

Knowledge of and attitudes to the health outcomes approach among community mental health professionals

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Abstract

A focus on health outcomes has significant potential for increasing health gain if adopted by health care staff as part of their professional practice. Understanding health care staff attitudes and receptiveness towards health outcomes may facilitate uptake of this workplace innovation. Community mental health clinicians (n = 101) were sent a questionnaire assessing their knowledge of and attitudes to the health outcomes approach, their expectations as to its likely impact on them, as well as features of their workplace in general. Analysis of the 65 returned questionnaires identified some pessimism about what focusing on health outcomes would achieve for community mental health clinicians or their clients. Training in practical applications of health outcomes measures, involvement in and ownership of health outcomes projects and recognition of health outcomes achievements would facilitate adoption of a health outcomes approach by community mental health clinicians.

The health outcomes approach

The last two decades have seen considerable change in the Australian health care system, and there appears little likelihood that 'change' will stop. One of the more significant changes has been the shifting emphasis towards health improvement or outcomes resulting from health interventions. Key milestones in health outcomes policy development have previously been reviewed (Rissel, Ward & Sainsbury 1996).

Defined by the Australian Health Ministers as 'a change in the health of an individual, a group of people or population, which is attributable to an intervention or series of interventions' (Australian Health Ministers Advisory Council 1993), health outcomes (and specific goals and targets to improve population and clinical outcomes) have been endorsed nationally (Department of Human Services and Health 1994). The New South Wales Health Department has specified goals and targets in four major priority areas of cancer (NSW Cancer Expert Working Group 1995), cardiovascular disease (NSW Coronary Heart Disease Goals and Targets Working Group 1995), injury (NSW Injury Expert Working Panel 1995) and mental health (NSW Mental Health Expert Party 1995).

The inclusion of mental health as a priority area recognises the need to focus more effort on mental health issues. The 1988 National Mental Health Strategy (Department of Human Services and Health 1988) provided the first nationwide approach to mental health service delivery. The current revision of this strategy endorses a focus on health outcomes (Department of Human Services and Health 1994). An Australian Health Ministers' Advisory Council report (1993) sets out 38 objectives appropriate to national mental health policy. Among these is:

To institute regular reviews of outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery. (Objective 30)

For national, State and Territory mental health outcomes policies to achieve improvements in health outcomes, local service providers need to implement programs consistent with these policies and a 'health outcomes approach' should assist this process. The NSW Mental Health Expert Working Party (1995) has identified a number of mental health indicators, including suicide rates, prevalence of psychiatric conditions, and leisure and employment prospects of people with a psychiatric diagnosis. Within the Central Sydney Area Health Service, the Needs Assessment and Health Outcomes Unit has been established to support health services in a systematic approach to health outcomes in priority areas, including mental health. Mental health indicators have been used to compare population health outcomes in Central Sydney with those of New South Wales overall (Rissel et al. 1996a) and for the five largest non-English-speaking language groups in Central Sydney with those of Central Sydney residents born in Australia (Rissel et al. 1996b).

Recently, the Needs Assessment and Health Outcomes Unit has completed a pilot study to assess the feasibility of routine outcomes assessment in community mental health centres (Osborne, Ward & Hance 1996). This study found that

community mental health staff gave a low priority to their participation in the study, despite its relevance to future service development. This raises questions regarding the attitudes of mental health staff towards measuring and applying health outcomes. It also suggests the possibility that the implementation of a health outcomes approach could be hampered by a reluctance of clinical staff to participate. To our knowledge, no Australian research has systematically examined how mental health staff view health outcomes.

Community mental health staff

Background policy developments

Mental health services within New South Wales (and elsewhere) over the last 30 years have experienced sweeping policy changes and a search for new directions. This was preceded by a period of relative stagnation during which mental health care was mainly provided in institutions. While capable of embracing medical innovations, the institutions proved highly resistant to ideological change in relation to community-based services. Inpatient populations increased throughout this period at a greater rate than the population of the State. Accounts of this earlier history are given by Garton (1988) and Lewis (1988).

