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Literature review for a mid-term review of *Living Well*

November 2019

About this report

The report was prepared by Human Capital Alliance for the NSW Mental Health Commission as part of a mid-term review of *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*.

Acknowledgements

We acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia. Australia is the only place in the world where Aboriginal and Torres Strait Islander Australians belong. There is no place in Australia where this is not true.

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Executive summary

The NSW Mental Health Commission is currently undertaking a mid-term review of *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*. The purpose of the review is to assess what mental health reform efforts have been made against *Living Well* and to identify priorities and opportunities for the next five years of the Plan. This literature review forms part of a broader range of activities and consultations that are being undertaken for the mid-term review.

A review and comparison of the key content elements of mental health reform frameworks in Australian jurisdictions and several Commonwealth countries identified a number of ***common priorities and goals*** across the frameworks. These included prevention and early intervention; improving physical health; suicide prevention; improving access to a meaningful life; integrated care; and equity and diversity. All of these priorities were identified in *Living Well* but the presence and depth of the priorities varied across the frameworks.

Similarly, there were a number of common elements, in terms of the document structure, across the frameworks. These common elements included:

- a clear vision or statement
- values or principles that underpin the framework
- context/background information that has informed the framework
- clearly defined actions to achieve the goal or priority

The review revealed the ***frameworks vary in terms of clarity, readability and accessibility in terms of how well the elements align with the priorities or goals of the framework***. They also vary considerably in attention to the needs of implementation. Commonly there was ***limited evidence of framework developers paying sufficient attention to the implementation process*** and more specifically to the 'rules' of implementation science. Rather, the frameworks seem mostly to have been developed as broad guidelines which elements of the mental health system can then adopt (or not) according to the local / regional and service philosophy context. This approach can sometimes prove effective where a degree of local autonomy in implementation is a requisite for acceptance, but mostly this seems to lead to poor and / or uneven implementation.

Common implementation of framework problems included difficulty in achieving genuine consumer participation in reform design and development, challenges in shifting power distribution (between service sectors, between types of mental health workforce, and between service professionals and consumers), imprecise articulation of key concepts especially 'community' and 'recovery', and understanding the complexity of equity population groups and interactions between different equity concerns. On the other hand, ***good implementation efforts*** seem to be associated with strong leadership that focuses on the redesign of work flow and outcome monitoring, differentiation of core versus adaptable components of evidence-based interventions, organisational receptivity to change and competence in collaboration. Following the 'rules' of implementation science is important.

The literature review confirmed that currently there is ***limited literature reporting on evaluation of mental health reform frameworks***. This was widely considered to be a difficult area of research; both from a method and logistics perspective. As well, many frameworks are still in the comparatively early stages of implementation and therefore the evidence is likely to be still evolving. Any impetus to rise to these evaluation research challenges is somewhat undermined by an ***absence of strong advocacy and direction*** in most reform frameworks for evaluation and / or monitoring.

Where the challenges of method and logistics have been responded to, it tends to have been by adopting largely qualitative approaches (e.g. interviews with stakeholders and consumers) or by being focussed on select components of a framework (e.g. the integration element) rather than the entirety of the framework. The few evaluation studies that have employed robust methods (e.g. retrospective cohort studies with treatment and control groups) and taken a whole of framework approach have tended to find (a) implementation effort not compliant with the framework design and which was undermining achievement of outcomes and (b) where gains have been demonstrated they are so far only in terms of process (e.g. continuity of care) rather than demonstrable health outcomes (e.g. reduced readmission to acute care).

The ground for ***monitoring and evaluating mental health reform framework implementation and outcomes is established through the articulation of performance indicators***. Outcome measures or performance indicators were a common element of most frameworks, but the indicators ***varied significantly between frameworks*** in specificity, relevance to priorities and actions, and capacity to be measured. The *Contributing lives, thriving communities* (Australia) and the *Rising to the challenge* (New Zealand) frameworks provide useful examples of implementation and outcome performance measures that are plainly articulated and aligned, but not always able to be associated with data currently available or able to be easily gathered. Current performance indicators, especially the way they are measured (or not), are ***considered by most observers to be inadequate*** for the purpose of supporting accountability measures and driving quality improvement. A common criticism is that data collected satisfies the demands of service administration but fails to support understanding of progress in the reforms themselves. This particularly applies to some of the areas where frameworks have their strongest reform emphasis (recovery, consumer participation, etc.) and where measurement tools are most lacking. Some efforts are emerging though to better capture progress in these areas.

Some authors have argued that the purposes of accountability and quality improvement would be better served by ***focusing data collection and measurement on a more concise number of performance indicators***, a 'core' set that represents those essential reform components that cannot be altered without harming the integrity of the overall reform. Such a 'core' might be represented by those framework elements which featured prominently in both the review of framework priorities and performance indicators. This would include improving physical health and life expectancy of persons with a mental illness; improving access to aspects of a meaningful life including safe housing, education and employment; increasing access of persons with mental illness to required supports through integrated care; improving equity and diversity outcomes, especially for First Nations people; and increasing the sense of inclusion in the community with stronger social relationships.

Acronyms and abbreviations

ACA	Affordable Care Act
CFIR	Consolidated Framework for Implementation Research
FACS	NSW Family and Community Services
IJIC	International Journal of Integrated Care
KPI	Key performance indicators
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NSW	New South Wales
PHN	Primary Health Networks
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
QLD	Queensland
RTE	Relative Technical Efficiency
SUSHI	Sustainability of healthcare innovations
UK	United Kingdom
WA	Western Australia
WESP	World Economic Situation and Prospects

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Overview & introduction

Overview

Since 2012, the Mental Health Commission of NSW, as an independent agency, has been responsible for monitoring, reviewing and improving the mental health and wellbeing for people in NSW by working with government and the community.

One of the first key initiatives of the Commission was *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, which was adopted by the NSW Government in 2014. The vision of *Living Well* is:

> *"The people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms."*
>
> *(Living Well: A Strategic Plan for Mental Health in NSW, pg. 14)*

Living Well was an early attempt by the Commission to construct a plan and direct mental health reform in NSW by setting out a 10-year vision for mental health and wellbeing. With community at the heart of *Living Well*, and the Commission's work, a co-design approach was adopted by the Commission and consultations with more than 2,000 people and organisations, including 800 people with lived experience of mental health issues and caring, their families and kinship groups were undertaken.

To initiate and achieve reform, *Living Well* outlines seven key priorities:

1. Making it local
2. Getting in earlier
3. Putting people first
4. Providing the right type of care
5. Better responses
6. Care for all
7. Supporting reform

A mid-term review of *Living Well*, conducted by the Commission, is now under way to assess against what actions have been achieved in the first five years of *Living Well*. The review will also aim to identify priorities and opportunities for the remaining five years of *Living Well*. This literature review is part of a broader set of activities and consultations as part of the review and to inform the necessary modifications of *Living Well*.

