services, particularly between hospital and community mental health services, for example follow-up care in the community following an acute inpatient episode of care, and between different parts of the health service, for example between mental health and substance abuse services (Steering Committee for the Evaluation of the Second Plan 2003, Teesson and Byrnes 2001, Ozdowski 2005, Woodruff 2006).

Service coordination between the health sector and other human services, despite the focus on intersectoral
linkages described in Chapter 5, had not been successfully implemented. A ‘silo’ mentality continued to exist within government departments at the Commonwealth and State/Territory level (e.g. mental health, health, housing, education, disability, geriatrics, child and family services) (Betts and Thornicroft 2001:12). Little was known regarding the factors which promote or inhibit intersectoral collaboration (St Vincent’s Mental Health Service (Melbourne) and Craze Lateral Solutions 2005). There were persistent reports of fundamental service failures by disorganised and dislocated health and welfare systems, and a lack of coordination between welfare, housing, mental health, health, education, employment, disability, police, and emergency care services (Betts and Thornicroft 2001:12, MHCA, BMRI and HREOC 2005, SANE Australia 2003).

These failures were attributed to fragmented governance, funding and service delivery models (Callaly and Fletcher 2005, Townsend et al. 2006). There was relatively little emphasis on the psychosocial components of mental illness and recovery/rehabilitation typically provided by the psychiatric disability support sector (Harvey et al. 2002) which from this period onwards assumed a greater focus in mental health reform.

The failure of intersectoral service linkages was summarised as follows by Waghorn and Lloyd (2005):

Australia has a national mental health strategy which guides on-going reform of mental health services. This strategy recognises the challenge of inter-sectoral [variant spellings SIC] difficulties in terms of disability support, education, housing, and employment. However, the intersectoral collaborations called for by the strategy have not been adequately evaluated. This is probably because no such collaborations appear to have materialised, even though these are recognised as essential to address the social and economic
marginalisation of people with mental illness ...

The lack of inter-sectoral collaboration in Australia exacerbates the structural division of public mental health services from other key sectors such as housing and employment. This in turn obstructs inter-sectoral policy development as well as the coordination and delivery of mental health and vocational services.

Woodruff similarly commented that lack of coordination of services was exacerbating existing problems (2006):

The reasons above are complex but at one level they include the inadequate community support following de-institutionalisation, uncoordinated primary care, inadequate resourcing of public hospitals including a lack of psychiatric beds, and a lack of appreciation of non-medical factors contributing to the problems ... In addition however, there is a desperate need to co-ordinate Federal, State, and Local government initiatives, not just with respect to health spending but also to all the other areas which contribute to the terrible burden of mental ill-health such as welfare payments and housing.

Rey and colleagues (2004) emphasised that it was not the National Mental Health Strategy policy directions that were the problem but rather:

Implementation of the [National Mental Health] Strategy needs revision; the fact that after 10 years psychiatrists perceive that the quality of mental health care in Australia is not improving cannot be ignored. Policy, even good policy, by itself does not necessarily result in better clinical care.

**Policy responses**

For people with severe mental illness requiring specialist services, early intervention, particularly during early psychosis, was strongly identified as a strategy which could not only reduce the public health burden, but could do so cost-effectively (McGorry and Yung 2003). Other recommendations included that recovery-oriented services should be incorporated into all areas of routine practice, and that a fundamental reorientation to a more proactive

One typical media response to the 'crisis' in access to care for those with severe mental disorders was to recommend more inpatient beds be provided. Some experts criticised this commonly-proposed solution, however, noting that up to 40% of patients in acute mental health facilities could be safely discharged from hospital if adequate community based services and supports were available to them (MHCA 2006, Hickie et al. 2005). Accommodation, rehabilitation, outreach and other forms of community support were generally supplied by NGOs which received around five% of the mental health budget nationally. This was considered an inadequate proportion as NGOs and families had taken on most of the burden of care after patients were discharged from hospital under deinstitutionalisation (SANE Australia 2003).

To improve services outside hospital required intersectoral coordination. Between 2004 and 2006, the MHCA advocated for a more coordinated service response from a range of Commonwealth government departments and agencies including the Department of Prime Minister and Cabinet (PM&C), Department of Health and Ageing, Department of Employment and Workplace Relations (DEWR), Department of Families, Community Services and Indigenous Affairs (FaCSIA) and Centrelink. Advocates argued that a whole of government social policy framework was necessary to solve the issues identified with housing, community support, and employment (MHCA, BMRI and HREOC 2005, SANE Australia 2003, Habibis 2005, Hickie et al. 2005).

Specific recommendations were made for special populations. For example it was suggested that the detainee population could be provided with much more effective mental
health care if psychiatrists’ visits were more frequent, and the number and deployment of mental health trained nurses, psychologists and primary practitioners were reconsidered (Palmer 2005). Structural modifications and greater flexibility were recommended avenues for governments to pursue in the improvement of mental health care to detainees (Palmer 2005).

1.4 Service quality and effectiveness

Problem areas

I identified two main problem areas in the data sources from the literature review that coded to this theme – the need to measure service quality and to measure service outcomes.

(a) Measuring service quality

Measurement and monitoring of service quality remained an ongoing challenge for the complex systems that comprised mental health care, largely due to the lack of consensus regarding how performance measurement concepts should be applied to mental health care, and variable implementation by State and Territory governments (Performance Indicator Drafting Group 2005, Steering Committee for the Evaluation of the Second Plan 2003, Technical Specifications Drafting Group and AHMAC NMHWG Information Strategy Committee 2003). It was recognised that definitions of quality were imprecise, and estimates as to whether the services provided to patients had increased in number or quality were lacking (AHMAC NMHWG Information Strategy Committee 2005, Hickie, Groom and Davenport 2004).

Progress in implementing standards for mental health care had not met expectations, and had been introduced in an ad hoc manner (Betts and Thornicroft 2003).
Despite developments in mental health data collection, it was not possible to monitor changes over time in the mental health of the Australian population, or in levels of unmet need (Steering Committee for the Evaluation of the Second Plan 2003). It was widely agreed that existing mental health information systems remained underdeveloped (Performance Indicator Drafting Group 2005, Steering Committee for the Evaluation of the Second Plan 2003, Richmond and Savy 2005).

(b) Measuring service outcomes

Australia was relying on models of care without accountability for stipulated outcomes (Betts and Thornicroft 2001, 13). There was a lack of consensus regarding the routine use of appropriate outcomes measures, which was only just beginning to occur in practice (Betts and Thornicroft 2001, 13, Hughes 2006). Similarly there was concern that the long-term outcomes of promotion/prevention programs had not been evaluated properly (AICAFMHA 2001, 2004, Mitchell 2000a).

Service quality, accountability and transparency as well as coordination and linkages between them were considered to be lacking in sectors other than health, most notably within immigration detention, when dealing with people with mental health problems (Betts and Thornicroft 2001, 12, Palmer 2005, Senate Select Committee on Mental Health 2006b, 235).

Policy responses

Major recommendations for improving service quality included better education for the mental health workforce regarding evidence based medicine (Andrews and Tolkien II Team 2006,
Web-based education was considered a cost effective method for educating the broader workforce (Andrews and Tolkien II Team 2006). Education strategies had particular relevance to the primary care sector, given the pivotal role of general practitioners in managing mental disorders (Mental Health and Special Programs Branch 2000d).

Following similar reforms in the general health sector, governments were encouraged to implement a range of mental health service quality strategies including: (1) development of, and reporting against quality indicators; (2) consumer and carer participation initiatives; (3) quality accreditation using continuous quality improvement; (4) safety strategies; (5) workforce development including leadership development; and (6) evidence based practice (AHMAC NMHWG 2005, AHMAC NMHWG Information Strategy Committee 2005, Briggs 1999, Eagar, Burgess and Buckingham 2000, NMHETAG, National Education and Training Initiative and National Mental Health Strategy 2002, Palmer 2005, Performance Indicator Drafting Group 2005, Pirkis et al. 1999, Technical Specifications Drafting Group and AHMAC NMHWG Information Strategy Committee 2003, Burgess, Pirkis and Coombs 2006).

1.5 Resources

Problem areas

I identified two main problem areas in the data sources from the literature review that coded to this theme – insufficient resources and problems in the financing mechanisms.

(a) Insufficient resources

Insufficient financial resources continued to be reported. Advocates pointed out that, although mental illness was the
third largest contributor to the total disease burden, and
the largest overall cause of disability, it was only the 7th
ranked disease area by expenditure in Australia, i.e.
implying funding for mental health in Australia was not
commensurate with the magnitude of the disease burden
(Hickie, Groom and Davenport 2004, MHCA 2006, Griffiths
2006, Haikerwal et al. 2005). Whilst resourcing for mental
health had increased steadily over the previous ten years,
this expenditure had risen no faster than health
expenditure in general, suggesting that, proportionally, the
National Mental Health Strategy had not resulted in an
increased level of health sector resources as was required
to address the level of unmet need for services and disease
burden (Steering Committee for the Evaluation of the
Second Plan 2003). Commentators did not attribute service
‘failures’ to a lack of clear and appropriate policy directions,
but rather to insufficient investment and commitment
(Steering Committee 2003).

Insufficient human resources were also identified as
a problem. Serious workforce shortages across all mental
health professional groups was hindering the ability of
government and non-government providers to meet the
increasing demand for services (Betts and Thornicroft

(b) Financing mechanisms

Multiple funding sources for mental health services had
created duplication and gaps, opportunities for cost-
shifting, and tensions between public and private sector
services and providers (Eagar et al. 2005, Townsend et al.
2006). The funding split between the Commonwealth and
State/Territory governments for different forms of
community services, including the social support services

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delivered by non-government agencies had resulted in poor intersectoral coordination and was a source of frustration for consumers (SANE Australia 2003, Eagar et al. 2005, Townsend et al. 2006). Callaly and Fletcher argued that better alignment of Commonwealth and State/Territory funding arrangements was needed to support the delivery of more integrated health care (2005).