Occupancy of psychiatric hospitals fell dramatically from 1963 in response to treatment innovations, a growing civil liberties movement, and the need to contain the costs of the ever-expanding institutions. This occurred in the context of a medico-legal system which regarded the discharged patients as having been pronounced 'cured'. Although no cure exists for most of the illnesses which lead to psychiatric hospital admission, the concept of providing alternative care in the community for these patients was slow to be adopted. The result was high readmission rates, with many individuals cycling between hospital and community. Individual hospitals responded with domiciliary nursing services, but it was not until the introduction of the community health program in 1973 that publicly funded mental health professionals were based in the community. Even this measure, whatever else it may have achieved, failed to reduce readmission rates (NSW Department of Health 1983).

Following a review of mental health services (NSW Department of Health 1983), two further components were added to the provision of community mental health services. Living skills centres provided day programs intended to teach self-care skills to those who had lost them through dependence on psychiatric hospitals. Crisis teams aimed to provide treatment at home as an

alternative to readmission in the event of exacerbation. The crisis teams also focused community health centre staff efforts on clients with severe and chronic mental illnesses and those who were most at risk of readmission. Community mental health staff were required to compete with hospital services for resources, making community mental health services as a whole vulnerable to budget cutbacks. The new services proved effective in reducing readmission rates (Hoult, Rosen & Reynold 1984) but could hardly overcome ideological resistance to community-based services and high readmission rates created by 30 years of inadequate community follow-up.

High readmission rates, hitherto largely unnoticed by the general public, were used by opponents of the new changes (principally, the NSW Nurses' Association and the Public Service Association) as evidence of the failure of community-based mental health services. Subsequently, Barclay's 1988 report made the (to some, surprising) recommendation that the problems besetting mental health care be addressed, not by expanding community care, but by providing more hospital beds (NSW Department of Health 1988). By 1993 a Human Rights Inquiry went as far as to describe the transition of hospital care to community-based care as a 'national disgrace', chiefly because resources saved through closing beds or wards were not put into community mental health services (Burdekin 1993).

As a result of this history, today's community mental health workers face three distinctive problems. First, the expectations and demands upon them are high, with no prospect of relief. Second, the definition of their mission and roles has become blurred by shifting policy. Third, there is a tendency for community mental health staff to see themselves as scapegoats for long-standing problems which are endemic to the whole of the mental health system.

Job satisfaction

There is a substantial North American literature specifically concerned with community mental health workers' attitudes to their work (although, unfortunately, there is no Australian literature). This literature focuses on job satisfaction and has emerged as a result of a recognition that low job satisfaction is a prominent problem for this group of workers (House 1989; Newsome & Pillari 1991; Boyer 1993; Katz-Epstein 1993; Ben-Dror 1994). It is a problem implicitly acknowledged in the National Mental Health Strategy, which emphasises the need to 'attract and retain sufficient numbers of skilled, experienced mental health professionals' (Department of Human Services and Health 1994, p 250). This job satisfaction problem is thought to lead to high turnover, absenteeism and the phenomenon known as 'burnout', that is, a dramatic decline in a worker's level of motivation. Dissatisfaction has been found

to increase with age (Ben-Dror 1994), but this may be secondary to the effect of a worker's length of service in their present position and length of service in the mental health field in general (Boyer 1993).

Dissatisfaction is also predicted by the composition of the caseload. Oberlander (1990) found that burnout rates were positively associated with the chronicity of the caseload. Boyer (1993) found that the proportion of clients with schizophrenia was positively correlated with the degree of both job dissatisfaction and burnout, as was the proportion of clients who were substance abusers. Schizophrenia and substance abuse are strong contributors to the chronicity of mental illness. A commonly identified source of dissatisfaction is unrealistic demands (Becker & Becker 1986; Katz-Epstein 1993). Burnout and dissatisfaction have been shown to be alleviated by clinical supervision (Newsome & Pillari 1991), praise from superiors (Martin 1991), socialising with colleagues (Leiter 1988), clear role definition (House 1989) and opportunities for advancement (Martin 1991).

Workplaces and change

Within the personnel or human resources management literature, the introduction of major changes, such as a greater focus on demonstrating better health outcomes, tends to be viewed as particularly difficult. Several perspectives have been put forward on how to overcome these difficulties, with authors being divided as to whether change should be imposed by a strong and controlling management (Etzioni 1975; Ordione 1979) or facilitated by eliciting the willing participation of all concerned (Herzberg 1966). Attempts to reconcile these two approaches have included emphasising leadership rather than control or cooperation, and seeking to resolve the multiplicity of perspectives on the current situation and the meaning of the change through dialogue (Ouchi 1981; Peters & Waterman 1982).