Review questions

The literature review was guided by the following review questions:

- What mental health reform plans and policies that have been developed in Australia and overseas over the past 5 years that relate to an overall reform strategy (or elements of) consistent with *Living Well?*
- What have been the key priorities in mental health reform and how were these identified?
- What are the key enablers or conditions that supported implementation of mental health reform priorities or barriers that have hindered achievement?
- What evidence exists of the effectiveness or outcomes of mental health reform priorities that have been implemented?
- What KPIs and reporting mechanisms have been used to assess reform outcomes and the time period applied to the performance indicators?

Literature search & review method details

Inclusion criteria

The review considered examining mental health reform strategies and evaluation of their impact. A broad definition of mental health was used based on Wilczynski & Haynes' study examining optimal search strategies for identifying mental health content in MEDLINE (2006) (See Table 1 for all terms used).

Table 1: Initial search strategy

Process	Detail
Sampling strategy	Selective: Samples databases from medicine, nursing, allied health and social science fields within specified limits.
Type of study	All; quantitative research (randomised controlled trial, controlled clinical trial, controlled before and after study, uncontrolled before and after study), qualitative (grounded theory, ethnography, action research, exploratory approaches, phenomenology), document, policy and systematic reviews; and peer reviewed commentaries, editorials and discussion pieces; select grey literature (government documents).
Approaches	Subject searching, citation searching, contact with authors
Range of years	Beginning of 2009 -
Limits	English, human
Inclusion and exclusions[¶]	Inclusion: Peer reviewed publications that examine the impact of mental health systems / frameworks / reforms / policies / strategies in developed countries (e.g. Australia, United Kingdom, Canada, New Zealand, the United States of America, Europe, other OECD countries) Exclusions: developing country health care
Terms used[§]	"Mental Health" OR "mental disorder$" OR "mental illness" AND "reform" OR "system" OR "framework" OR "Priority" OR "strategy" OR "plan" OR "policy" OR "guideline$" AND "impact" OR "outcome$" OR ""impact" OR "effect" OR "influence" OR "performance"
Electronic sources	CINAHL

The review considered studies that explore the concept (and impact) of mental health reform and included studies that were undertaken in Australia and in other developed countries, as defined by the United Nation's World Economic Situation and Prospects (WESP) country classification (United Nations 2019). It did not consider studies from developing countries. After initial searches were conducted in one database (CINAHL), search terms were modified to narrow the search field as was the included countries, the focus being on the UK, Canada, New Zealand, selected European countries and the USA. The addition databases searched were MEDLINE, Cochrane Library and PsychINFO.

Separate searches were undertaken of known websites where relevant documentation was thought likely to be held. This included the Kings Fund (UK), Substance Abuse and Mental Health Services Administration (USA) and Te Pou (NZ) websites, and the websites of

organisations similar to the NSW Mental Health Commission including those of the National Mental Health Commission, the Western Australian and QLD Mental Health Commissions. Unpublished studies, published reports and grey literature were also used for this review.

Methods

The systematic review was conducted in accordance with the Joanna Briggs Institute methodology for systematic scoping reviews (Peters *et al.* 2017). The search strategy targeted published studies. An initial limited search of CINAHL was undertaken to identify articles on the topic. The text words contained in the titles and abstracts of relevant articles, and the index terms used to describe the articles were used to develop a full search strategy (Table 1). The search strategy, including all identified keywords and index terms, was then adapted for each included information source. Reference lists were screened for additional studies.

Following the searches, all identified citations were collated and uploaded into EndNote version 7 and duplicates removed. Titles and abstracts were initially screened by one reviewer for assessment against the inclusion criteria for the review (Table 2). Potentially relevant studies were then retrieved in full and assessed in detail against the inclusion criteria by two further reviewers.

Table 2: Abstract screening process

Process	**Decision**		
1. Does the paper examine mental health reform?	Yes – Go to 2	No – Exclude	Cannot Tell – Exclude
2. Does the study examine mental health reform in a developed country?	Yes – Go to 3	No – Exclude	Cannot Tell – Get full paper
3. Does the study examine the impact of mental health reform?	Yes – Include paper & Go to 4	No – Consider for Background or screen reference list	Cannot Tell – Get full paper
4. Does the paper describe an empirical research study or evaluation (including systematic reviews)?	Yes – Include Paper	No – Consider for Background or screen reference list	Cannot Tell – Exclude

Results

2835 articles were identified using the first search strategy (CINAHL only). Following refinement of the search terms, re-running of the search strategy (MEDLINE, PsychINFO), removal of duplicates and article screening, 232 papers were considered for inclusion with 58 included in the final synthesis. The results of the search are presented in a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram (Moher *et al.* 2009) (see Appendix 1).

Mental health frameworks

A review of frameworks

In the last decade or more several countries or regions / provinces of federated countries (like Australia) have embarked on significant reform of their mental health systems and services. As early as 2009 Adams, et al. (2009) were able to undertake a comparative study of 'mental health transformation' in six countries including Australia, Canada, United Kingdom (UK), New Zealand, Italy and the United States of America (USA).

Table 3 lists the mental health reform frameworks identified through this current review and formed the basis of analysis.

Table 3: Mental health frameworks reviewed

Jurisdiction	Mental health framework
Australia	*Contributing lives, thriving communities: National Review of Mental Health Programmes and Services*
Australia	*The Fifth National Mental Health and Suicide Prevention Plan*
New South Wales (NSW)	*Living Well – Strategic Plan for Mental Health in NSW*
Western Australia (WA)	*Mental Health 2020: Making it personal and everybody's business*
Queensland (QLD)	*Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023*
New Zealand	*Rising to the challenge: The Mental Health and Addiction Service Development Plan 2012–2017*
Canada	*Changing Directions, Changing Lives – Mental Health Strategy*
Scotland	*Mental Health Strategy 2017-2027*
England	*No health without mental health*

Common priorities and goals of mental health strategies

The governments associated with each of the frameworks listed in Table 3 have sought to develop strategies based on the needs of people, services and systems. Therefore, almost universally, the strategies were developed as a guide or 'blue print' for *how* change should occur and with a focus on key action areas or goals for *what* kind of change should occur.

Table 4 summarises the 'what' in terms of key priorities for each of the mental health reform frameworks included in the review. Similar to what Adams, et al. (2009) found almost a decade ago, several common priorities or goals were able to be identified across the

frameworks. The common priorities (in relative order of prevalence of inclusion in frameworks) were as follows:

- policies, systems, infrastructure
- integrated care
- prevention and early intervention
- equity and diversity
- workforce development
- improving physical health
- addressing social determinants
- suicide prevention
- First Nations people

A brief description of each of these priorities is provided in the following sections.

Prevention and early intervention

Across the strategies there was universal focus on reducing the incidence and prevalence of mental illness, as well as reducing the associated health, economic and social impacts.

The approaches to achieve this, however, are variable. For example, the Mental Health Strategy for Scotland had a strong focus on implementing early intervention and prevention strategies for young people through school-based support and education, supporting families through parenting programs and access to mental health services, and supporting children who have experienced trauma or are disabled to reduce the likelihood of experience mental illness. Several other frameworks similarly focus on the young, but some, including the Canadian framework, *Changing Directions, Changing Lives,* also put emphasis on promotion of wellbeing for the elderly through sustaining relationships and maintaining physical health, creating mentally healthy workplaces and supporting youth through later years of school.