Policy responses

There was a general consensus that funding for mental health services should be allocated on the basis of population need (Burgess et al. 2002). In his Tolkien II report prominent academic Gavin Andrews (2006) proposed that mental health services should (and could) be planned on the basis of need, and that this could be achieved in a cost-effective manner through a stepped-care service model (Andrews, Issakidis and Sanderson 2004). Policy makers, planners and clinicians were encouraged to take every opportunity to ensure that specialist resources were directed to those in greatest clinical need (Burgess et al. 2002, Rosen 2006).

evidence based, cost effective treatments exist for most mental disorders and that optimal treatment could avert a greater proportion of the burden of mental disorders for no additional investment (Andrews 2005, 2006, McGorry 2005).

Following the Mental Health Classification and Service Cost (MH-CASC) study (Buckingham et al. 1998) there was growing interest in answering the following important questions: who receives what services from whom, at what cost, and with what effect (Eagar, Burgess and Buckingham 2000, Chisholm 2005)? The development and implementation of a national model for the collection and analysis of aggregated and de-identified data based on a minimum data set and outcome measures was proposed (Morris-Yates and Strategic Planning Group for Private Psychiatric Services 2000).

To meet future workforce demands it was suggested that the number of funded places and financial incentives for accredited medical and allied health training courses should be increased (Betts and Thornicroft 2001, Senate Select Committee on Mental Health 2006a, 2006b). Workforce development initiatives to increase retention rates were also identified as critical (Betts and Thornicroft 2001).

Investment in new ways for the current workforce to deliver mental health services, such as new Medicare item numbers and innovative referral systems was suggested as a potential initiative for the improvement of linkages between the specialist and primary sectors (Betts and Thornicroft 2001, Mental Health and Special Programs Branch 2000d).

2. The Political Response and the opening of the policy window

That there had been some substantial changes in the mental health service system, in line with the directions of the National Mental Health Policy (James, K. Casey, Blackwood, Buckingham, Groves, Raphael, D.
Casey and Smyth, key informants interviews) during the time of the first and second plans was undeniable. Total government spending on mental health increased by 90% between 1993 and 2005, equivalent to $1.8 billion or $73 per person per year. Spending on mental health in 2005 was $3.9 billion, an 85% increase in real terms since 1993. Commonwealth government spending was $1.38 billion, State and Territory government spending totalled $2.38 billion and that of private health insurers $163 million. Mental health accounted for 6.8% of total national expenditure on health care and 7.3% of total government health spending nationally. However this proportion had not changed between 1993 and 2005, suggesting mental health spending had not increased as a proportion of total health expenditure (Department of Health and Ageing 2007).

Overall the number of hospital beds decreased. There was a 66% reduction in long stay beds in psychiatric hospitals between 1993 and 2005. By June 2005, beds located in these hospitals accounted for only 38% of Australia's total psychiatric inpatient capacity, compared with 73% in June 1993. Those beds remaining in psychiatric hospitals provided long term care to people with very severe and ongoing mental illness and those detained on forensic orders. The number of acute beds, almost all of them in general hospitals, increased (416 beds), but their availability remained relatively constant when population growth was taken into account (Department of Health and Ageing 2007).

While overall bed availability decreased, community services expanded significantly. Spending by State and Territory governments on community based mental health services increased by 185% or $777 million between 1993 and 2005. In 1993, 29% of State and Territory mental health spending was to provide services for people in the community. By 2005, the community share of total mental health expenditure had increased to 51%. The number of clinical staff providing community mental health care grew by 129%. While growth in the clinical workforce had not kept up with growth in spending, in 2005 there were 4,340 more health professionals employed in State and
Territory funded community mental health services than in 1993 (Department of Health and Ageing 2007).

By June 2005, 78% of State and Territory services in Australia had been reviewed to assess their compliance with the National Standards for Mental Health Services and over 90% had begun collecting and reporting consumer outcomes information. Whether these changes had actually improved the clinical outcomes for patients was still unknown (Department of Health and Ageing 2007).

The majority of the key informants held the view that the availability and distribution of services had increased during the time they were involved with or had observed mental health reform and this was supported by the quantitative data on increases in funding, community services and staffing, and the use of service standards and patient outcome measures. Nevertheless prominent advocates categorised the mental health system as being in crisis (MHCA 2006, MHCA, BMRI and HREOC 2005, Raphael 2000, SANE Australia 2004, Hickie and Groom 2002, Sanderson et al. 2003, Woodruff 2006). The problem areas presented by the stakeholders covered the spectrum of issues seen during the life of the National Mental Health Strategy but, as described in this chapter, the most prominent ones were very similar to those articulated in the years prior to 1992: concerns about the human rights and influence of consumers on service planning and delivery; a focus on services for those with severe mental illness including problems with the quality and outcomes of clinical services, access to acute mental health care; the supply of and coordination with housing and community support services; the lack of financial and human resources and the way in which financing was provided.

This led to understandable questions as to why the system could be in crisis, if there had been reform consistent with the agreed national policy direction. When considering this in 2005 I commented (Whiteford and Buckingham 2005):

Given the current disquiet about service delivery, has the direction of reform been the right one? Several evaluations of the Strategy, a recent review by the Canadian Senate and a prevailing view in
the mental health sector support the directions of the Mental Health Strategy...

The main criticism has been of a perceived failure to implement the policy directions of the Strategy. However the evidence ... indicates that the service system is being reformed in the agreed directions. While the development has been uneven, with disparities in funding and services continuing between the States and Territories, change in many areas has been substantial ...

The key question therefore is not whether national policy settings are incorrect, or whether policy directions have been implemented, but whether the pace and extent of change has been enough. There are indications that it has not.

Compared to 1992, consumers, carers and advocates had become much more active and vocal with greater expectations (Whiteford and Buckingham 2005). A decrease in stigma and better community education meant the longstanding and significant unmet need was being addressed as more individuals sought treatment. Commonwealth, State and Territory mental health programs were reporting increased demand for mental health care (Department of Health and Ageing 2004) with data showing a steady increase in overnight admissions to acute psychiatric units (AIHW 2004). In 2003 the MHCA released a report, Out of Hospital, Out of Mind detailing problems with mental health services in Australia in 2002 and recommending priorities for the National Mental Health Policy 2003-08, especially in the areas of community services (Groom, Hickie and Davenport 2003). This report was a forerunner of the advocacy to come.

The overwhelming view was that the reform momentum started with the first plan had been lost. One key informant (Hickie) commented that ‘the States dropped the ball’ with respect to maintaining the reform agenda and that the Commonwealth ‘pulled back to its area’ and was ‘no longer providing national leadership’ in the lead up to the COAG consideration of mental health. Another key informant (Smyth) commented that mental health had not been given the attention needed to fix growing problems in the services, another (K. Casey) recalled a leading consumer advocate saying the Commonwealth had ‘abandoned the real mentally ill’, while another (Groves) commented that the third
and fourth mental health plans had aspirations to be whole of government plans but in reality were only health plans. The view was summarised well by senior clinician and advocate Alan Rosen (Rosen 2006):

The effects of competition for limited resources between core mental health service delivery and the shift to a population-based public health approach (to prevention of mental illness and promotion of mental health), leaves our services vulnerable to doing neither particularly well. The recent loss of momentum of these reforms, due to failure of governments to continue to drive and fund them adequately, is causing the erosion of their considerable achievements.

Appendix 1 provides an overview of one example in a high profile area, police shootings of people with mental illness. Gains from reforms introduced in 1995 as indicated by fewer shootings were slow and uneven and were not sustained. Intractable problem areas such as this frustrated mental health consumers, carers and advocates. John Mendoza (key informant interview) identified the police shooting in New South Wales on 2 December 2004 of Thuong Lam, a person with schizophrenia as an event that drew attention to persistent concerns about the adequacy of community services, although in this case the Coroner found that the treatment that had been received by the deceased had been ‘appropriate at all relevant times’ (New South Wales State Coroner 2006, 96).

Prominent professor of psychiatry Gavin Andrews (2005) summarised the prevailing view, that most criticisms were directed at the services for those with severe mental illness in specialist public sector services:

How is it that Australia’s mental health services are in disarray? A Senate inquiry is mooted, and the press run stories of concern almost every week. Most of the stories are about failures in public-sector acute-care services that are the responsibility of the State and Territory governments.

The initial response of the Commonwealth government was to allocate responsibility for the inadequacies to State and Territory governments. At the release of the MHCA report Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia
(MHCA, BMRI and HREOC 2005) on 19 October 2005, the Commonwealth Minister for Health, Tony Abbott directed responsibility for the service failures at the State and Territory governments according to Hickie (key informant interview). Another key informant (Mendoza) described the States and Territories as being ‘in denial’ about the extent of the problems in their services.

The Howard Liberal-National Coalition government had been re-elected on 10 November 2001 and 9 October 2004 with the next election due in 2007. There was no specific mention of action to address mental health in the 2001 Coalition health policy and no clear electoral commitment for mental health reform (K. Casey, key informant interview), however there was a commitment in the 2004 health policy to increase funding for mental health care by $110 million over four years, with an emphasis on youth mental health, enhanced primary care and increased community awareness of mental disorders (Hickie et al. 2005). The Coalition government was seen to have strong credentials in economic management but had been criticised in a number of social policy areas and had been specifically attacked by the Opposition for a lack of attention to mental health (Gartrell n.d.):

> The Howard government has shown a complete lack of interest and leadership in the area of mental health. Health Minister Tony Abbott has shrugged off most of the responsibility for mental health services, saying it is a State responsibility. He has also said that people with mental health problems already have “a reasonable range of services available to them.”

> So low does mental health rate within the Howard government that Tony Abbott has relegated responsibility for it to his Parliamentary Secretary. Further, there is no longer a Branch dedicated solely to mental health in the Department of Health and Ageing. From January 2004 up to the day the Federal Election was called, Hansard shows Tony Abbott spoke 400 times in Parliament and not once mentioned mental health.

The Prime Minister considered mental health an important piece of social policy reform that needed to be addressed (Smyth, key informant). Ian Hickie (key informant interview) believed for Mr Howard it was ‘an opportunity to be socially progressive’.