Social psychological theories also shed light on the factors which facilitate and impede the introduction of innovations, such as a health outcomes approach. Cognitive dissonance theory holds that individuals try to maintain attitudes which are internally consistent (Festinger 1957). Various strategies are employed to reduce the 'dissonance' between existing attitudes and ongoing experience, for example, feeling that measuring health outcomes is not important and increasing management commitment to demonstrating improved health outcomes. Innovation diffusion theory is an attempt to identify the factors which facilitate the adoption of new practices (Rogers 1983). Originally it involved the study of situations where individuals are free to adopt an innovation or not as they choose. When applied to situations where the organisation as a whole must either

adopt or not adopt an innovation, the theory becomes less applicable (Greer 1977). Despite this ambiguity, it remains reasonably clear that certain features of a proposed change are predicted to be associated with positive attitudes to the proposed change on the part of those who will be involved in it. These include simplicity, reversibility, compatibility, flexibility and freedom from risk (Rogers 1983). Therefore, the degree to which the health outcomes approach (as an innovation) is simple and consistent with current activities will be associated with positive attitudes towards the health outcomes approach and its adoption.

Health outcomes and community mental health staff

Given the history of the mental health field in Australia plus research evidence on factors associated with satisfaction, there are several reasons to anticipate that New South Wales community mental health staff may have negative attitudes towards a 'new' innovation that focuses on health outcomes. First, for historical reasons staff may fear a systematised bias against mental health. Second, the health outcomes approach requires quantification of outcomes, and the intangibility of the problems mental health workers treat could pose technical difficulties. Finally, the health outcomes approach proposes evaluation on the basis of *changes* in health status. The chronicity of many mental health problems means that considerable effort is expended in preventing deterioration, that is, in bringing about non-changes in health status.

A strong focus on health outcomes is a major innovation in the Australian health system. Attitudes towards such innovations have rarely been studied among Australian health care staff and never with mental health workers. Therefore, this study sought to identify the factors associated with positive and negative attitudes to health outcomes among community mental health workers.

Method

Eligible respondents were employees of Central Sydney Area Health Service who were:

- employed in the adult mental health division
- based in the community (and excluding hospital employees)
- designated as health professionals (for example, practising medicine, nursing or an allied health profession)
- employed in clinical roles involving direct client contact (including five staff who had a mixture of clinical and management duties but excluding those whose contact with clients was solely for research purposes), and

- employed on a regular basis (including full and part-time permanent staff and full and part-time locums but excluding casual staff).

A total of 101 eligible respondents were identified from staff lists. These staff members were sent a letter advising them of the forthcoming survey. This letter was followed one week later by a copy of the questionnaire with a covering letter urging them to participate. Reminder letters were sent out one and then two weeks later. Those individuals who did not respond within a week of receiving the final reminder were telephoned and asked to return the questionnaire.

Instrument development

The questionnaire covered respondents' knowledge of and attitudes towards the health outcomes approach, knowledge of possible outcomes measurement instruments (Andrews, Peters & Teeson 1994), beliefs about the likely impact of the health outcomes approach upon the individual and on mental health services in general, opinions about what type of outcomes measures are appropriate, attitudes to their work environment and basic demographics. Respondents were asked to score their answers to the attitudinal questions on a five-point Likert scale.

Three scales were constructed as dependent variables. The first dependent variable was a scale of eight items which assessed whether the respondent thought the health outcomes approach would achieve what it was intended to achieve. It demonstrated good internal consistency (Cronbach's Alpha = 0.80). The second dependent variable was a scale of five items which assessed whether the individual thought the health outcomes approach would have a favourable impact on him or herself (Cronbach's Alpha = 0.77). The third dependent variable was a scale of five items which assessed whether the individual thought the health outcomes approach would have a favourable impact on mental health services (Cronbach's Alpha = 0.75). The independent variables were items which previous literature suggests predict positive attitudes to an innovation. These include the perceived simplicity, flexibility, compatibility and risk of innovation, whether the individual thought they could influence it, and the extent to which the workplace was perceived as supportive of the individual. The final draft was piloted with an Adult Mental Health Team outside the area of the study.