Suicide prevention

Suicide prevention was a common key priority addressed across all of the reform strategies reviewed. However, some countries, such as Scotland and England, had opted to develop separate, more detailed, companion suicide prevention frameworks as has NSW (MHC NSW, 2018).

Specific actions for this priority were generally focussed on increasing community awareness and information and improving and strengthening emergency responses. Most frameworks also focussed on specific groups of people, populations and workforces known to be at a greater risk of suicide. For instance, the New Zealand framework, *Rising to the challenge*, emphasises services that target populations such as Māori and Pacific peoples, refugees and people with disabilities.

Table 4: Comparison of common priorities of mental health frameworks

Jurisdictions & MH frameworks / Common priorities & goals	Australia	Australia	NSW	WA	QLD	New Zealand	Canada	Scotland	England
	A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*
Prevention and early intervention			✓	✓	✓	✓	✓	✓	✓
Suicide prevention	✓	✓	✓	✓		✓	✓		
Integrated care	✓	✓	✓	✓	✓	✓	✓	✓	✓
Equity and diversity	✓	✓	✓	✓	✓	✓	✓		✓
First Nations people	✓	✓	✓	✓		✓	✓		
Improving physical health	✓	✓	✓		✓			✓	✓
Addressing social determinants			✓	✓	✓		✓		✓
Policies, systems, infrastructure	✓	✓	✓	✓	✓	✓	✓	✓	✓
Workforce development	✓	✓	✓	✓	✓	✓	✓		

Key to Table 4 mental health frameworks

A = Contributing lives, thriving communities: National Review of Mental Health Programmes and Services

B = The Fifth National Mental Health and Suicide Prevention Plan

C = Living Well – Strategic Plan for Mental Health in NSW

D = Mental Health 2020: Making it personal and everybody's business

E = Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023

F = Rising to the challenge: The Mental Health and Addiction Service Development Plan 2012–2017

G = Changing Directions, Changing Lives – Mental Health Strategy

H = Mental Health Strategy 2017-2027

I = No health without mental health

Integrated care

Integrated, or joined-up, care was embedded across all frameworks and identified as a key priority in all but one framework (England). This priority was typically focussed on better integration of services, sectors and governments to ensure accessible, timely and tailored care and support to improve mental health and physical health outcomes for people living with a mental illness.

Equity and diversity

A common priority was ensuring equitable access to mental health care and support and responding to the needs of diverse communities. This priority also typically focussed on acknowledging that some groups of people were at a higher risk of experiencing a mental illness and therefore often required tailored responses. LGBTI people (Lesbian, Gay, Bisexual, Transgender and Intersex), people with disabilities, culturally and linguistically diverse communities and refugees were all identified as specific groups across the frameworks more likely to experience stigma and discrimination.

First Nations people

Improving the mental outcomes of First Nations people was a common key priority for Australia, New Zealand and Canada. However, *Contributing lives, thriving communities* has given services to Aboriginal and Torres Strait Islanders greater prominence compared to *Living Well* (NSW), *Making it personal and everybody's business* (WA) and *Shifting Minds* (QLD) where it was embedded as part of broader priorities.

Across different frameworks, this priority typically recognised that First Nations people had distinct mental health needs in relation to their cultures but also due to experiences of racism, discrimination and ongoing impacts of colonisation.

Improving physical health

Improving the physical health of people living with a mental illness was addressed within each of the frameworks and was identified as a key priority in four of the frameworks.

In recognition that physical health was inextricably linked with mental health, this priority area was generally focussed on actions to improving physical health promotion and interventions in primary care, reducing the prevalence of chronic illnesses such as diabetes and rates of smoking, and to a lesser extent, alcohol and drug use.

Social determinants

Housing, employment and education were some of the social issues explicitly identified as key priority areas in five of the frameworks. Social determinants (" … *conditions in which people are born, grow, live, work and age*" WHO, 2016) were also referenced, to some extent, in all of the frameworks as critical issues that need to be addressed as part of mental health reform.

Such issues were discussed and understood as contributing to poor mental health outcomes that needed to be addressed alongside and as part of mental health services. Issues such as

housing and homelessness had greater prominence within the frameworks, such as in *Making it personal and everybody's business* (WA) where 'A good home' was listed as Action 3 of nine Actions. While Scotland's *Mental Health Strategy 2017-2027* did not include a specific strategy related to psychosocial issues, it is an example of a framework where such issues were embedded across the broad priorities such as working with business and increasing employment opportunities for people living with mental health was identified as one of 40 proposed actions (Action 36).

Policies, systems, infrastructure

A common priority area across all of the frameworks, this priority was typically focussed on the policies, legislation, governments systems and infrastructure that needed to be improved or developed to implement change and enable reform.

In several of the frameworks, for example the *Changing Directions, Changing Lives* (Canada) and *Making it personal and everybody's business* (WA), there was a greater emphasis on ensuring safety and quality of services through improving improved data collection, monitoring of services, and improved involvement and engagement with people living with a mental illness and their families. Improved use of technology to enhance information-sharing between providers or to increase online mental health services was also identified as an element of infrastructure in *Living Well* and *Contributing lives, thriving communities*, yet, in other frameworks technology was addressed within priorities related to integrated care or joined-up services.

Workforce development

In most of the frameworks, development of the workforce involved in the mental health service delivery was viewed as a key priority to enable systems changes and improving mental health outcomes. This priority was typically focussed on the need for workforce strategies to plan, develop and sustain the workforce through appropriate recruitment and training.

The role of peer workers or peer support was recognised across all of the frameworks and was only identified as a key action in *Living Well* (NSW), *Shifting Minds* (QLD), *Contributing lives, thriving communities* (Australia) and *Changing Directions, Changing Lives* (Canada) as a critical component of the workforce development and mental health reform.

Common elements of frameworks

There were also common elements identified across the mental health reform frameworks in terms of framework structure and the 'how' reform was to be approached (see a summary of the analysis in Table 5). The common elements were:

- vision
- values or principles
- context/background information
- Actions

Presence of the elements was assessed in terms of how well they were articulated and how well they aligned with the priorities or goals in the frameworks. A brief description of each of these elements is provided in the following sections.

Table 5: Comparison of common elements of mental health frameworks (See Table 4 for key to the mental health frameworks)

Jurisdictions & frameworks / Common elements	Australia	Australia	NSW	WA	QLD	New Zealand	Canada	Scotland	England
	A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*
Vision	✓	✓	✓	✓	✓	✓		✓	
Values or principles			✓	✓	✓				✓
Context/background information	✓	✓	✓	✓	✓	✓	✓	✓	✓
Actions	✓	✓	✓		✓	✓	✓	✓	

Vision

This element was an upfront, clear, and often short, statement that outlined the objective of the framework and ultimate goal for improving population mental health outcomes and system reform. In *Living Well* this element of the framework is somewhat 'buried' compared to other frameworks where the vision can be found at the beginning of the document.