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The Parliament had announced the establishment of a Senate Select Committee on Mental Health on March 8, 2005, chaired by Australian Democrats leader Lyn Allison, to inquire into the provision of mental health services in Australia. The Committee was initially asked to report to the Senate by 6 October 2005, however a strong public response to the Committee’s work led the Senate, on 18 August 2005, to extend the Committee’s reporting deadline to 30 March 2006. A further extension was granted on 1 March 2006 allowing the Committee to report prior to 28 April 2006. The Committee tabled its first report on 30 March 2006 and its final report on 28 April 2006.

The Committee’s recommendations were wide ranging but served to refocus attention onto the services in the community for those with severe mental illness as a priority, to promote social reintegration and human rights with measurable specific targets for consumer outcomes. Although the Committee called for a balance between programs delivering mental health promotion, illness prevention, early intervention and the delivery of services for people with established mental illness, it was the recommendations about the need to address the unfinished agenda of the first plan that were widely supported. A content analysis of the submissions to the Senate inquiry found that stakeholder concerns about Australia’s mental health care system could be described within themes relating to the broad range of clinical and support services needed in the community for those with established mental illness (Townsend et al. 2006).

The MHCA, among many others in the field, welcomed the outcomes of the Senate inquiry, pointing to the need to put in place:

The infrastructure to enable supported de-institutionalisation to occur - the infrastructure Australia should have built 20 years ago when the old asylums were closed (Dwyer and Leggat 2006).

There is a lingering concern however that although mental health reform in Australia has been heading broadly in an appropriate direction these reforms are already losing momentum; and core local mental health services are being eroded or have never been adequately developed … there is further concern that the closing of institutions in Australia has been half-hearted and incomplete; that it has not been accompanied by full transfer of real investment in mental health services and facilities; and that
under-resourced services are again being expected to be everything to everyone (Rosen 2006).

Under pressure from strong stakeholder advocacy and the recommendations of the Senate inquiry, the Commonwealth, State and Territory governments began to formulate a response. They were lobbied strongly and continuously by advocates such as Ian Hickie, John Mendoza (who was CEO of the MHCA) and Pat McGorry. John Mendoza (key informant interview) referred to ‘building a bonfire’ which included Commonwealth government Parliamentary breakfasts attended by about two fifths of all Parliamentarians. Throughout 2005, the MHCA developed and executed a deliberate strategy to engage key media, a critical mass of politicians from all sides of the Parliament and the MHCA membership to build the case for national leadership and intervention in mental health services. Mendosa referred to the release of the Not for Service report as a ‘lighting rod’ for community concern about the state of mental health care across Australia.

According to Mendoza the MHCA strategy involved

‘backgrounding key political journalists and producers of national influential media, hosting breakfasts and internal briefings for Federal Party Committees; continuous stream of stories about the problems in mental health care (consumers, carers, providers, other sectors such as Police); engaging with State/Territory statutory officers (Public Advocates etc). The net effect was that the media and political players were primed and well informed when the [Not for Service] report was released’.

Hickie has described being involved in four years of sustained national and State level advocacy in an essay in the Medical Journal of Australia (Hickie 2009) and an op-ed in the Sydney Morning Herald on September 23, 2011:

In 2004 I traversed the country with colleagues documenting the failings of our mental health systems. Our report Not for Service: Experiences of Injustice and Despair stirred John Howard and Morris Iemma to initiate the investment of $5 billion between 2006 and 2011 in reform measures.

In the Commonwealth government, Parliamentary Secretary Christopher Pyne had responsibility for mental health. He was advised and his views influenced by advocates such as Ian Hickie, Pat McGorry,
the MHCA (John Mendoza and Keith Wilson), *beyondblue* (Jeff Kennett) and SANE Australia (Barbara Hocking) (K. Casey, key informant). Mr Pyne was supported by several colleagues as he worked hard to formulate new reforms (K. Casey and Smyth, key informants). Ian Hickie (key informant interview) nominated assistant Treasurer Helen Coonan as an important supporter. Mendoza (key informant interview) nominated Warren Entsch, Kay Hull, Helen Coonan, Kevin Andrews, Brendan Nelson and Joe Hockey.

Key informants (Hickie, Mendoza and Smyth) also emphasised the important role played by Morris Iemma who, following his elevation from Health Minister to NSW Premier in July 2005, made mental health one of the NSW government’s priorities. Mendoza (key informant interview) said after the October 2005 launch Mr Iemma wrote to Prime Minister Howard proposing a national summit on mental health and offered New South Wales as the host. Mr Mendoza believed that Mr Howard, rather than have a State government host a national summit, moved to put the matter on the COAG agenda. Key informants (K. Casey and Mendoza) identified John Perrin, social policy advisor to the Prime Minister and his successor Perry Spurling, as well as the Prime Minister’s Chief of Staff Arthur Sinodinos, as crucial in securing the Prime Minister’s support.

As had occurred in the opening of the two previous policy windows there were events in the community that attracted considerable public and media attention and mandated a response from government. The most prominent were two Australians with mental illness, Cornelia Rau and Vivian Solon, detained in the immigration detention system (and in the case of Ms Solon unlawfully removed to the Philippines). The experiences of these two women highlighted systematic failures of the health and immigration detention systems and failings in inter-departmental coordination and cooperation (see Appendix 2) (McMillan 2005, Palmer 2005, Senate Foreign Affairs Defence and Trade References Committee 2005, Freckelton 2005, Griffiths 2006, McSherry 2005). The adverse publicity following revelations that the Department of Immigration, Multicultural and
Indigenous Affairs (DIMIA) had mistakenly detained these women and had ostensibly denied them adequate medical care was not able to be contained, coming as it did on the back of already considerable public disquiet about the treatment of non-Australian asylum seekers in the detention centres.

One of Australia’s most senior political commentators, Michelle Grattan, noted that the case of Cornelia Rau resonated in the community for revealing that a mentally ill Australian could become lost in our detention system, and that the government was unable to limit the debate once sparked (Prince 2005). Several key informants (K. Casey, Mendoza, Hickie, Smyth) identified the Cornelia Rau and Vivian Solon cases as influential in promoting Commonwealth government action and this is my view as well. Ian Hickie (key informant interview) referred to the Cornelia Rau episode as demonstrating ‘the power of the individual case story’. Figure 5 shows the frequency of references to mental health over the twenty year period covered by the thesis peaked in 2005, with release of the Palmer Inquiry report on Cornelia Rau in July (Palmer 2005) and the Comrie report on Vivian Solon in September (McMillan 2005) cited in many of the Hansard references, along with the MHCA and HREOC Not for Service report released in October 2005.

During this period, personal experiences of mental illness in the political community also gained prominence in the media (Barns 2006). In 1997 Federal ALP Senator Nick Sherry attempted suicide (Ewing 1997). In 2000, Labor MP Greg Wilton completed suicide (Mitchell 2000b). In 2003, the leader of the Australian Democrats Senator Andrew Bartlett was involved in an alcohol-induced altercation, which the media associated with substance abuse (Brown 2003). In 2005, former NSW Liberal leader John Brogden attempted suicide (Seccombe 2005). In 2006, all of these cases and mental health more generally received renewed attention in the media when Western Australian Premier Geoff Gallop resigned due to depression (Barns 2006). It was within this climate that the pressure for mental health reforms was growing. From a political perspective, this pressure was arguably more
difficult to ignore when individual members of Parliament were seen to be affected and were willing to acknowledge it.

The linking of the Kingdon’s three streams occurred with adoption of the COAG National Action Plan on Mental Health. From the problem stream prominent advocates described the mental health system as being in crisis (notwithstanding the evidence that the availability and distribution of services for people with mental illness had progressively increased). Better resourced, organised and articulate advocates (including the Mental Health Council of Australia (MHCA) reports, Out of Hospital, Out of Mind in 2003 and Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia in 2005) described human rights abuses, a lack of services for patients (especially those with severe mental illness), a lack of coordination between clinical, housing and community support services and problems with the deployment of limited financial and human resources.

Policy solutions in areas of Commonwealth responsibility, especially health and social services for people with mental illness and psychiatric disability, were identified by advocates and in the MHCA reports. From a Commonwealth political perspective there was also a need to respond to the policy recommendations from a Senate Select Committee on Mental Health (an interim report from which was released in March 2006 and a final report in April 2006). Also from a political perspective there were external events, specifically two Australians with mental illness, Cornelia Rau and Vivian Solon, detained in the immigration detention system that helped galvanise the government to support mental health reform and several high profile Australians experience mental health problems, including suicide.

Prime Minister Howard and New South Wales Premier Iemma both agreed to place mental health reform on the COAG agenda where intersectoral policy areas such as health, housing, community services, and employment could be addressed simultaneously, along with those areas already being subjected to reform such as the police, justice and the immigration system. These two individuals were identified as
performing roles most closely aligned with that of ‘issue entrepreneurs’ within government. Each was in a position to elevate mental health policy to COAG for consideration and Howard’s decision (encouraged by key staff in his office) to support mental health reform was, of course, critical for Commonwealth government engagement.

At the 10 February 2006 COAG meeting it was argued that Commonwealth, State and Territory governments needed to put funding into the mental health sector and a new multi-sector action plan covering the health, welfare and related sectors was required. The communiqué (COAG 2006a) from that meeting stated:

"Additional resources will be required from all governments to address the issues. COAG has asked Senior Officials to prepare an action plan ... no later than June 2006."

On 5 April 2006 the Commonwealth government announced a $1.9 billion package over five years as its contribution to the COAG national action plan and the funding was provided in the 2006-2007 Commonwealth Budget on 9 May 2006 (Australian Government 2006). Christopher Pyne commented (Parliament of Australia 2006):

"It is not a traditional area of responsibility of the Commonwealth; it is a responsibility of the States. After a great deal of debate and discussion in this country over the last few years, it has become quite obvious that the States have not stepped up to the plate, no matter how much political pressure has been applied to them. As a consequence, the Prime Minister decided that he would step forward and put $1.9 billion of Commonwealth spending on the table and ask the States to match that spending. The area of spending that the Commonwealth will be responsible for is more primary health and clinical services and some of things that we traditionally fund through Medicare. The States are responsible for acute hospital beds, prisons, crisis services and emergency services—the areas that they have been traditionally responsible for. This package does not delve into their areas, but it tries to do the Commonwealth’s part of mental health well and then calls on the States to do their part of mental health well. We are not going to take over their areas of responsibility but nor are we going to let them off the hook by simply funding, through shared agreements, areas that we know they should be doing. We are going to do our areas well and expect the States to do their areas well, which would be a nice change.