Analysis strategy

The independent variables and demographic variables were regressed on each of the three dependent variables. All significant independent variables (Alpha < 0.05) were then entered into a single model, together with those demographic variables which were significant or approaching significance (Alpha < 0.10).

Results

The total number of questionnaires received was 68. However, three responses were not entered for analysis because they had large numbers of skipped items, leaving a response rate of 64%. Respondents were predominantly nurses (55%), aged 40–49 years (39%), female (57%) and had been employed in their current position for less than two years (46%) (see Table 1).

The majority of respondents (68%) had heard of ‘health outcomes’ prior to the present study being conducted and understood what a focus on health outcomes was intended to achieve. Most agreed or strongly agreed that a greater focus on health outcomes was intended to bring about:

- ‘improved quality of service’ (59%)
- ‘resources allocated more efficiently’ (66%)
- ‘assessment of the efficacy of interventions’ (62%)
- ‘collection of data on results, not just processes’ (67%)
- ‘better client satisfaction’ (50%).

However, fewer respondents agreed or strongly agreed that a greater focus on health outcomes would actually achieve ‘improved quality of service’ (38%). Similar differences were also observed for ‘resources allocated more efficiently’ (45%); ‘assessment of the efficacy of interventions’ (37%) and ‘better client satisfaction’ (33%). Responses to these items also indicated that respondents were fearful that a health outcomes approach would be used to cut resources.

When asked about the impact of a health outcomes approach on them as individuals, respondents indicated that they expected their jobs would be more tedious without achieving any commensurate improvements. Respondents expected increases in ‘hassles’ (75%) and ‘workload’ (68%) as well as decreases in ‘autonomy’ (49%). Most anticipated no change in ‘recognition’ (68%) or ‘individual performance’ (52%), and the majority of respondents expected either no change or a decrease in ‘satisfaction’ (81%).

Table 1: Characteristics of the study sample (n = 65)

Category	Percentage
Occupation	
Medicine	6
Nursing	55
Social work	11
Psychology	12
Ethnic health	6
Other allied health	10
Age	
Less than 29 years	19
30–39 years	31
40–49 years	39
50–59 years	9
60+ years	2
Sex	
Male	43
Female	57
Length in present position	
< 2 years	46
3–5 years	25
6–10 years	20
11–20 years	8
20+ years	2
Length in service in mental health services	
< 2 years	6
3–5 years	20
6–10 years	28
11–20 years	31
20+ years	15

Respondents saw the main beneficiaries of the approach as those most removed from the clinical situation, with 42% thinking junior management would benefit, 61% thinking senior management would benefit, 61% thinking administrators would benefit and 76% thinking researchers would benefit. Only 22% thought clients would benefit and even fewer (14%) thought clinicians would benefit. Respondents' fears about focusing on health outcomes tended to apply to the anticipated impact on health services in general, rather than on mental health services specifically, with 33% of respondents expecting resources would be decreased in mental health relative to other areas and 51% expecting resources would be decreased for health services as a whole. Two out of five respondents (39%) anticipated that quality of services would increase for mental health relative to other areas, whereas only 21% expected that the overall impact of the health outcomes approach would be to increase quality of services. The same proportion (39%) of respondents expected that recognition for mental health services would increase relative to other areas while 24% expected increased recognition per se. At the same time respondents' fears of increased tedium applied equally to both health services in general and mental health services in particular: A high proportion of respondents (75%) expected increased 'hassles' and 73% expected 'hassles' to increase 'relative to other areas of health care'. High but similar proportions also expected increased workload (68%) and increased workload relative to other areas of health care (70%).

Staff were evenly divided on whether the performance of mental health services could be quantified. With regard to potential outcomes measures, measures of global functioning and consumer satisfaction were viewed more favourably than population indicators or measures of symptomatology. The number agreeing or strongly agreeing with measures of global functioning was 83% and with measures of client satisfaction was 80%. The number agreeing or strongly agreeing with population indicators was 62% and with measures of symptomatology was 68%. The majority of respondents do not routinely use any type of instrument which could be used to assess individual consumer outcome.

Regressing the demographic variables on the three dependent variables in turn found only two significant associations. Length of service in present position was inversely associated with expectations that the health outcomes approach would achieve what it is intended to achieve ($p = 0.02$). Total length of service in mental health was inversely associated with positive expectations about the impact of the health outcomes approach upon oneself ($p = 0.05$). Occupation, age and sex were not significantly associated with any of the dependent variables.