Values or principles

Guiding values and principles that underpin the development of a framework was present and clearly articulated in the three of the frameworks including *Living Well*. As with the vision, this element was found at the beginning of the document to guide the readers' understanding and basis of the framework. Frameworks such as *Contributing lives, thriving communities* (Australia) did not include a specific set of values or principles but instead explicitly communicated and embedded across the document that a 'person-centred approach' was the primary intent underpinning the development of the framework.

Context/background information

The context and background information to the framework typically focussed on outlining the prevalence of mental illness, the history of service delivery and experiences of people and a rationale for change and reform. It was clearly articulated in most of the frameworks, but perhaps less clearly identifiable in *Living Well*.

Actions

A set of actions within each of the key priorities was a common feature identified in most of the frameworks. The actions specify how the broader priority would be achieved and, in some cases, identified the specific roles and responsibilities of the priority. Where present, the actions were clearly aligned within the priority in the frameworks. A useful example of well aligned actions and priorities can be found in *Contributing lives, thriving communities* (Australia).

Implementation of frameworks

Implementation science

Damschroder and Hagedorn (2011) argue that attention to implementation requires the same level of effort as that devoted to developing evidence-based practice. They argue that failure to do so can lead to poor or incomplete implementation of an evidence-based intervention and may result in:

> *"… (a) too little or too much of the core elements of the intervention being used; (b) nonstandard or variable use of the intervention across patients, providers, or settings; or (c) use of the wrong intervention altogether."*

All of these issues, they argue, can contribute to a low rate of translation of evidence-based interventions into routine use. Fleury et al. (2017) highlight a similar theme:

> *"Reform implementation represents a critical transitional period between the planning stages of system transformation and integration of reforms by service managers and providers. Research … suggests that nearly two-thirds of reforms fail during this implementation period."*

In the implementation of the mental health reform frameworks across many countries highlighted earlier, there was limited evidence of framework developers and policy makers giving sufficient attention to the implementation process and, more specifically, to the 'rules' of implementation science (Torrey, et al., 2012; see pages 20 and21 below). On the contrary, the frameworks seem mostly to have been developed as broad guidelines from which elements of the mental health system can then adopt (or not) according to the local/regional and service philosophy contextual situation. This approach often represents a pragmatic response to the complex and, sometimes, conflicting array of interests and power relationships between central and provincial governments (Naylor, 1999).

Yet, for some frameworks this approach appears to have delivered some level of success (Mulvale, et al., 2015). For example, the implementation of a national youth mental health framework in a Canadian province, the framework being described as … "*a non-prescriptive document that contains all of the ingredients for governments to consider …*", was assessed by Mulvale et al. as a helpful resource that kick-started the process of conceptualising a provincial intervention. The national framework helped busy policy makers to move quickly through the process and focus on local issues, potentially saving time and resources. More importantly, the national framework was (Mulvale, et al., 2015):

> *" …. a neutral point of reference in a jurisdiction where differing clinical and philosophical approaches to improving child and youth mental health had previously made it difficult to find common ground."*

This positive outcome, however, is not universal. Bartram and Lurie (2017) describe another national mental health reform framework where provincial level implementation was affected by conflict between administrations at the centre, and periphery, reducing the total level of funding available to support implementation.

Implementation problems

When the key principles of implementation science to design, launch and administer mental health frameworks are not adopted a range of common problems can arise:

- Significantly lower levels of consumer and carer participation in service planning and delivery than was expected (Groom, et al., 2003). Individual and systemic barriers exist to genuine participation of consumers and carers in the development, delivery and evaluation of public mental health services, of which Gee et al. (2016) suggest the systemic barriers are more difficult to overcome. These include lack of awareness, limited participation opportunities, slow progress for change, policy issues and mental health culture including stigma. The systemic barriers are grounded in the fundamental 'social covenants' under which mental health has historically functioned and can only be addressed by a profound shift in mental health profession assumptions (Gee et al., 2016).
- The mental health workforce can represent a broader challenge to change (Fleury, et al., 2017), sometimes as a shift in power distribution is resisted (Proctor, et al., 2016) and at other times because of poor competence in the new forms of delivery (Te Pou o te Whakaaro Nui & Ministry of Health, 2018). For example, reforms in the UK intended to 'soften' the boundaries between professions working within multidisciplinary community mental health teams, involved the creation of new support worker roles and some re-distribution of the workload of psychiatrists within the teams. This reform tended only to create isolated support workers with no real reduction in the psychiatrist workload (Proctor, et al., 2016). Proctor, et al. (2016) conclude:

  > *"There is no evidence of the teams' being seen as the site of a more egalitarian form of inter-professional working … let alone of the emergence of a 'universal practitioner' or 'generic worker'.*

  While the above outcome was attributed largely to entrenched ways of organising work, other workforce issues can be attributed to competence. Piat and Sabetti (2009) note that a key element in mental health reforms, a recovery orientation, can be undermined by mental health practitioners and primary health care workers who do not have a sufficient understanding of the concept.

- Imprecise use of key concepts that underpin and drive the direction of mental health reform. As noted in an earlier section, two key concepts, arguably the most critical, driving reform have been the concept of 'community' and the concept of 'recovery'. Frederick, et al. (2017) note that the term community is ubiquitous in current mental health literature but especially in mental health reform frameworks (noting the term is used over 200 times in each of Canada's 2009 and 2012 national mental health frameworks). Yet the concept "*… often goes undefined and retains its 1960s image as a vaguely conceived place of promise outside the institution that offers belonging and inclusion for all those who live there.*"

  Frederick, et al. (2017) argue:

  > *"… that mental health policy, research, and practice should move away from the term community in favour of a framework that addresses basic needs, disability justice, intersecting social identities, and the structural forces that impact the lives*

of people with psychiatric disabilities as they "recover" in settings outside of hospital."

The concept of 'recovery' is also prominent and frequently coupled with conceptions of community wherein 'the community' is conceptualised as the primary place where patients recover. Piat and Sabetti (2009) dissect the origin of the concept and note that it takes on slightly different meanings in different mental health reform framework documents with considerable tension between consumer definitions of recovery and those of clinicians. The definition adopted can have far reaching impact on implementation, especially if it remains ill-defined and, therefore, unable to be measured.

- Another related conceptual problem occurs with the simplification of equity goals. Cook et al. (2017) note that conventional approaches to addressing diversity in policy analysis often start with one identity category or equity 'strand', such as race, to which others are then added. This assumes that people in these categories have a uniform set of experiences that can then be brought together simplistically to understand differences. Using the policy of self-directed care in mental health reform (e.g. the NDIS in Australia) as a basis for analysis, Cook et al. illustrated how an intersectional or multistrand approach reveals unintended areas of inequity resulting from a policy that on face value appears equity neutral. They argued the need for a multistrand analysis and policy approach.

In an ex-ante evaluation of the Belgian mental health reform framework, Nicaise, et al. (2014) identified three major threats to the effectiveness of the reform:

- issues concerning the relationship between integrated care network structures and purpose
- the continued influence of hospitals despite the goal of shifting the service balance towards community care
- the heterogeneity in the actual implementation of the new reform agenda.