John Mendoza (key informant interview) believed the decision of the Prime Minister to announce the Commonwealth reform package on 5
April 2006, well before the COAG meeting on 14 July 2006 ‘jumped the
gun on the States’ to apply political pressure on State and Territory
governments to make a financial contribution and also to ‘pre-empt the
Senate report’ (the final report of the Senate Select Committee on
Mental Health, chaired by the Australian Democrats (Senate Select
Committee on Mental Health 2006b) released on 28 April 2006. Mendoza
also commented that the Department of Prime Minister and Cabinet
(PM&C) and the Prime Minister’s office (PMO), as well as being
‘frustrated with the slow progress and lack of money on the table from
the States and Territories were also frustrated with the progress by the
Department of Health and Ageing (DOHA) ... the Commonwealth
contribution to the mental health reform package was developed within
PM&C and PMO. Howard played a hands-on role in some aspects
particularly the ‘Personnel Helpers and Mentors Program’ and splitting
the responsibility between FaCSIA (the Department of Families and
Community Services and Indigenous Affairs) and DOHA.

At its meeting on 14 July 2006, COAG agreed on a National Action
Plan on Mental Health 2006–2011 (COAG 2006b), a five year, $4.1
billion government plan which covered the health and welfare sectors
(COAG 2006b).

While the problems being addressed by the 2006 COAG National
Action Plan on Mental Health covered a number of areas including
improving access for people with common less severe mental disorders,
it gave particular attention to the need to improve services to those with
the highest need; specifically those individuals with severe and
persistent mental illness. The highlighted failures for these individuals
were not just in the health system but also in the disability support and
housing sectors. This was essentially a return to the concerns raised in
the initial intersectoral reform of the first plan endorsed by the then
Commonwealth Labor government (Whiteford 1994b). The criticism of
the first plan’s ‘narrow’ focus on severe mental illness, discussed in
Chapter 7, was not evident in 2006. The language of the COAG National
Action Plan of Mental Health was to better address the needs of
individuals with severe and persistent mental illness, whilst not abandoning the population health approach of the second plan which included illness prevention, health promotion and early intervention.

3. Conclusion

The opening of the policy window in 2006 was in response to problem areas concerning human rights of patients, deficiencies in services for those with severe mental illness including problems with access to and quality of clinical services, the supply of and coordination with housing and community support services; the lack of financial and human resources and the way in which financing was provided. Commonwealth, State and Territory mental health programs were reporting increased demand for mental health care along with evidence that the reform momentum achieved during the first plan had been lost. Policy solutions involved more than better clinical care. Non-clinical support services in the community and better coordination of the range of human services providing treatment and care was being demanded.

Consumers, carers and advocates had become much more active and vocal with greater expectations and exerted considerable external pressure on governments. There was a concerted lobbying campaign by individual advocates such as Ian Hickie, John Mendoza and Pat McGorry and organisations such as the MHCA, beyondblue and SANE Australia that had prominent and media-savvy leaders. The highly publicised plight of Cornelia Rau and Vivian Solon necessitated government action.

The Commonwealth government, needing to ensure it was not politically vulnerable in social policy and faced with an upcoming election, needed to respond to these escalating problems and demands as well as pre-empt the report of the Senate Select Committee on Mental Health. The Prime Minister, his staff and department took responsibility for the next stage of the mental health reform, supported by (and at times in competition with) State and Territory leaders, the most prominent of which was the New South Wales Premier, Morris Iemma.

At its meeting on 14 July 2006 COAG endorsed a five year
However by October 2006 the Prime Minister was criticising the State and Territory governments for not allocating sufficient funding to the COAG National Action Plan (Abbott 2006) and the apportioning of responsibility for criticisms to other jurisdictions continued. On the motion of Senator Lyn Allison a new Senate inquiry into Australian mental health services was initiated on 28 March 2007 (Senate Standing Committee on Community Affairs 2008b, 1). This inquiry was launched with goal of ensuring the enthusiasm for the COAG reforms was translated into tangible outcomes (Parliament of Australia 2008, Senate Standing Committee on Community Affairs 2008b, 3-4). The Coalition lost the federal election on 24 November 2007. The Rudd Labor government was sworn in on 3 December 2007. Morris Iemma was replaced as NSW Premier in September 2008. The final report of the Senate Committee inquiry Towards Recovery: Mental Health Services in Australia (Senate Standing Committee on Community Affairs 2008c) was tabled in Parliament on 25 September 2008, and a fourth National Mental Health Plan 2009-2014 was agreed by the Commonwealth, State and Territory governments in 2009 (Department of Health and Ageing 2009). The government issued a formal response to the Inquiry on 25 August 2011 (Parliament of Australia 2011), and an independent summative evaluation of the 2003-08 National Mental Health Plan later described significant progress in Australian mental health service reforms since the inception of the Strategy (Curie and Thornicroft 2008). Nonetheless, the reforms proposed and undertaken by the Labor Commonwealth government continued to be criticised by stakeholders (Rosenberg, Hickie and Mendoza 2009, Rosenberg, Mendoza and Russell 2012, Sweet 2009).
CHAPTER 9 - Explaining TWENTY YEARS OF mental health policy reform

Changes in mental health policy have produced cycles of reform in services for centuries. However, the reforms undertaken during these cycles, while often producing some improvements, have rarely been sustained. As noted in Chapter 3, attempts to develop and implement a policy solution to perceived problems have often been accompanied by either the failure to solve the problem(s) or the emergence of new problems. These cycles have also characterised mental health reform in Australia (Lipton 1983) with mental health issues moving into and out of the public arena and government attention. A cyclical pattern was also evident during the twenty year period covered by the thesis with the three national mental health plans and the COAG national action plan. However it was a pattern different to one of policy and funding neglect followed by bursts of government action in these areas. There was continuous government attention in that some reform was underway throughout the twenty years, but with cyclical attention to and then relative neglect of different components of mental health reform.

As noted in Chapters 1 and 3, most mental health policy literature focuses on policy content. In this thesis I examine policy content in the context of other evidence to ascertain why certain mental health policies were adopted during three successive time periods (1988-96, 1996-2003, 2003-08). To do this I summarise the problems in the mental health sector confronting governments in Australia over that period (Table 3), the policy solutions proposed to respond to these problems and the policy directions that were adopted by the Commonwealth government during this time (Table 4). I undertook a systematic review of published literature as well as a review of Parliamentary records for the relevant periods. This was supplemented by information from key informants and my observations as an expert key participant in mental health reform.
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<th>Table 3: Problem areas for each key theme and time period</th>
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<tr>
<td><strong>Human Rights and Community</strong></td>
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<td><strong>Community Attitudes</strong></td>
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<td><strong>Need</strong></td>
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<tr>
<td><strong>Service Structure</strong></td>
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<tr>
<td><strong>Poor continuity of care between inpatient and community clinical services.</strong></td>
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<td><strong>Poor intersectoral linkages between clinical and other social services.</strong></td>
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<td><strong>Service Quality and Effectiveness</strong></td>
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<td><strong>Lack of information on service effectiveness.</strong></td>
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<td><strong>Resources</strong></td>
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Table 4: Policy responses for each key theme and time period

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<tr>
<td>National Mental Health Statement of Rights and Responsibilities (March 1991) and National Mental Health Plan required nationally consistent state/territory mental health legislation.</td>
<td>Establishment of a national mental health advocacy and advisory body (National Community Advisory Group) and requirement that each state and territory have a similar body.</td>
<td>National Standards for Mental Health Services (January 1997) in community and hospitals, confirmed by independent accreditation agencies.</td>
<td>Renewed focus on human rights of people with mental illness in community and in hospital.</td>
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<td>National public education and awareness campaigns greatly expanded.</td>
<td>Further national programs and agencies to promote public awareness and reduce stigma.</td>
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<td>Community Need</td>
<td>Disability reform package in the 1991 Commonwealth Budget included psychiatric disability for first time but the burden of care on families and carers remained largely a state responsibility.</td>
<td>Epidemiological studies to establish community prevalence and burden of mental disorders.</td>
<td>Priority again being given to people with severe mental illness.</td>
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<td>National primary mental health care reform launched June 1999 with attention to broader private sector mental health reform.</td>
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<td>Resources</td>
<td>$135 million over 5 years in 1993 and $169 million over 4 years in the 1994 Commonwealth budgets with most of the funding provided to the States and Territories through Schedule F of the Medicare Agreements.</td>
<td>Funding for mental health included in 1997 Commonwealth budget for Second National Mental Health Plan (delivered in the 1998 – 2003 Australian Health Care Agreements (Schedule G)) with additional funding for general practitioners in the 2001 Commonwealth Budget.</td>
<td>In April 2006 the Commonwealth announced $1.9 billion over five years as its contribution to the COAG national action plan with this funding provided in the May 2006 Commonwealth budget.</td>
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<td></td>
<td>Increased resources for primary mental health reform in 2005 Commonwealth budget.</td>
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<td>Focus on cost-effectiveness in financing of services.</td>
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The problems which emerged in the decades leading up to the adoption of the National Mental Health Policy in 1992 were a legacy of thirty years of de-institutionalisation without a corresponding establishment of adequate clinical, housing and support services for individuals with severe mental illness living in the community. When services, either in the hospital or community were accessed, quality treatment was not routine and some treatments constituted human rights abuse.

Policy solutions such as anti-stigma campaigns, legislating to protect patient rights, expanding community mental health services and integrating them with hospital services, improving the quality and quantity of the mental health workforce and expanding housing and support services for people with mental illness living in the community were strongly advocated. These solutions shared both technical and philosophical consistencies. Other policy solutions (e.g. re-institutionalisation), were not considered as they were inconsistent with, or even in conflict with, the more strongly supported policy directions (e.g. promoting human rights and the delivery of care in the least restrictive mode).

