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**Quality and capacity Whence Mental Health NGOs?**

## Introduction

The NGO sector in mental health is small, almost minuscule, less than 2.5% of the mental health budget and it is not growing in any significant way. The roots of this lies, in the nature of the health sector with its emphasis on experts, on technology, on acute interventions, on specialist division of the individual into subsystems of disease and with its distance from individuals and communities. The size of the NGO sector is also a result of both the history of the NGO movement in mental Health and of the way grants were initially made many years ago. Some services, are now run by the Non- Government sector because the services have been tendered Area Health Services, using their own mental health budgets, this in essence contracting out services to the NGO sector. The major growth in the sector, however, has been through the Boarding House Reform Program, where the Ageing and Disability Department has funded both supported accommodation and activity and leisure programs.

To illustrate the size of the sector, I refer you to Table 1, comparing the mental health sector to the disability sector. This compares mental health with one other set of programs (Disability), but we should bear in mind that this is but one example of NGO funding in Health and Community services. The table shows the funding level on the NGO Program though the Mental Health budget. It does not include funds provided through tenders at Area level or Commonwealth Grants such as those to employment programs or through other departments[i].

Table 1. A Comparison of the Non- Government Sector in Disability Services and in Mental Health

| SERVICES | MENTAL HEALTH* 2000/2001 | DISABILITY** 1999/2001 |
|---|---|---|
| GOVERNMENT SERVICES | $528 M | $278.1M |
| NON-GOVERNMENT SERVICES | $13 M | $217.46M |

NB This information applies to two different financial years
**Source: Centre for Mental Health, - does not include additional $107 M new monies or tenders from AHS*
***Living in the e Community, Annual report of Ageing and Disability Department 1999-2000*

The development of a strong, healthy and active non-government sector in mental health, a purpose to which I assume you are all committed, will depend on building a strong infrastructure, on sustainable skills, structures and resources, on commitment from government and non-government organisations, consumers, and the community. It will require setting objectives, setting priorities and a commitment by the sector to change, quality service improvement and evaluation of its activities. Those features take up capacity[ii].

The way health services approach the NGOs sector is problematical for the task of development. In the health portfolio we have something called the NGO program, NGOs are not a program they are a way of delivering services in a number of program areas. The consequence of this lack of conceptual clarity is confusion about why Health could use NGOs, what it expects from them, what are program objectives, and what are its priorities. It is not clear when NGOs are preferable to government services and when they are not.

Capacity must also for include the ability for the not only for a sustainable delivery of services but must also include the ability for the sector to change and transform itself to meet contemporary challenges. When I started working in mental health services the issues were the medical model, de-institutionalisation, compliance with oral medication, and eligibility for Commonwealth Social Security Benefits People with mental illness did not get them). The issues today are mainstreaming, discrimination, employment, housing. and the attainment of full citizen ship rights for people with mental illness and prevention, early intervention for others in the community.

Given the limitation of public policy in the mental health sector, NGO s must agitate for reform. To capture the support of consumers, carers and the wider community the sector must engage in an active and vigorous debate and in action for change. One of the ways it can do this is to organise around notions of capacity and quality. It must examine its own performance and the support given in public policy in achieving quality and improving capacity. Some excellent work on quality is been undertaken in Health and we can use some of the models and perhaps borrow some notions from the Disability Sector.

**A Quality Framework**

NSW Health has been a leader in Human and community Services in attempting to grapple with notions of quality and service improvement. Its "Framework for managing the Quality of Health Services in NSW"[iii]. It focuses on clinical care and identifies six performance areas and five cross-dimensional issues. The six performance areas are:

1. Safety
2. Effectiveness
3. Appropriateness
4. Consumer participation
5. Efficiency
6. Access

The five cross-dimensional issues are:

1. Competence
2. Information management
3. Continuity of care
4. Education and training for quality
5. Accreditation

The Framework also sets up mechanisms for managing quality. It sets up Area Quality Councils, which link all part of the Area Health Service; the area mental health service would be represented but not NGOs (mental health or other).

Because much of the structure of Area Quality Council is clinically oriented, and assumes that AHS is part of a properly funded system with clear policies, I have

identified my own components to quality in the mental health NGO sector. Some of these indicators are imbedded in the relevant standards. You can add or subtract from this list with some discussion:

- Clear policy objectives;
- Adequate funding;
- Planning for the appropriate allocation of resources,;
- Consistent and effective implementation;
- An appropriate framework for quality improvement;
- Understanding of contemporary practice;
- Good governance at the level of the organisation;
- Accreditation / standards;
- Workforce training and development;
- Evaluation;
- The presence of checks and balances such as internal and external complaint mechanisms;
- Regulation and review; and
- Participation.

To put these notions in context we must understand the history of Disability serviced sand mental health services.