What enables and facilitates implementation

Successful implementation involves specific activities affected by a multitude of factors ranging from characteristics of the reform itself, to organisational, environmental, and individual features. A body of work has evolved in recent years that identifies the circumstances under which implementation is likely to be most successful and have the highest 'fidelity' to the design requirements of the intervention (Torrey, et al.., 20112; Ibrahim and Sidani, 2015).

This literature suggests that multifaceted interventions, such as has been attempted with mental health reform frameworks in several countries, present a particular implementation challenge (Fleury et al., 2017):

"Innovation is easier to implement when core components are well-known and defined …[and] … fares better with simple, specific interventions rather than complex and lengthy interventions requiring major change at the organizational or practice levels."

Other factors at play include the political, economic, social and cultural context, as well as health system characteristics (Damschroder & Hagedorn, 2011). Fleury, et al. (2017) focus on the organisation-level aspects that need to be addressed to enable implementation success including:

- leadership
- financial and human resources
- staff retention
- receptivity to change
- experience with inter-organisational collaboration.

Fleury, et al.'s (2017) major study involved collection of qualitative and quantitative data on five projects that were attempting to implement evidence-based mental health practice to assess the importance of different organisational aspects. They concluded:

> *"Site leadership and effort focused on workflow and practice reinforcement were linked consistently to successful implementation … Although training is widely assumed to be a key strategy in promoting implementation, its impact on fidelity is at best uncertain, and training at the expense of other implementation activities appears to be counterproductive. We recommend that sites devote strong leaders to implementation efforts. These leaders should focus on redesigning the flow of work to support the implementation and on reinforcing program improvements though fidelity and outcome monitoring and feedback."*

Looking more broadly at the 'framework' level Damschroder and Hagedorn (2011) offer three pieces of advice to promote wider implementation of evidence-based practices:

- differentiation of core versus adaptable components of evidence-based interventions
- development of methods to design implementation strategies, effectively adapted to the broad context
- design and testing of predictive models to assess likelihood of effective implementation and prospects for sustainability while taking into account salient contextual factors.

They offer a recommended strategy for accomplishing the adoption of this advice which includes using appropriate tools for qualitative (e.g. CFIR) or quantitative (e.g. ORCA) assessment of implementation progress, selection of the intervention based on best available evidence, identifying 'core' vs 'adaptable' intervention components and tailoring implementation activities to the site.

In specific regard to the assessment process, Damschroder., et al. (2009) constructed the Consolidated Framework for Implementation Research (CFIR) which has been widely tested as a means to assess implementation progress (e.g. Ament, et al., 2012) of health service interventions. The CFIR is composed of five major domains: intervention characteristics (e.g. evidence strength and quality), outer setting (e.g. patient needs and resources), inner setting (e.g. culture, leadership engagement), characteristics of the individuals involved (e.g. beliefs

about the intervention), and the process of implementation (e.g. plan, evaluate, and reflect). A summary of all the components of the CFIR taken from Ament, et al. (2012) is provided in Figure 1.

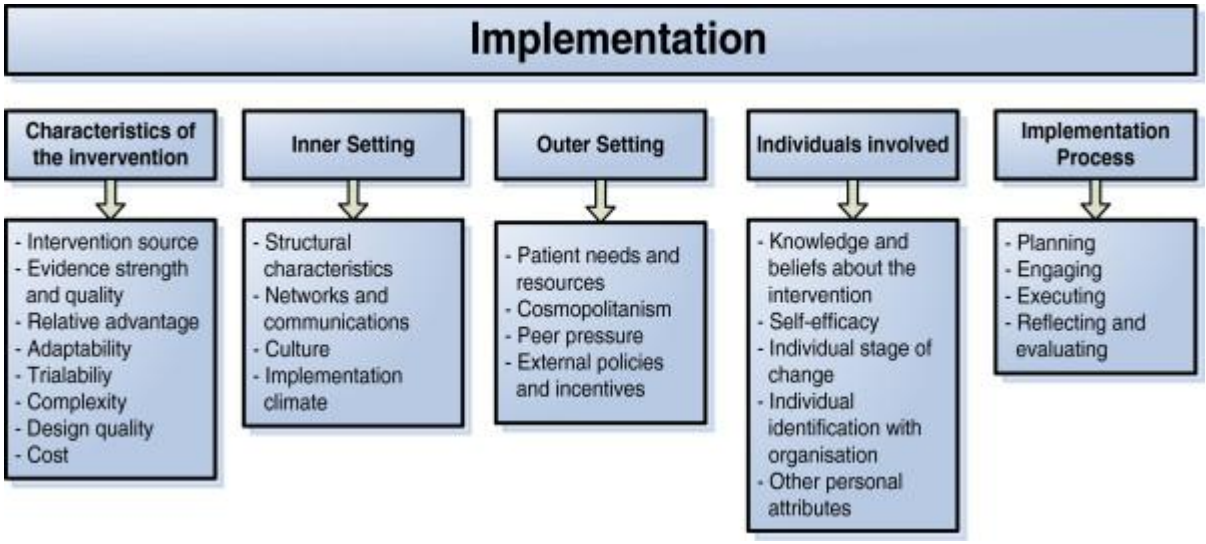

Figure 1: Summary of CFIR taken from Ament, et al. (2012)

Evaluation of the outcomes of frameworks

Dearth of evaluation effort

A number of authors have lamented the limited number of evaluations of the many mental health reforms around the world that have been initiated (e.g. Damschroder & Hagedorn, 2011; Fleury, et al.., 2017) while acknowledging the difficulty of the task in terms of complexity of the interventions (Nutbeam and Milat, 2017), data (NMHC, 2019) and method challenges (Park, et al., 2014). Some authors argue too that the timeframe for observing outcomes from such a fundamental change in direction, where implementation will take many years, is likely to be very long – much longer than the time so far afforded the many reform efforts. As one observer noted (NMHC, 2019):

> *"These [mental health] reforms are ambitious in their scope. They are also interrelated which adds to the complexity of their implementation, and it will take time before their implementation leads to sustained change for consumers and carers."*

An analysis of the many mental health reform frameworks however, indicates that monitoring and evaluation is rarely made a focus or priority of the framework – a possible contributor to the evaluation effort deficit. In Table 6 an attempt to gauge the importance of evaluation and monitoring was made by counting the number of times those words (or derivatives) were used in the key framework document and whether a specific evaluation strategy was built into the framework's implementation. As an example, *Living Well*, mentions either evaluation or a form of the word monitoring a total of 33 times, whereas the terms 'community' or 'communities' are mentioned 533 times and 'recovery' 90 times. As well, the focus on knowledge formation and exchange while mentioning the NSW Government's broader Evaluation Framework, goes on to emphasise the development of evidence-based practice, which might not require evaluation of the Framework or Framework elements[1].

Table 6: Analysis of mental health reform frameworks' focus on evaluation

Mental health reform framework	Number of times words used in the framework		Evaluation / monitoring strategy
	Evaluation	Monitor / monitoring	
Living Well – Strategic Plan for Mental Health (NSW)	19	14	Inclusion of a 'research and knowledge exchange' that is not specific to evaluating Framework interventions

[1] While not a strong focus of *Living Well*, under the Mental Health Commission Act, the Commission is required to "*… monitor and report on the implementation of Living Well: A Strategic Plan for Mental Health in NSW 2014-2024, and also to review and evaluate services and programs provided to people who have a mental illness".* There is also a major mid-term review currently under way of the *Living Well* framework. As well, it has been noted that other parts of Government, other than the Commission, are undertaking specific program evaluations although these are not of the total Framework.