While the problems were predominately those of the State and Territory governments, in the late 1980s and early 1990s the Commonwealth government quantified the cost of mental illness to its budget. The cost was found to be more than all State and Territory spending combined and exposed illogical policy settings, for example the Commonwealth spending more on income security for people with mental illness than the States and Territories on treatment services but excluding this group from access to Commonwealth programs designed to decrease dependence on welfare and assist people to return to the workforce. These issues along with concerns about unregulated cost-shifting from the State and Territory governments to the Commonwealth helped convince the Commonwealth that mental health was not only a State and Territory responsibility and it needed a policy framework for this area.
At a political level there was a reformist government Minister, Brian Howe, the political imperative to respond to criticism from the Human Rights and Equal Opportunities Commission and a period of social policy reform with reform of Commonwealth/State programs an emerging political priority for the Commonwealth government. These factors created an environment and a need to pursue mental health reform, leading to the opening of the 1992 policy window with the adoption of a National Mental Health Policy and the first National Mental Health Plan. This window was the most important as once the first five year plan started, a pattern was established where governments were required to consider whether they would maintain, revise or abandon mental health reform at the conclusion of each plan.

The problems that led to the opening of the policy window in 1998 started, not because of a failure to implement the policy directions of the first National Mental Health Plan, but with a stakeholder backlash against the focus of the first plan on severe mental illness. It was argued that State and Territory services used an arbitrary definition of severe mental illness, essentially psychosis, to ration services in an inequitable way, excluding most other mental disorders. This was seen to abandon prospects for prevention and early intervention. Epidemiological research being undertaken at this time demonstrated that common mental disorders such as anxiety, depression and substance abuse and not low prevalence disorders such as psychosis caused most of the population burden attributable to mental disorders, usually went untreated, and treatment that was available was mostly provided in general practice, an area of Commonwealth policy responsibility.

Policy solutions such as community education campaigns, increasing treatment of common mental disorders, enhancing the capacity of primary care, or general practice to identify and treat these disorders and the introduction of more mental health promotion, illness and suicide prevention and early intervention programs were strongly advocated. Again there was a technical and philosophical consistencies
shared by these solutions. Other policy solutions (e.g. those related to severe mental illness promoted in the first National Mental Health Plan), were inconsistent with the advocacy to shift the policy focus to a population (those with common mental disorders) neglected in the first Plan and to ‘brand’ the Second Mental Health Plan to align it with the politics stream of the new government.

Also again there was a government Minister, Michael Wooldridge who, for technical and personal reasons, promoted the view that the Commonwealth government should remain involved in mental health reform and made the case to his colleagues. Concurrently there was a political imperative to respond to the perception that individuals responsible for mass shootings, as had occurred at Port Arthur, would fall within the responsibility of mental health services as well as these tragedies needing other policy responses such as gun control. Dr Wooldridge was able to develop a policy direction within mental health that encompassed a broader population health focus and emphasised the role of primary care, was supported by stakeholder advocacy and scientific evidence and also allowed the Liberal-National Coalition government of the day an approach that distinguished it from that of the previous Labor government.

The problems that led to the opening of the policy window in 2006 arose, again not primarily because of inaction in implementing the policy directions of the second plan, but because the service reforms started under the first plan had waned. The rights of patients, deficiencies in health, housing and community services for those with severe mental illness, the lack of financial and human resources and the way in which financing was provided again became prominent concerns of advocates. Stakeholders and advocates were becoming more organised and vocal, with increased expectations around better access, quantity and quality of services. Policy solutions focussed on consumer (patient) rights, stigma reduction, increased access to services (including non-clinical support services), an improvement in the quality of care and the
outcomes achieved by services which needed more human and financial resources. The State and Territory governments were arguing for more Commonwealth support with COAG increasingly being used as a vehicle for progressing intergovernmental relations. The range of policy solutions in the COAG plan incorporated health related solutions similar to those advocated in the first Plan (i.e. those related to severe mental illness) and those advocated in the second Plan (i.e. those related to common mental disorders) as well as reforms in non-health social sectors. This provided a political result seen to provide solutions meeting the expectations of the main advocacy groups which had emerged over the preceding twenty years.

These pressures on government for action over and above the Third National Mental Health Plan (which was seen to be ‘more of the same’) were added to by the highly publicised cases of Cornelia Rau and Vivian Solon and an imminent report from a Senate Select Committee on Mental Health. With an upcoming election where the Coalition was perceived to be vulnerable in social policy areas these factors united for the opening of the 2006 policy window. The Commonwealth Coalition government and the New South Wales Labor government took mental health to COAG and a whole of government COAG National Mental Health Action Plan was adopted.

1. **Dynamics in mental health reform**

   The literature refers to mental health reform as cyclical and, as noted earlier, there was a cyclical pattern evident during the twenty year period covered by the thesis but it was of attention to and then relative neglect of different components of mental health reform. The problems that led to the opening of the policy window in 1992 waned as a policy focus in 1998 but re-emerged as a focus in 2006. However with consecutive national mental health plans operating, reform driven by Commonwealth funding never ceased, and the results of this reform have been described in the regular National Mental Health reports (Department of Health and Ageing 2010). While there was no time when reform ceased several key informants emphasised that the plans
produced varying degrees of success. A full assessment of policy implementation is outside the scope of this thesis.

The opening of the first policy window differed from the next two windows because there was no national mental health reform process to which the Commonwealth was politically or financially committed at the time of the adoption of the *National Mental Health Policy* and first plan. Powerful social, economic and political factors coalesced to open this window: escalating clinical and social problems for patients in the aftermath of psychiatric de-institutionalisation, the high profile public Human Rights and Equal Opportunities Commission (HREOC) inquiry underway, recognition of the high cost of mental illness to the Commonwealth budget, unregulated cost-shifting from the State and Territory governments to the Commonwealth government, a socially reformist government Minister with a personal interest and a government agenda promoting cross portfolio social policy reform to which mental health was particularly suited.

Subsequent policy windows were essentially a revision of the policy directions within the broad mental health framework of the *National Mental Health Policy*. Once signed up to the first *National Mental Health Plan*, the Commonwealth government was required to consider its position on involvement in national reform at the conclusion of each five year national mental health plan. The need for the consideration of its position necessitated the issue of mental health being placed on the Commonwealth political agenda. The establishment of the National Mental Health Strategy created community and professional expectations of an improvement in mental health services and provided a national agenda around which advocates could rally, building momentum and expectations for ongoing reform.

Another difference in the opening of each of the policy windows related to the role of advocates. In the lead up to the first window in 1992 there was limited external advocacy, with the RANZCP and ANAMH almost alone in applying pressure to the Commonwealth government, although this changed when the HREOC inquiry started in 1991. All of
the development of the National Mental Health Policy and first plan was done by government bureaucrats. By the time of the 1998 policy window stakeholders and advocates, including NGOs, were more influential and their representatives were involved in the development of the second plan. In the lead up to the 2006 policy window there was an organised, concerted lobbying campaign by individual advocates and organisations with high profile leaders, the like of which had never previously been seen in Australia, though it was a harbinger to things to come. Thus it can be seen that a loose epistemic group of specialists did emerge over the twenty years.

As well as differences in the policy windows, there were factors common to the opening of each window. On each occasion there emerged from within the plethora of mental health issues confronting government, a set of defined problems and proposed policy solutions around which enough stakeholders and advocates rallied to allow government to perceive a consensus and be confident of enough stakeholder support. On each occasion there was also a highly publicised mental health issue that had dominated the media, which drove the public debate. In 1992 it was the Human Rights and Equal Opportunities Commission (HREOC) inquiry, in 1998 the Port Arthur shootings and in 2006 the Cornelia Rau and Vivian Solon cases, the most prominent amongst a plethora of examples. These greatly raised the political stakes for the government of the day, demanding a policy response. On each occasion, taking action in mental health reform suited the political agenda of the Commonwealth government at each particular time with the government able to adopt a policy direction that was consistent with and advanced its political aspirations.

Importantly, also on each occasion there was a Commonwealth politician in an influential position who took an interest in the area, essentially fulfilling the role of an ‘issue entrepreneur’ within government, ensuring the political stream responded to policy demands. Although the reasons these politicians promoted mental health differed, the policy window would not have opened had it not been for their
actions. This was demonstrated following the election of the Rudd Labor government in November 2007. This new government was under considerable pressure to continue mental health reform. Senate reports in 2008 and 2010 recommended action (Senate Standing Committee on Community Affairs 2008a, 2008c) and prominent Australians including psychiatrist Pat McGorry, Australian of the Year in 2010, advocated strongly for mental health. Despite positive government rhetoric at both the Australia 2020 summit in 2008 and the COAG meeting in April 2010 (Crosbie 2009, McGorry 2010) no major policy announcements and no significant commitments were made in the 2009 and 2010 budgets. Health Minister Nicola Roxon indicated the Government intended mental health reform would occur at an unspecified date in the future (Smith 2010) and it became clear to stakeholders that no political action was intended.

This led to a backlash against the Labor government with the highly public resignation of the Chair of the Commonwealth government’s National Advisory Commission on Mental Health John Mendoza on the 18 June 2010. Mendoza identified a lack of political will for mental health reform by the Rudd government as main reason for his resignation (Mendoza, key informant interview; Yfe and Star 2010). This was accompanied by widespread lobbying by individuals and advocacy groups, including a public advocacy campaign by GetUp!, which eventually led to the new Prime Minister, Julia Gillard, to respond with the appointment of a Commonwealth Minister for Mental Health (Mark Butler) in September 2010 and a $2.2 billion investment in mental health over 5 years announced in the budget on May 10, 2011 (Australian Government 2011). Mental health was clearly a more prominent public issue than it had been before 1992 and advocates were much more organised and influential.

Prior to 1992 there were a series of policy cycles where mental health was briefly an issue to which the Commonwealth government paid attention. However these short periods were followed by extended periods of relative political neglect (Lipton 1983). This changed after
1992, superseded by the need to have a permanent political and bureaucratic capacity within the Commonwealth government to respond to mental health as a policy issue. The cycles after 1992 were therefore about a change in an existing Commonwealth mental health policy direction rather than bringing a new mental health policy into existence.