For the dependent variable measuring the expectation that the health outcomes approach would achieve what it was intended to achieve, two predictor variables

were included in the most parsimonious model, which explained 28% of the variance. The two variables retained were perceived ability to influence the approach, which was positively associated ($p < 0.01$), and perceived absence of risk, which was less strongly but positively associated with the belief that a health outcomes approach would achieve what it was intended to achieve ($p = 0.04$).

For the dependent variables measuring positive expectations about the impact of the health outcomes approach on oneself, two predictor variables were included in the most parsimonious model, which explained 25% of the variance. The two variables retained were perceived compatibility of the approach with existing practice, which was positively associated ($p = 0.002$), and perceived absence of risk, which was less strongly but positively associated with positive expectations of the impact of the health outcomes approach on oneself ($p = 0.03$).

For the dependent variable measuring positive expectations about the impact of the innovation upon mental health services, three predictor variables were included in the most parsimonious model which explained 39% of the variance. The three variables retained were perceived ability to influence the approach ($p = 0.02$), perceived simplicity of the approach ($p = 0.02$), and the extent to which the respondent thought he or she received recognition for their achievements at work ($p < 0.01$).

Discussion

Knowledge of and attitudes to the health outcomes approach

Overall, respondents appeared to understand the principles of the health outcomes approach but lacked the practical skills and availability of valid and acceptable measurement tools to participate in it. Perceptions of what health outcomes are intended to achieve were in accord with the actual rationale. At the same time, respondents had little knowledge of those instruments which are proposed for use by mental health workers in a health outcomes approach. Those who had any practical experience of the main instruments commonly used were in the minority for all but one of the instruments and three out of four respondents agreed that they would need more training before they could use appropriate health outcomes measures as a routine part of their work. This seems to confirm Andrews, Peters and Teeson's (1994) assertion that considerable education is needed before mental health workers could participate in a health outcomes approach. It also suggests that practical training of mental health staff would be of more value than education in the principles of the health outcomes approach, and this point may also apply to other clinical staff.

Attitudes to the work environment

The results tend to suggest a pessimistic workforce, suspicious of change and, in particular, afraid that change will lead to a reduction in their resources. There are likely to be several factors contributing to this. Staff may be extrapolating from past experience. This would be a reasonable attitude according to Burdekin (1993), who found that previous major policy changes reduced the level of resources available for mental health care. It may be a valid objection by mental health staff to not participate in a process which they perceive to be flawed, or which they perceive to reflect health care policy driven by economic rationalism, with a declining emphasis on care. However, not all the findings can be explained in this way. Staff expected an increased focus on health outcomes to adversely affect all areas of health care, not just mental health. One explanation for this is that staff morale is likely to be low among this sample, as it is elsewhere among community mental health staff, leading to general pessimism about the future. Alternatively, the findings may reflect the general tendency for any major change in any workplace to be resisted.

Predictors of positive expectations

The strongest and most consistent predictor of positive expectations of an increased focus on health outcomes was the extent to which staff thought they would be able to influence the way this approach would be applied to their workplace. Some aspects of positive expectations were also predicted by the perceived simplicity and compatibility of the approach, the extent to which it was seen as free from risk and the extent to which staff felt they received recognition for their achievements.

Conclusions

The results indicate at least four opportunities to facilitate the introduction of a health outcomes approach to community mental health services.

1. Consultation and discussion with mental health staff is necessary to address possibly legitimate concerns about the viability and justification of implementing a health outcomes approach in mental health services. Such discourse may act to increase ownership of new directions and participation in health outcomes projects.
2. Practical education in the use of instruments for measuring individual consumer outcomes is needed by the overwhelming majority of respondents.
3. Staff should be given opportunities to participate in and share responsibility for the health outcomes approach. Health outcomes training workshops

should allow for two-way interaction between participants and presenters. In addition, it would seem that it is desirable that participation be ongoing, not only to facilitate staff involvement but also to lessen the riskiness of the health outcomes approach, since ongoing participation implies the possibility of remedying unforeseen circumstances.

4. It is desirable that every effort be made to avoid unnecessary complexity, inconvenience and tedium for clinical staff. This is supported not only by the importance of compatibility and low risk demonstrated in this study, but also by findings elsewhere that a high volume of paperwork is conducive to burnout.

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