Mental health reform framework	Number of times words used in the framework		Evaluation / monitoring strategy
	Evaluation	Monitor / monitoring	
Mental Health 2020: Making it personal and everybody's business (WA)	2	6	No evaluation strategy
Rising to the challenge (NZ)	8	36	A strategy section that specifically addresses monitoring implementation
Changing Directions, Changing Lives (Canada)	-	-	A number of performance indicators provided but without a clear strategy of how or when to undertake measurement
Mental Health Strategy 2017-2027 (Scotland)	4	5	No evaluation strategy
No health without mental health (England)	7	13	No specific evaluation strategy focus

The stand out framework in Table 6 is that of New Zealand, which has a strong commitment embodied in the framework to monitoring of implementation. While less obviously committed to outcomes evaluation, each one of the six reform framework strategies in the '*Rising to the challenge. The Mental Health and Addiction Service Development Plan 2012–2017*' is accompanied by a suggested means by which implementation progress can be assessed. The framework also makes a longer-term commitment to develop more precise key performance indicators (KPIs).

One framework though not included in Table 6 is the more obvious exception to the rule of low prioritisation of evaluation effort. The National Mental Health Commission's '*Contributing Lives, Thriving Communities*' reform framework (NMHC, 2014) devotes one of nine strategies to implementing national targets and local performance measures. Within this strategy the framework attempts to outline a vision of what success will look like and outlines a set of eight national targets that include improved prevention and early intervention, better physical health of persons with a mental illness, more meaningful lives, better experiences of care and reduced suicides. More importantly, progress of the framework implementation has been monitored annually since 2016 through a series of 'National Reports' (e.g. NMHC, 2019). These reports, while more descriptive than quantitative, and more formative than summative in their evaluation intent, nevertheless maintain a focus on at least progress in administrative reforms.

The reports acknowledge persistent data deficiencies (e.g. NMHC, 2019):

> *" .... there are gaps in the available national mental health services data collections. These gaps limit the ability of governments and mental health service providers to compare the existing level and mix of mental health services with the optimal level recommended by planning tools."*

Some of the more ambitious reform agenda represent also the most challenging aspects of change to measure (NMHC, 2019):

> *"Improving social inclusion and meaning in life for consumers is a key priority of all governments. Currently there is no data available to report on progress towards achieving outcomes in these areas."*

Findings from the evaluation research

Not only has there been an underwhelming level of framework evaluations, but also the quality and rigour of those evaluations undertaken has been modest. Research evaluations have tended to be qualitative in nature (based on opinions or perceptions of key stakeholders) or focused on specific strategies within frameworks rather than the entire framework (suite of strategies).

An example of the former is the annual 'report cards' of the National Mental Health Commission monitoring the progress of the Australian mental health reform framework. These reports, starting in 2016 (NMHC, 2017) and published each year with the latest in 2019 (NMHC, 2019) are based largely on expert observations and document review with some descriptive data analysis where access to relevant data is possible.

For example, the 2019 annual report card noted a deterioration in the number of people who died by suicide (based on available statistics), reported on government funding of specific policies in support of the reform framework, identified progress in data collection processes and described key infrastructure reforms, specifically the channelling of mental health funds through Primary Health Networks (PHN) and the implementation of the National Disability Insurance Scheme (NDIS). Both these reforms were noted by Hickie (2017) as sources of risk to reform success; the PHNs because of an unclear capacity to support the complex and large challenge presented to them, and the NDIS because of the potential for their actions to be uncoordinated with other parts of the mental health system.

Another slightly different example of a qualitative approach is that of Nicaise, et al. (2014) who undertook a content analysis of the Belgian policy blueprint for the mental health reform to perform an ex-ante evaluation of the framework's plan of operation, based on the current knowledge of mental health service networks. They found that it was unclear how the framework could achieve its goals since the two main policy priorities, seeking a better balance between hospital and community care and integration of care, would require different network structures, and different modes of governance, and that mechanisms for change were not sufficiently detailed.

An example of the latter approach is the research proposal by Park, et al. (2014) and the retrospective study by Fleury, et al. (2017) looking at specific aspects of Canadian mental health reform; recovery-oriented services and network integration respectively. The Fleury, et al. study of the development and implementation of integrated mental health service

networks in Quebec is instructive, as it was based on the collection of a large amount of qualitative data through interviews of service managers (n=90), psychiatrists (n=6) and 'network stakeholders' (n=102). They found that networks were in various processes of development and expansion, but none displayed full integration. They also identified an underestimation of the importance of operational mechanisms such as clinical evaluation tools and best-practice guidelines in implementing mental health reform as the main barrier to network integration. Other factors hindering network integration included the persistence of a strong hospital-centrism in some networks, resistance to change, and fears among some organisations of losing their autonomy.

An exception to the piecemeal approach to mental health reform evaluation is that of Lorant, et al. (2019) who attempted to assess the outcome of the Belgian national mental health reform. They focused on the four main areas of targeted reform; a strengthening of community care capacity, improved continuity of care, reduced use of acute care facilities and support for social integration. The research method involved collection of data from patients (n=1250) in 19 'networks' that had been established by the reform (the treatment group) and from patients (n=150) in non-reform networks (the control group). Lorant, et al. (2019) found:

> *" … patients who had been more exposed to the reform policy had a slightly [statistically significant] better perception of continuity of care. The rate of hospitalization was not affected by overall exposure to the reform, though it was lower [not statistically significant] … for patients recruited from the commissioned networks than for those from the control areas. Similarly, social integration was not affected by the reform process …"*

Another exception is the work of Almeda, et al. (2017), who attempted to assess the overall effect of the introduction of a mental health reform framework in the Basque Country of Spain. They chose a little used economic measure, the Relative Technical Efficiency (RTE), which attempts to assess the relative (between different intervention regions) effectiveness of the use of set inputs to produce an output. They modified the RTE method somewhat with some assisted decision-making and an attempt to allow for some level of uncertainty. They found some positive impact of the framework but overall:

> *"… higher global RTE in the output-oriented orientation than in the input-oriented one. This suggests that a decision strategy based on improving the input management … could be appropriate."*

Almeda, et al. (2017) were advocating for greater attention to implementation effort to obtain greater efficiency in input utilisation. In another paper (Almeda, et al., 2019) the RTE method was advocated more broadly for analysing mental health services and systems performance.

While not specifically focussed on a mental health reform intervention, Thomas, et al. (2018) attempted to assess the impact of the introduction of the Affordable Care Act (ACA) in the USA on mental health outcomes. They analysed the results from the Health Reform Monitoring Survey[2] of a pre-ACA (2013) sample of persons with a mental illness and a post-

[2] The Health Reform Monitoring Survey is a survey of the nonelderly in the USA that began in 2013 as part of establishing the ACA. It is conducted by the Urban Institute Health Policy Centre.