2. **Strengths and weakness of the Kingdon model applied to mental health and other health policy areas**

I chose Kingdon’s model which provides a framework for understanding most of the policy process examined in this thesis. Because the model was used to organise the information collected, any attempt to validate the model using this data would be tautological and therefore redundant as it could not independently establish the predicative validity of the model. Sabatier has criticised Kingdon’s model as lacking testability (Sabatier 1999). However it is possible to identify areas where the data collected for the thesis seemed to fit the model and areas where it did not.

It was not difficult to find, for each policy window, clear problems, policy solutions and a political context within which the opening of the window occurred. This political stream was, on all three occasions, independent of the problem and policy streams. However these two streams were not independent. In most cases, the individuals who had identified the problems were also promoting policy solutions to those problems. These individuals were often technical experts in the field of mental health, had a strong sense of professional identity and a professional stake in solutions to policy problems affecting the mental health sector. This lack of independence is consistent with other critiques of the Kingdon model as noted in Chapter 2; that the three streams of problems, policy and politics display varying degrees of interdependence. Stream independence should be viewed as a conceptual device to help examine the various elements in the streams to uncover rationality, rather than an absolute condition.

While categorising data into problem and policy solutions was
straightforward, Kingdon’s model did help explain some of the changes and reasons why these became elevated in the hierarchy of policy attention. It was clear, as Kingdon described, that information or indicators demonstrating service deficiencies are not automatically accepted as evidence of a problem needing policy attention (Kingdon [1995] 2003, 91). For example the problems highlighted by the HREOC inquiry in 1992 had been present for generations. It did help for the problems to be ‘countable’ (Kingdon [1995] 2003, 93), for example the Commonwealth expenditure on people with mental illness identified by the Eisen-Wolfenden report. However as Kingdon noted the problems did not come to political attention because there were indicators to describe them.

Kingdon ([1995] 2003, 109) notes that translating conditions into problems often involves a process of categorisation. People see a problem quite differently if it is put into one category rather than another. Again this was found in the data collected. For example the HREOC report emphasised the human rights of people with mental illness and psychiatric disability, moving them from a category where they were seen as less deserving and even a potential danger to community safety, into a category where they were seen as individuals deprived of basic human rights.

Kingdon points out that conditions become defined as problems when it is believed that something needs to be done about them. Something needing to be done is also often a result of a change in the national perception or mood in relation to the problem. Kingdon’s conceptualisation of the national mood has been singled out as being rather indeterminate and he acknowledges that his model is unable to account for how policy makers gauge or perceive national mood ([1995] 2003, 152-72). This inability to operationalise a concept of national mood was identified by Soroka (1999) as another limitation to the testability of the Kingdon model.

The change in perception or mood by the public often requires a focusing event or crisis or to be connected to a powerful symbol. In
mental health, both conditions occurred. As described in Chapter 6, Chapter 7 and Chapter 8, there was a progressive change in perception by the public about mental health. It became less stigmatised and people with mental illness and their families experienced less shame and were more vocal in advocating for better services. Mental health problems became something that could happen to anyone, not just someone else. There were also focussing events evident in the opening of the mental health policy windows, for example the Port Arthur shootings and the cases of Cornelia Rau and Vivian Solon.

The Kingdon model has also been found useful in understanding other areas of health policy. It was applied to a case study of cannabis law reform in Western Australia (Lenton 2004) where the problem of cannabis use and the policy solution of decriminalisation were being debated in public. The Labor Opposition differentiated themselves from the incumbent Coalition government by committing to a policy of decriminalisation. After winning the election a policy window was opened, a Community Drug Summit held which considered legislative options for cannabis use and a public mandate to pursue politically contentious policies.

It was also applied to a case study of reforms to manage recidivist drink driving in Western Australia (Lenton 2008). Media coverage of serious drink driving accidents and statements from a respected magistrate identified the need for policy attention to this area by government. Researchers, using the results of studies, proposed a refocus of policy responses away from increasing penalties to more evidence based alternatives (e.g. alcohol interlock devices, assessment for alcohol problems) which received wide media coverage and were subsequently supported by the government.

Lenton (2007) uses Kingdon’s model to explain how drug and alcohol research forms only one small component of the range of factors influencing policy making, policy implementation and legislative change. He describes the Kingdon framework as the ‘closest fit’ model given his experiences in drug and alcohol policy reform, commenting that:
Feeding the research findings and recommended policy response directly to the politician drafting their drugs policy was a tangible example of bringing together the problem, policy and political streams.

Schmied-Blackman (2005) examined and critiqued the agenda-setting model proposed by Kingdon with respect to the issue of tobacco control in the State of California. The problem of tobacco’s damage on health had gradually permeated the public understanding but the policy solution of applying excise tax was not considered politically viable. The public was increasingly informed about the practices of the tobacco industry, culminating in the revelation that seven American tobacco companies’ CEOs lied to the US Congress about the addictive properties of nicotine. This weakened the industry’s standing in lobbying against tobacco control measures allowing the passage of Proposition 99 (to apply excise tax to tobacco products).

As discussed in Chapter 3, Zwi and colleagues (2011) found that mental health policy change in the Solomon Islands was driven by multiple factors including: socio-cultural issues; bureaucratic motivation; research and evidence; external factors including international aid; and political, security and economic concerns. Hamid and Everett (2007) used the Kingdon model to describe the development of Iraq’s mental health policy.

The Kingdon model has limitations and establishes a preconfigured cyclical dynamic. It does not predict when a policy window might open. However it does however provide a framework for identifying and explaining the factors which are most important in the policy window opening.

3. Future Directions

Throughout the period covered by this thesis, and since 2008, the cycles of mental health reform in Australia have led to progressive improvement in mental health services with no clear period of ‘stagnation and decline’ to borrow the terms used by Rochefort (1998) but with periods of neglect of parts of the reform agenda. The public and professionals did not tolerate this neglect. Public information and
knowledge about mental health (often referred to as ‘mental health literacy’) has improved (Reavley and Jorm 2012) and the number of inquiries and reports produced over time suggests the issue of mental health service quality has indeed penetrated various levels of the Australian policy agenda (Rosen 2008). The policy debates amongst stakeholders, advocates and government have become more public and at times more vitriolic (Colvin 2010, O’Brien 2010, Rattan 2012, Rosenberg 2012). These directions are likely to continue.

Important challenges remain to be tackled. While there are fluctuations, reversals and changes in nearly all areas of government policy, Rochefort (1998) argued that there is a particular instability in mental health policy. He identified changes in the understanding of mental illness over time, exaggerations in mental health ideologies and rhetoric, the incomplete development of psychiatry as a scientific discipline, a mismatch between the goals of mental health policy and the means by which these goals can be achieved, the impact of professional organisations and changes in public opinion with evolving social changes as factors contributing to an unstable policy process. These along with others such as the political mood of the time can all be identified as contributing to the policy fluctuations in Australia and action to address these technical and professional issues should help introduce more stability and consistency in mental health policy.

In addition to the technical problems, tackling mental health policy and services for people with mental illness creates for policy makers problems of the intractable or ‘wicked’ variety (Hannigan and Coffey 2011); that is, issues that are highly resistant to resolution, socially complex, difficult to define and multi-causal involving the responsibility of several different service sectors (Rittel and Weber 1973). As noted above the problems that mental health policies are trying to solve are complex and resistant and problem formulations and their solutions are contestable. In addition policy actions taken can have widespread system consequences and solutions that have been successful for one part of the problem can create difficulties in other
areas. The evidence available to guide the development of solutions is inadequate, open to challenge and a priority for policy and services researchers.

One key informant who worked in government told me that the opening of a policy window required ‘a lot of luck ... timing was on our side’. This is a common view with the perception that the development and adoption of public policy is an unpredictable, even irrational, process. However from this thesis and the work of other authors, the cyclical nature of mental health reform can be understood to a degree but is changing. While mental health still moves up and down the Commonwealth policy agenda it has not, since 1992, moved off the Commonwealth policy agenda. The cyclical nature is now about a movement between policy directions and emphasis not whether there will be a mental health policy at all.

The policy space in mental health is now much more contested with multiple agendas competing for government attention. For there to be ongoing improvement in the mental health of the population and in the treatment and care of people with mental illness there needs to be clear identification of the problems causing the greatest impact, evidence-based policy solutions and an understanding of how these solutions can come to be adopted by government. For example the analysis undertaken of the three policy windows suggests that policy decisions focused on finite number of problems achieved better outcomes than when the policy and its implementation plan attempted to appease as many stakeholders as possible and implement overly ambitious reforms. The policy and political challenge will be how to contain the advocates from one part of the stakeholder community (for example those advocating for the treatment and care of people with severe mental illness or those advocating for prevention and early intervention) while focussing on a finite number of problems and resisting the temptation to overpromise and try and accommodate all agendas.

As has been noted the opening of each of the three policy
windows was associated with a public crisis, often a story or stories of personal tragedy. All health services have failures and personal tragedies. Mental health might well have more than its share due to its legacy of stigma and marginalisation. However addressing the issues raised by authors such as Rochefort and Hannigan above, especially now that mental health is a constant on the Commonwealth health agenda, is to promote policy solutions without having to rely disproportionately on a personal tragedy or presenting the system as being in crisis and its services as failing? While a ‘crisis’ might obligate governments to do something, albeit reluctantly, it can devalue achievements of previous reform, damage the morale of those working in services, worsen public and political scepticism about mental health and impact adversely on the recruitment and retention of staff.

There continue to be service failures and tragedies in mental health and these should and do get aired. However as the mental health advocacy community becomes more sophisticated, and the stigma and discrimination that surrounds mental illness lessens, the sector should be able to emphasise its successes, identify the deficiencies and highlight the benefits that will accrue to consumers and their families from innovative solutions. Governments like to be associated with success, not only the hope of success and not always the compulsion to intervene in a crisis. Mental health policy cycles will continue but need to progressively mature, avoid destructive competition for prominence of policy ideas and ensure engagement of those for whom mental health services exist (Rosen 2008).
APPENDIX 1 - NATIONAL RESPONSE TO POLICE SHOOTINGS OF PEOPLE WITH MENTAL ILLNESS

In November 1995, a police officer in the Australian Capital Territory fatally shot a man with schizophrenia. In response to this event, the Australian Psychiatric Disability Coalition called on the Commonwealth government to initiate a Royal Commission to investigate the treatment of people with mental illness by police and by crisis intervention services. Other prominent individuals and organisations, including the Human Rights Commissioner Chris Sidoti, the Australian Council for Civil Liberties, ANAMH and the Australian Council for Social Services, also declared their support for a Royal Commission.