**A Potted History Of Mental Health And Disability**

Disability services in NSW have a different recent history than mental health services. Mental Health services have been provided in the main by state government first in institutions later in general hospitals and community health centres, by private practitioners or private hospitals, the latter groups being partly or completely subsidised by the Commonwealth. There has been very little involvement of benevolent associations or parents' groups. Mental health personnel have often started the small NGO sector, seeking avenues to experiment with new ideas such as halfway houses etc. To this day, there is a heavy representation of mental health staff on the board of many a mental health NGO.

The story is different for other disabilities, those services comprising services for people with intellectual, physical or sensory disabilities. There existed many services run by government through the health portfolio, in a manner very similar to those services for people with mental illness. In fact the services to people with mental illness and those for people with intellectual disability were run in the same institutions. However, there was alongside government services there was a strong non- government sector for people with a variety of disabilities, founded by either people with benevolent motives or by parents coming together to start alternatives to government provision for their children. The Spastic Centre, Sunshine Homes, the Challenge Foundation may be familiar names to you. The sector was funded through fund raising, though subsidy from the State Government and later on, through the Federal Government. Federal government funding was through the Handicapped Persons Act in the seventies and this was replaced in 1986 by the Disability Services Act. This Act focused attention on service providers and how clients receive services[iv]. The Act saw the shift to a disability model from a medical model and the inclusion but not the funding of mental health services. In 1987, following a recommendation of the Richmond Report (1983) intellectual disability services were separated from Health services and moved to the Community Services portfolio. This shift represented the combined views of staff, parents and advocates, with a

strong commitment to the closure of institutions, and to a community based educational approach to services rather than to a curative, treatment approach.

Overlap and lack of co-ordination of funding by different tiers of government saw the negotiation of the Commonwealth – State Disability Agreement (CSDA) in 1992. There was a parallel movement in mental Health when, following a number of commissioned reports, the Commonwealth became involved in policy and planning for mental health services. The CSDA, the National Mental Health Policy and Plan were part of a systematic look by government, initiated by the Commonwealth at the roles of various levels of Government. Other discussions were around the need for government to become more efficient and to introduce more competition to increase efficiency. Some of the themes of micro-economic reform were:

- Competition and competitive tendering;
- Funder/Provider splits which lead to improved efficiency and improved quality;
- Unit Costs;
- Outcomes based funding;
- Data collections;
- Choice for the consumer and individual packages;
- Targeting;
- Brokerage; and
- Flexibility.

Under the CSDA in 1993, the states assumed responsibility for accommodation and support services, independent living training, recreation services and respite care. The Commonwealth retained responsibility for employment and both State and Commonwealth shared responsibility for planning, standards, research and advocacy and evaluation. The Commonwealth made funds available to the States for reforms to the disability sector. The reforms included devolution of services providing congregate care, setting up complaint mechanisms for consumers and adopting principles for the provision of services to people with disabilities. In NSW, these reforms were encapsulated in the *Disability Services* Act 1993 (DSA) and in the *Community Services (Complaints, Review & Monitoring)* Act 1993 (CRAMA). The CSDA was to be implemented in NSW through the Community Services portfolio. The CSDA targeted all disabilities including psychiatric disabilities but the mental health services in NSW found this difficult and opted to stay in the health portfolio. Mental Health NGOs were nominated as Disability Services in the first CSDA but were to continue to be administrated by the Health Minister in a complex arrangement with the Minister for Community Services. The result was predictable; no funds were made available through the reform process.

The establishment of the Ageing and Disability Department took the microeconomic reforms further and separated funder and provider. NGOs and Government services came to compete on an equal footing for funding using the framework of the DSA. The twists and turns in this story are fascinating but are the subject of another paper on another day.

**Comparing Services**

The framework for quality and the system of safeguards and principles around the CSDA will now allow us to compare mental health NGOs with government run services and with the disability sector.

Table 3. A comparison of the Disability sector and the mental health sector in the approach to quality may provide us for some useful directions. But first some history.

| Criteria of quality | DISABILITY SERVICES | GOVT. MENTAL HEALTH SERVICES | MENTAL HEALTH NGOS |
|---|---|---|---|
| Clear Policy Objectives | Broadly yes spelled out in the DSA<br>Commitment by Government to Devolution over 12 years<br>Specific elements and programs may not be shave objectives clearly spelled out | Partly-in State mental Health policy and in Mental Health Act. No clear commitment by government to devolution of institutions. | Nil |
| Adequate funding | No but growing<br>Funding allocated through EOI (Expressions of Interest) | No but growing | No |
| Planning for allocation of resources | Yes- some programs are planned long term | Yes through resource allocation formulas etc | No |
| Consistent and effective implementation | No-many changes in departmental structures, delays.<br>More recently disability services regrouped in one department | Difficult - Criticisms about transparency of the process as mental health services are part oaf very large and expensive AHS and it is hard to track the money | No |
| Appropriate framework for Quality | No | Yes | No |
| Understanding of contemporary practice | Variable | Probably but also variable depending on geographic factors | Probably yes but difficult to answer that question centrally |
| Good Governance | Variable- Govt services good on awards, OH&S, EEO etc but variable in rest of sectors covered by standard 8 in Standards in Action | Variable- But AHS have to fulfil requirements of public bodies. | Generally – finances are Ok and audited Compliance with various legislation OK |
| Accreditation and standards | DSA – *Standards in Practice*[v] | Yes- EQUIP, CHASP or National Mental Health Standards[vi] – | Nil - although some services comply with DSA and have |