ACA (2016) sample of persons with a mental illness (both samples approximately 1,500 in size). Post-ACA reforms, people with mental health conditions were significantly less likely to be uninsured and to report unmet need due to cost of mental health care and they were significantly more likely to report a usual source of care.

Performance indicators and accountability

Indicators

Many observers of mental health reforms around the world have noted either the absence of performance indicators, the poor form of expression of indicators (in ways that are not objective or amenable to measurement) or the lack of data appropriate to indicator measurement, all of which precludes applying accountability for implementation and outcomes (Piat and Sabetti, 2009; Fleury, et al.., 2017; Bartram and Lurie, 2017; Rosenberg and Salvador-Carulla, 2017). Hickie (2017) expresses great concern in Australia about:

> *" … our lack of national investment in measuring (quantitatively and qualitatively) the impact of mental health programs on genuine health, social and economic outcomes … Urgently, we need to adopt and support a more systematic outcomes-based framework … Without such focus and designated investment, we run the great risk that, once again, we will invest our money and hopes in theoretical structures that do not deliver real-world improvements in access to high-quality care or effective suicide prevention."*

This is not to say that mental health reform frameworks do not have any performance indicators for the reforms being advocated. The performance indicators from a selection of mental health reform frameworks, those that have best articulated the desired outcomes, are shown in Table 7.

Table 7: Summary overview of performance indicators from selected Australian and National mental health reform frameworks

Mental health reform performance indicator	Selected frameworks (see key below table)					
	A	B	C	D	E	F
Reduce proportion of children developmentally vulnerable						
Decrease prevalence of anxiety, aggression and hyper-activity in 5-year olds, early intervention						
Reduce smoking rates of persons with a mental illness						
Increase physical health checks for persons with mental illness and physical health outcomes						
Increase number of consumers in safe and adequate housing						
Reduce rate of young persons and adults not in employment or training						

Mental health reform performance indicator	Selected frameworks (see key below table)					
	A	B	C	D	E	F
Improve employment rate of adults with a mental illness						
Increase psychological health and safety standards in workplaces						
Increase access of persons with mental illness to required supports						
Improve consumer experience with services and confidence that services are safe and high quality						
Reduce suicide and attempted suicide						
Increase percentage of people who report positive mental health and well being						
Decrease number of people with mental illness who feel discriminated or stigmatised						
Increase sense of community belonging and inclusion, stronger social relationships						
Decrease hospital readmission rates within specified period						
Increase proportion of First Nation people with mental illness accessing services						
Using current / existing resources more effectively						
Increased integration between acute and primary mental health care and balance across sectors						
Improve outcomes of adults with high prevalence mental health disorders						
Decrease seclusion within mental health inpatient settings						
Increased protection of human rights						
Increased participation by people with a mental illness in service planning and design						
Increased safety and support at times of crisis and highest risk						
Increased prevention in schools, workplaces and communities						

Key to frameworks

A = Contributing lives (Australia)
B = Changing Directions, Changing Lives (Canada)
C = Rising to the challenge (NZ)
D = No Health Without Mental Health (England)
E = Living Well (NSW)
F = Shifting Minds (QLD)

Note that in Table 7 only performance indicators explicitly stated in the framework have been included. This means, while a framework may mention the importance of a particular issue (e.g. the experience of mental health consumers and their carers with mental health services) and even suggest specific related strategies, it may still not include a relevant performance indicator. It may also mean that specific indicators were not mentioned because data is already being collected through an existing process.

The indicators that emerge most prominently across the frameworks from Table 7 are:

- increased physical health and life expectancy of persons with a mental illness
- improved access to aspects of a meaningful life including safe housing, education and employment
- increased access of persons with mental illness to required supports and an increase in the percentage of people who report positive mental health and well being
- increased sense of inclusion in the community with stronger social relationships.

Some aspects of mental health reforms that are most often identified as key to reform though, such as a recovery orientation to services, participation of consumers and carers in service planning, design and evaluation, integration between service levels but particularly between acute and primary care levels, and shifting of resources from inpatient care to community based care are not as prominent, a point noticed elsewhere (Fleury, et al.., 2017; Piat & Sabetti, 2009; NMHC, 2019).

Aside from the frameworks noted above, there are many other sources of mental health system performance indicators both in Australia (e.g. the *National Mental Health Performance Framework*[3], see Brown and Pirkis, 2009) and overseas. In addition there are performance indicators for the social determinants of wellbeing based on the NSW Human Services Outcomes Framework that identify indicators for seven domains including for social and community, education, empowerment, safety, housing, economic and health (FACS Analysis and Research, 2017).

Rosenberg, et al. (2015) indeed argue that the number of indicators is both overwhelming and yet still inadequate because the indicators fail to support understanding of the situation at the regional level and progress in reform at the macro level. They propose a concise set of 12 indicators across three domains (health, social and system reform), consistent with the core value of the National Mental Health Commission framework — the right to lead a

[3] Recently superseded by the *National Mental Health Performance Framework 2020*

contributing life. The indicators they claim emphasise factors that can drive reform, rather than outcomes that are likely to reflect more complex determinants, acting over longer time frames. The indicators are detailed in Table 8, and mirror to some extent the list of prominent indicators extracted from Table 7.

Table 8: Mental health reform performance indicators proposed by Rosenberg et al. (2015)

Death rates < 3 and < 12 months after discharge from any mental health facility, including cause of death
Proportion of the population receiving mental health care services — both among the general population and, specifically, the population aged 12 to 25 years
Participation rates by people with a mental illness of working age in employment
Participation rates by people with mental illness aged 16 to 30 years in education and training
People with a mental illness reporting they have stable housing
Community surveys of attitudes towards mental illness (to understand prevailing community and business attitudes and stigma towards mental illness)
Consumer and carer experience of care
Readmission rates to hospital or re-presentation to emergency departments within 28 days after discharge
Life expectancy for people with severe and persistent mental illness
Number of people accessing specialised programs to enhance economic and social recovery (through currently unmonitored community service organisations)

Measurement and accountability

Independent of the number and nature of performance indicators, many observers of mental health reforms have lamented the failure to measure performance in any way that would allow the holding of service providers, at provincial, regional or local levels, to account for reform progress (Brown and Pirkis, 2009; Bartram and Lurie, 2017; Rosenberg and Salvador-Carulla, 2017). While acknowledging that some of the blame for this resides in the poor choice of indicators (Rosenberg, et al.., 2015), the larger fault is thought to exist in the data collected. Rosenberg and Salvador-Carulla (2017) argue:

> *"Existing data focuses on administrative and health service indicators, failing to reflect broader social factors which reveal quality of life. In spite of twenty years of investment and effort [in mental health reform] Australia has been described as outcome blind, unable to demonstrate the merit of [funds] spent on mental health annually."*

The use of the term 'outcome blind' is particularly strong, but they assert that existing systems of accountability are not fit for purpose and cannot drive reform change and service quality improvement.