The then Commonwealth Minister for Health, Dr Carmen Lawrence, decided not to establish a Royal Commission but on 23 November 1995 wrote to all State and Territory health ministers and to the Commonwealth Minister for Justice proposing the establishment of a taskforce comprising police and health ministers to examine the treatment of mentally ill people by police and crisis teams at the national level and to identify best practice.

Responses to the Minister's proposal varied significantly between jurisdictions (Mental Health Crisis Intervention Ad Hoc Advisory Group 1998). Queensland, the Australian Capital Territory and New South Wales were in support of the proposal. The Northern Territory declined to participate but expressed an interest in learning the outcomes of the proposed taskforce meeting. Victoria proposed an alternative approach – the establishment of a meeting of experts to share information and ideas, to consider ways in which health and police agencies could work together to resolve crisis situations, and to develop ‘action-orientated’ advice for consideration by police and health ministers. This proposal was supported by Tasmania, Western Australia and South Australia.

In March 1996, the Commonwealth convened an ad hoc advisory group involving the health and police sectors, consumers, carers and mental health NGOs to examine existing crisis intervention practices and
police training protocols, to identify good practice collaborative approaches and to develop recommendations for future consideration by health and police ministers.

According to the Australian Institute of Criminology, of the thirty-five people shot dead by police between 1990 and 1995 at least eleven had an identified mental illness. Twenty of the thirty-five fatal shootings were in Victoria and of those at least seven had an identified mental illness. This far exceeded any other jurisdiction, despite the fact that Victoria provided above average funding for community mental health services compared with other jurisdictions (see Table 5), suggesting the issues involved are far more complex than simply the level of resourcing. Whilst adequate resources were important in the capacity of mental health, police and ambulance services to effectively respond to mental health crisis situations, the advisory group identified other significant contributing factors. These included: stigma and the attitudes and the level of mental health awareness of responding personnel; the inadequacy of police training in mental health issues which varies significantly between jurisdictions; and the lack of collaboration between emergency service and health personnel in crisis response (Mental Health Crisis Intervention Ad Hoc Advisory Group 1998)

### Table 5: Deaths resulting from gunshot inflicted by police, Australia, 1 January 1990 to 21 November 1995

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<td>3</td>
<td>12</td>
<td>5</td>
<td>35</td>
<td>11</td>
</tr>
</tbody>
</table>

* The psychiatric history of many of the people recorded as being fatally shot is unknown and this column only records those whose psychiatric history is
definitely known by the Australian Institute of Criminology. Victoria Police advised the ad hoc committee that during the period of the 19 people fatally shot by police in Victoria, 10 had a mental illness (Mental Health Crisis Intervention Ad Hoc Advisory Group 1998).

In May 1996 the following guiding principles and recommendations, amongst others, were proposed and endorsed by police and health ministers. The final report was published in March 1998 (Mental Health Crisis Intervention Ad Hoc Advisory Group 1998). The Committee’s recommendations were implemented to varying degrees across jurisdictions with examples below:


2. Development of national guidelines to regulate the use of non-lethal weapons such as capsicum spray. Capsicum spray was first trialled in Queensland in 1996 under Project Lighthouse and evaluated in 2009 (Criminal Justice Commission and Queensland Police Service 1999), commenced in Victoria in January 1998 (Office of Police Integrity Victoria 2009), and Western Australia in 2007 (Corruption and Crime Commission 2010).

3. Improvement of training of mental health staff, police officers and ambulance officers including reinforcing the principle of peaceful resolution of mental health crisis situations as the primary objective.

4. Establishment of a health and police ministers’ working party to examine the ethical and legislative issues regarding information sharing and confidentiality consideration related to cross-agency management of mental health crisis situations. This was established and reported in 2000 (Expert Advisory Committee on
Information Sharing in Mental Health Crisis Situations 2000).

Victoria, the jurisdiction with the highest number of fatal shootings by police of people with mental illness, made the most concerted effort to address the issues raised in the ad hoc committee’s report. Between 1980 and 1995, thirty-five people were fatally shot by police in Victoria, twice as many as all other jurisdictions combined (Office of Police Integrity Victoria 2005). A protocol was established between Victoria Police and the Victorian Department of Health to improve collaboration in mental health crisis intervention between the two agencies. Project Beacon was established in 1995 which introduced a planned approach to the education and training of police in crisis management, minimised the use of force and, in 1998, introduced capsicum spray as an alternative to firearms. In the ten years following Project Beacon there were sixteen fatal shootings, a significant per capita reduction. However, in the period from January 2004 to January 2005, the number of fatal shootings by police in Victoria increased again, with six people fatally shot. The review found that Victoria Police had ‘lost the strategic focus on safety and avoiding the use of force’ that it had developed under Project Beacon, emphasising the need for continued focus and perseverance if a shift in an entrenched attitude and culture was to be achieved (Office of Police Integrity Victoria 2005).
APPENDIX 2 - CASE STUDY: CORNELIA RAU AND VIVIAN ALVAREZ

Cornelia Rau is a German born permanent resident of Australia with a history of mental illness (Palmer 2005, 1) who in 2004 was being treated for schizophrenia in a psychiatric hospital in Sydney as an involuntary patient. Ms Rau was reported as ‘missing’ to the police on 18 March 2004 (Palmer 2005, 2). A fortnight later, she came to the attention of the Cairns police in North Queensland following concerns raised about her behaviour by local residents. Ms Rau identified herself as a tourist, variously giving her name as ‘Anna Schmidt’ and ‘Anna Brotmeyer’ from Munich, Germany. The police were unable to verify her claim and Ms Rau could not produce any documentation or identify family contacts. She was taken into police custody on 31 March 2004 (Parliament of Australia 2005) and referred to officials from the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA), as a suspected illegal immigrant. Due to the lack of immigration detention facilities in Queensland, Ms Rau was moved to the Brisbane Women’s Correctional Centre where she was detained for six months and then for four months in the Baxter detention centre in South Australia before the error of her incarceration was discovered (Parliament of Australia 2005). The family of Ms Rau recognised her from an article published in the Sydney Morning Herald in February 2005 (Prince 2005). Ms Rau was subsequently admitted to the Glenside Psychiatric Hospital in Adelaide for treatment (Parliament of Australia 2005). Ms Rau’s illegal detention highlighted failures in mental health service provisions, the Department of Immigration and lack of coordination between States dealing with missing persons inquiries; subsequently it became the subject of a federal government inquiry known as the Palmer Inquiry (Palmer 2005).

Vivian Alvarez, an Australian citizen of Filipino descent, was found by a social worker in Lismore, New South Wales, with no place of residence. With obvious physical and mental health problems she was
then hospitalised (Palmer 2005, 183). Despite Ms Alvarez claiming Australian citizenship, she was unable to produce the required evidence at that time. Immigration officials considered her an unlawful non-citizen as there was no record of her entering Australia (Palmer 2005, 184). On the 20 July 2001, Ms Alvarez was deported to Manila (Levett et al. 2005). The Queensland Police Service contacted DIMIA and requested they carry out further checks using the names Solon and Young. Her mother’s family name is Alvarez, her father’s family name is Solon, her former married name, was Young (Crowley-Cyr 2005).

On 20 August 2003, Channel 9 television broadcast details of Ms Alvarez at the end of the Without a Trace program devoted to stories about missing persons. Officers at the DIMIA became aware that the missing persons case publicised on television was that of Ms Alvarez but failed to act on this. Due to the persistent inquiries by Mr Young (her ex-husband), the matter was brought to the attention of the Minister for Immigration and Multicultural and Indigenous Affairs. Ms Alvarez was located in a hospice in the Philippines after a priest recognised her from various news reports. On 18 November 2005 Ms Alvarez returned to Australia (ABC 2005). On May 2005, Peter McGauran, the Acting Minister for Immigration and Multicultural and Indigenous Affairs, referred the matter to the Palmer Inquiry (Palmer 2005, 196-7). The formal inquiry was conducted by Neil Comrie and the report was known as the Comrie Report (McMillan 2005).

On 8 February 2005, Minister for Immigration Amanda Vanstone announced an official inquiry into the Cornelia Rau matter would be conducted by former Australian Federal Police Commissioner Mick Palmer. She announced the Palmer Inquiry would examine (Vanstone 2005):

Complex issues arising from the Rau case, including the effectiveness of Commonwealth/State cooperation in locating missing people and in the provision of mental health services.

The inquiry attracted some criticism. Former Victorian Premier and Chairman of beyondblue, Jeff Kennett maintained the inquiry should be public and armed with the powers of a Royal Commission. Premier of
Queensland Peter Beattie was opposed to the limited scope of the Palmer Inquiry as was the Victorian Premier, Steve Bracks. Keith Wilson, Chairman of the Mental Health Council of Australia, asserted that the rules of the Rau inquiry ‘invited buck-passing and cover-ups’. Barbara Hocking Director of SANE Australia, considered it an attempt to ‘do something fairly quickly to get it out of the way’. Both the German ambassador and Ms Rau’s family expressed concern that the inquiry was closed to public scrutiny and had limited terms of reference (Freckelton 2005).

Nevertheless the inquiry proceeded and focussed not only on the immigration detention system but also the mental health services for people with severe mental illness. The Prime Minister, John Howard, commented (Elizabeth 2005, 4):

> This case raises questions not only about the immigration detention system, which has attracted all the critical attention, but it also raises some questions about the mental health policies that this country has followed for a long time.

The Palmer Inquiry established the failure of mental health services to adequately care for patients in the community and poor intersectoral linkages with other government departments (Townsend et al. 2006).
APPENDIX 3 - KEY INFORMANTS

1. Politicians and ministerial advisors

Brian Howe (interviewed 7 June 2010)

Commonwealth Minister for Community Services and Health, 1990-91.

Commonwealth Minister for Health, Housing and Community Services, 1991-93.