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| (NB see Appendix for Standards | | on their own or as incorporated in EQUIP | continued to use them. National Mental Health Standards more suited to AHS although some of the standards can be used in NGOs .<br>More recently funding made available for accreditation but model unclear |
| Workforce training and Development | Not - There is an industry development unit in DADHC (formerly ADD) | Substantial work on issues such as early prevention, dual Diagnosis, MOAT | Access through AHS- nothing available to tackle problems specific to NGOs |
| Evaluation | Limited- national data collection in place. | Limited – data collection in place. | Very limited – data collection varies and is not consistent. |
| Complaint mechanisms | DSA standard 7 - requires organisations to have internal complaint mechanisms.<br><br>Consumers can also use external body such as the Community Services Commission (CSC).<br><br>Complaints against Government bodies on probity issues can go to Ombudsman | No specific mention of complaint mechanisms in Mental Health Standards. Most AHS have internal complaint mechanisms.<br>Consumers can use Health Care Complaint Commission (HCCC) or in some Cases Ombudsman | AHS can ask for co-operation of NGOs in complaint investigation but cannot force co-operation. Internal Complaint mechanisms required as part of conditions of grant but no guidelines on what represents a good system.<br><br>NGO can complain to Ombudsman about Health if concerned about probity of process.<br><br>Consumers cannot use CSC or HCCC or Ombudsman |
| Regulation and Review | CSC can review people in care.<br><br>Community Visitors go to residential services.<br><br>No systematic review similar to reviews in | Mental Health Review Tribunal does judicial review of all people in long term care as well as involuntary patients under different parts of the ACT. | Nil |

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| | mental health legislation of all individuals in long term care. | Mental Health Act regulates Hospitals, Community health centres, regulated prescription and administration of medication. Sets out a number of other regulatory mechanisms Community Visitors appointed to Hospitals and CHCs. | |
| Participation | Requirement under Standard 5 of the Standards in Act. | Part of Health Policy - most AHS have consumer councils - Mental Health Services in most cases have Community Consultative Committees. Many AHS have consumer consultants | Some have consumer consultants - some not al have consumers at Board level.<br>No requirement to have consumer participation and consultation. |

As you can see by the Table 3 above, the systems are not in place for NGOs in mental Health to deal with quality and they are disadvantaged in the task of building capacity and ensuring quality. They cannot provide a guarantee to consumers that there are safeguards in the system. There is no accreditation, no external reviews or external complaint mechanisms. There is no access to a framework for ensuring quality even through Area Health Services. And I am sure that many NGOs would object to joining Area Health Services in Area Quality Councils.

There are no clear policy objectives and no agreement as to what the sector can or cannot do. There is no overarching legislation or framework such as exists in disability services, which bring together government and non- government services.

There are no systems in place at a statewide level for staff training and development and for career structure for people working in the sector.

In spite of this the sector has made some major contributions. However, the sector may need to contemplate whether the interests of consumers and it own interests would not be better served in a disability structure, which is much more familiar with the non-government sector. While there may be a philosophical commitment to the sector within Health, the NGO sector is not in a powerful position. The size of the sector, even were it to double in the next two years, would still be minute in comparison to government services and the structural inequalities would remain. It also operates in a system which the public conceptualises as requiring doctors, nurses, hospitals, medication.

The battle for recognition and appropriate structures is likely to be long and hard.
Its demands in order to increase its credibility and its capacity must include:

- Clear policies about its role in mental health and recognition of its diversity;
- Access to external review and complaint mechanisms;

- Access to standards and accreditation (including training etc);
- Access to training and development; and
- Input into planning processes.

And it must ensure participation by consumers and the rest of the community, for other wise we shall remain in the ghetto and away from the main action.

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[i] The NGO program is administered by Area Health Services but growth is funded centrally. There are no guidelines or tendered services, which requires them to comply with NGO guidelines.
[ii] Fitzgerald, R. "Capacity Building: "The Agenda for Community Services' – Paper given at a Colloquium held by the Australian Centre for Health Promotion and the NSW Health Department – University of Sydney – March 2000
[iii] NSW Health Department *A Framework for managing the Quality of Health Services in NSW,* February 1999

[iv] Forbes, S. "National and State Policy" in Ozanne &al.(1999) , *Reframing Opportunities for People With An Intellectual Disability*, School of Social Work , The University of Melbourne, Melbourne, Australia
[v] Ageing & Disability Department, *Standards in Action, Practice Requirements and Guidelines funded under the DSA.* 1998s
[vi] National Mental Health Strategy, *National Standards for Mental Health Services* 1996