Brown and Pirkis (2009) are more accepting of the challenge posed by the scope of data required to assess mental health reform ambitions, but still point to data concerns that remain relevant almost a decade later (Rosenberg, et al., 2017). These concerns include limitations on comparing outcomes across care settings where level of complexity or casemix varies and has not been properly taken into account, continued observation of consumer experiences in fragmented settings rather than being tracked across (acute and community) settings, and a failure to measure outcomes that "… *reflect the aspects of care considered most beneficial for recovery by consumers*." They note that few indicators of recovery are in routine use, nor was there a satisfactory means of measuring consumer and carer experience of mental health care.

In this regard the latest NMHC report card (NMHC, 2019) noted two key data collections (1) the *Your Experience of Service* (YES) survey which allows consumers to identify areas of service where improvements can be made and (2) the *Living in the Community Questionnaire* which can be administered to consumers during occasions of service and provides insight to social inclusion and meaning in life. Neither of these two important ways of measuring key outcomes have yet to be uniformly adopted, although the YES survey was completed in 2017/18 by a total of 24,000 consumers - 15,123 hospital (inpatient) consumers and 7,800 community consumers (inform, 2018).

The measurement and accountability challenges being encountered in Australia are by no means isolated and are common to many other countries attempting to implement mental health reforms (e.g. Bartram and Lurie, 2017; Lorant, et al., 2019; Almeda, et al., 2019).

Conclusion

The review revealed there is a high level of agreement around a relatively small number of common reform priorities found across eight reviewed mental health reform frameworks currently being implemented in Australia and several other countries. A review of the performance indicators of these same frameworks largely confirmed the common reform priorities were:

- improving physical health and life expectancy of persons with a mental illness
- improving access to aspects of a meaningful life including safe housing, education and employment
- increasing access of persons with mental illness to required supports through integrated care
- improving equity and diversity outcomes, especially for First Nations people
- increasing the sense of inclusion in the community with stronger social relationships.

These reform priorities could form the basis of what Damschroder and Hagedorn (2011) describe as 'core' components of a reform or intervention:

> *"Many interventions are complex and can be conceptualised as being composed of core essential components that cannot be altered without harming integrity and adaptable components that can be altered to fit organizational context [without compromising intervention outcomes]"*

A focus on fewer 'core' elements can potentially simplify implementation so that the reform then is more likely to be achieved with reasonable levels of fidelity with the framework. A focus on core elements need not preclude a service system, or even individual services, adopting additional non-core framework components.

This review has confirmed that evaluation research on the frameworks reviewed has so far been limited in terms of the number of evaluations undertaken and the method ambition (that is level of rigour). The limited level of research effort, so far, can be explained in terms of: (1) the significant challenge that evaluating such complex interventions presents, (2) the comparatively early stages of implementation and (3) the deficit of key data collections.

It is evident that greater advocacy on the need for evaluation and especially monitoring is required to reinforce accountability and continuous quality improvement mechanisms. Some believe this is the natural role for mental health commissions (Rosenberg and Rosen, 2012). A focus on the 'core' reform elements noted above for the development of performance indicators and measurement tools, would make the data collection process more manageable and the monitoring process more feasible. This would make the chances of what Rosenberg and Salvador-Carulla (2017) call 'outcome blindness' that they claim prevails in the current system of mental health services accountability can be diminished if not eliminated.

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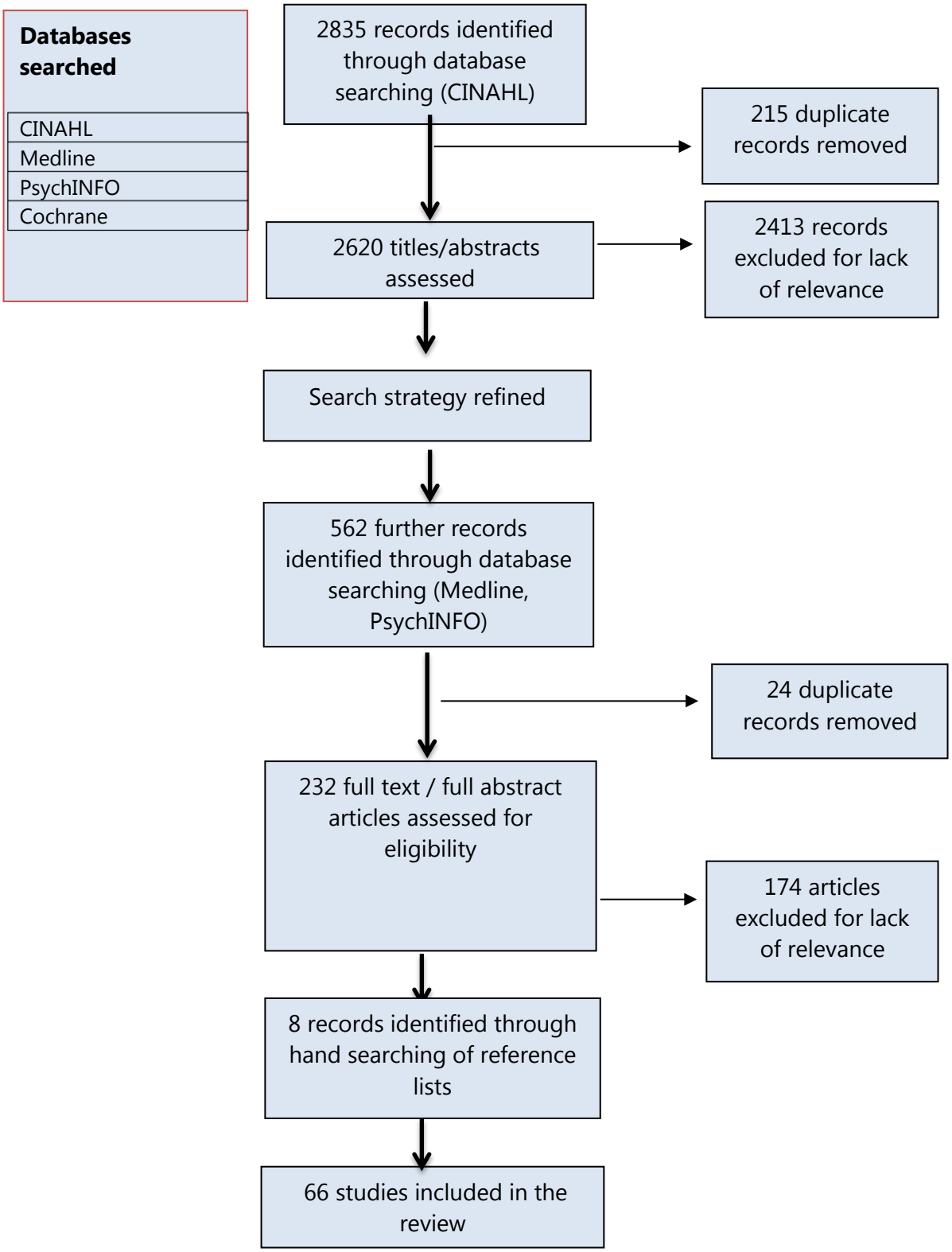
Appendix 1: Search results presented in a PRISMA format



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