Rebecca James (interviewed 25 May 2010)

Advisor to Dr Michael Wooldridge with responsibility for mental health, 1996-99.

Prior to this Ms James had worked in Dr Wooldridge’s electoral office from 1993 to 1999.

Kathy Casey (interviewed 18 May and 24 May 2010)

Mental Health Advisor to Parliamentary Secretary, Christopher Pyne, 2004–07.

Ms Casey worked on the Liberal Party 2004 election campaign and prior to that was the Manager for beyondblue, the National Depression Initiative from 2000 to 2004.

2. Commonwealth and State government officials

Andrew Podger (interviewed 22 October 2010)

Secretary of the Department of Health and Aged Care, 1996-2002.

Dermot Casey (interviewed 17 January 2011)
Director, Quality and Effectiveness Section, Mental Health Branch, Commonwealth Department of Health and Ageing, 1994-98.

Assistant Secretary, Mental Health Branch, Commonwealth Department of Health and Ageing, 1998-2004.

**Nathan Smyth** (interviewed 23 October 2010)

Assistant Secretary, Mental Health Branch, Commonwealth Department of Health and Ageing, 2005-09.

**Mary Blackwood** (interviewed 23 October 2010)

State Program Coordinator for Mental Health, 1993-96.
State Manager for Mental Health for Tasmania, 1997-99.

**David Meldrum** (interviewed 16 March 2012)

Director of Mental Health, South Australia, 1989–92.

**Beverley Raphael** (interviewed 8 October 2010)

Director of Mental Health, New South Wales, 1996-2005.

**Aaron Groves** (interviewed 21 January 2011)

Director of Mental Health, Western Australia, 2001–05.
Director of Mental Health, Queensland, 2005–12.

3. Mental health advocates – academic experts and NGO representatives

**Beverley Raphael** (interviewed 8 October 2010)
President, Royal Australian and New Zealand College of Psychiatrists in 1984.

Professor of Psychiatry, University of Queensland, 1987-95.

**Jeff Cheverton** (interviewed 2 December 2010)

CEO, Queensland Alliance for Mental Health, September 2004-11.

Board member, Mental Health Council of Australia, November 2005-11.

Prior to joining the Queensland Alliance, Mr Cheverton was with the Brisbane Youth Service and Queensland Council on Social Services.

**Ian Hickie** (interviewed 13 September 2010)

Clinical Director at the St George Hospital Mental Health Service, Sydney, 1995–2000.

CEO of *beyondblue*, 2000-03.

Executive Director, Brain and Mind Research Centre, University of Sydney, since 2003.

**David Meldrum** (interviewed 16 March 2012)

Board Member and then CEO, Mental Illness Fellowship of Australia, board member from 2006, CEO from 2009.

**John Mendoza** (interviewed 9 December 2011)


Prior to joining the Council Mr Mendoza was with the Australian Sports Drugs Agency from 1996 to 2004. After leaving the Council Mr Mendoza was Chair of the Commonwealth government
National Advisory Council on Mental Health.

4. Independent consultants

Shane Solomon (interviewed 11 May 2010)

Consultant for the National Health Strategy (a review of Australia's health system) 1990 to 1993, contributing author to "Help Where Help is Needed: Continuity of Care for People with Chronic Mental Illness.

Mr Solomon has worked as Under-Secretary of Health at the Victorian Department of Human Services, Group Chief Executive Officer of the integrated Sisters of Mercy Victorian hospital and aged care services and CEO of the Hong Kong Hospital Authority.

Bill Buckingham (interviewed 8 February 2011)


Prior to 1994 Mr Buckingham was Chief Psychologist, then Manager, Statewide Service Planning, in the Victorian Health Department Division of Psychiatric Services.
APPENDIX 4: SUMMARY OF POSITIONS HELD BY THE CANDIDATE AND PUBLICATIONS RELEVANT TO THE THESIS

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<th>Period</th>
<th>Key informant (for all or some of the period)</th>
<th>Relevant positions I held for that period</th>
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<td>M Blackwood, B Buckingham, D Casey, I Hickie, R James, A Podger, B Raphael</td>
<td>Director of Mental Health Commonwealth Department of Health and Ageing (1997 to 1999) and Mental Health Advisor from 2001</td>
</tr>
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</table>
Positions I held relevant to thesis

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<th>Policy Period</th>
<th>Policy Window</th>
<th>Position Held by Candidate</th>
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<td>1992 (adoption of National Mental Health Policy and first plan)</td>
<td>1989-96, Director of Mental Health, Queensland Department of Health</td>
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<tr>
<td>2003-08 (Chapter 7)</td>
<td>2006 (adoption of COAG National Mental Health Action Plan)</td>
<td>2000 - current, Mental Health Advisor, Commonwealth Department of Health and Ageing, Canberra</td>
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</table>

My committee involvement relevant to thesis

2006-08 Chair, Steering Committee to revise the National Mental Health Policy

2002-03 Chair, Steering Committee to draft the National Mental Health Plan 2003-08

2002-03 Chair, Steering Committee to evaluate the Second National Mental Health Plan

2002 Joint Chair, Mental Health Reference Group established by Australian Health Ministers to inform the 2003-08 Australian Health Care Agreements
| Year   | Role                                                                                           |
|--------|                                                                                                |
| 1993-98 | Chair, Australian Health Ministers’ Advisory Council (AHMAC) National Mental Health Working Group to oversee the implementation of the National Mental Health Plan |
| 1996   | Chair, Australian Ministerial Taskforce to establish a National Mental Health Peak Body         |
| 1993-95 | Chair, National Mental Health Information Strategy Committee                                   |
| 1993-94 | Mental health representative, Queensland Strategic Planning Group for the Commonwealth/State Medicare Agreement |
| 1992   | Member, Working Group to draft Australia’s Mental Health Goals and Targets for the Australian Government |
| 1991-92 | Queensland representative, Australian Health Ministers’ Advisory Council, Mental Health Working Group drafting the National Mental Health Plan |
| 1989-91 | Queensland representative, Australian Health Ministers’ Advisory Council Working Party to develop a National Mental Health Policy |
Publications relevant to thesis


**Book Chapters/Reports**


APPENDIX A - SEARCH STRING FOR MEDLINE

Mental Health OR Mental Disorders OR Mentally Ill Persons OR Psychopathology

AND


AND

Australia
APPENDIX B - SEARCH STRING FOR EMBASE

Mental Health OR Mental Disease

AND

Health Care Cost OR Funding OR Health Care Policy OR Policy OR Government OR Resource Allocation OR Politics OR Public Figure OR Social Change OR Social Welfare OR Stigma OR Mass Medium OR Public Opinion OR Deinstitutionalization OR Consumer Advocacy OR Patient Advocacy OR Non Profit Organisations OR Advisory Committees OR Health Care Delivery OR Mental Health Service OR Civil Rights OR Public Health

AND

Australia
APPENDIX C - SEARCH STRING FOR PSYCINFO

Mental Health OR Mental Disorders OR Psychopathology

AND

Health Care Economics OR Health Care Costs OR Funding OR Policy Making OR Health Care Policy OR Government Policy Making OR Resource Allocation OR Law (Government) OR Welfare Services (Government) OR Government Agencies OR Government Programs OR Politics OR Politicians OR Political Attitudes OR Political Processes OR Political Issues OR Political Economic Systems OR Social Issues OR Social Change OR Social Influences OR Stigma OR Welfare Reform OR Health Care Reform OR Mass Media OR Public Opinion OR Civil Rights OR Public Health OR De-institutionalisation OR Legislative Processes OR Advocacy OR NGOs OR Nonprofit Organisations OR Health Care Delivery OR Mental Health Services

AND

Australia (searched as keyword, no mapped subject heading)
APPENDIX D - SEARCH STRING FOR APAFT (AUSTRALIAN PUBLIC AFFAIRS FULL TEXT)

Mental Illness

AND

Health Economics OR Public Finance OR Policy OR Economic Policy OR Monetary Policy OR Social Policy OR Politics OR Public Administration OR Ministers (Government) OR Politicians OR Social Change OR Social Responsibility OR Social Welfare OR Social Conditions OR Social History OR Reform OR Law Reform OR Mass Media OR Newspapers OR Broadcasting OR Journalism OR Attitudes OR Civil Rights OR Legal Rights OR Lobbying OR Public Health OR Nonprofit Organisations OR Committees and Inquiries OR Parliamentary Committees OR Royal Commissions OR Health Services

AND

Australia
APPENDIX E - SEARCH STRING FOR HEALTH AND SOCIETY DATABASE

Mental Health OR Mental Illness

AND

Expenditure OR Health Economics OR Public Finance OR Policy OR Population Policy OR Policy Evaluation OR Mental Health Policy OR Health Policy OR Economic Policy OR Policy Making OR Government OR Government Advisory Bodies OR Public Administration OR Federal Government OR Intergovernmental Relations OR Politicians OR Politics OR Lobbying OR Legislation OR Political Attitudes OR Social Responsibility OR Social Welfare OR Social Change OR Social History OR Attitudes OR Stigma OR Pressure Groups OR Law Reform OR Welfare Reform OR Mass Media OR Newspapers OR Journalism OR Publishing OR Radio OR De-institutionalisation OR Advocacy OR Consumer Protection OR Peak Bodies OR Civil Rights OR Public Health OR Nongovernment Organisations OR Mental Health Services

AND

‘Australia’ as subject field
APPENDIX F - SEARCH STRING FOR AMI (AUSTRALASIAN MEDICAL INDEX)

Mental Health OR Mental Disorders OR Psychopathology OR Mentally Ill Persons

AND


AND

Australia
Name changes to the Department of Health since its establishment in 1921 are listed here as a key to the Reference list, below: Department of Health (March 1921 - July 1987); Department of Community Services and Health (July 1987 - June 1991); Department of Health, Housing and Community Services (June 1991 - March 1993); Department of Health, Housing, Local Government and Community Services (March 1993 - March 1994); Department of Human Services and Health (March 1994 - March 1996); Department of Health and Family Services (March 1996 - October 1998); Department of Health and Aged Care (October 1998 - November 2001); Department of Health and Ageing (November 2001 -).
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