

Table of Contents

Acknowledgments

Appendices

Tables

Abbreviations

Recommendations

1. Purpose of report.....	1
2. Background.....	1
2.1 Development of a Compact between the NSW Government and NGOs	1
2.1.1 Review of grants administration	1
2.1.2 Capacity building for NGOs.....	2
2.2 Review of NSW Health NGOs Grant Program	2
2.3 Mental Health Reviews and Projects.....	2
2.3.1 Review of Clubhouses in NSW.....	2
2.3.2 Mental Health and Housing Partnerships Project	2
2.3.3 Employment Issues Project	3
3. Introduction.....	3
4. Mapping the mental health NGO sector.....	5
4.1 Methodology.....	5
4.2 Results	6
4.2.1 Total number of services provided by NGOs.....	6
4.2.2 Service types.....	7
5. Consumer mix, service inputs and capacity	8
5.1 Methodology.....	8
5.2 Results	10
6. Measuring consumer outcomes and service use	12
6.1 Consumer outcomes	12
6.2 Service use	14
7. Needs of NGO consumers	15
7.1 Description of survey and methods.....	15
7.1.1 Sample	15
7.1.2 Measures.....	16
7.1.3 Interview procedures.....	17
7.2 Summary of results.....	17
7.2.1 Description of consumers who participated in the survey.....	17
7.2.2 Met and unmet needs of consumers.....	18
8. Service use by consumers of mental health NGOs	20
8.1 Methodology.....	20
8.2 Results	21
9. Interface between NGOs and public mental health services	22
9.1 Supported residential services	24
9.1.1 Provision of housing and support services	25
9.1.2 Partnership between health, housing and NGO services	25
9.1.3 Key workers in supported residential services	25
9.2 Rehabilitation services	25
9.2.1 Outreach support services.....	25

9.2.2	Centre-based rehabilitation services or day programs	26
10.	Planning and funding issues for mental health NGOs	28
10.1	Joint planning of health services for a catchment area	28
10.2	Funding of mental health NGOs in NSW.....	29
10.3	Administration of NGO funding by Area Health Services	30
10.4	Funding and Performance Agreements	30
10.4.1	Performance indicators and evaluation	30
10.4.2	Accreditation.....	31
10.5	Role of NGO Contact Officers in AHSs	31
10.6	Tendering of services.....	32
10.6.1	Competitive tendering.....	32
10.6.2	Fixed price tendering.....	32
11.	Conclusion	33
	References.....	36

1. Purpose of report

This report presents the outcomes of the Mapping, Analysis and Performance (MAP) Project and identifies key planning and funding issues for mental health non-government organisations (NGOs). The MAP Project was funded by NSW Health, following a submission to the Minister for Health. As a result one of the strategies identified in *Caring for Mental Health* was the provision of funds to the Mental Health Coordinating Council (MHCC) “for a project that will provide a framework for NGO services in NSW” [1]. The MHCC is the peak body for mental health NGOs in NSW.

More specifically the objectives of the report are to -

- map the distribution of mental health NGOs in NSW
- identify the main service types in the mental health NGOs sector
- identify consumer mix, service inputs and capacities of mental health NGOs
- identify outcomes measures used in mental health NGOs
- profile the consumers of mental health NGOs
- identify areas of met and unmet need from a consumer perspective
- identify service use by consumers of mental health NGOs
- identify the interface between the NGO mental health sector and public mental health services and
- identify key planning and funding issues for mental health NGO services.

2. Background

The MAP Project should be seen in the context of a number of other state government and non-government projects reviewing the relationship between government and non-government sectors, and grants programs.

2.1 Development of a Compact between the NSW Government and NGOs

The Cabinet Office has engaged independent consultants to advise it on the development of a Compact between the NSW Government and NGOs. The Consultation Discussion Paper [2] states that the aim of having a Compact is to articulate an agreed understanding of what is desirable in the relationship between the NSW Government and NGOs regarding their respective roles and responsibilities.

There are two other projects related to the development of a Compact.

2.1.1 Review of grants administration

The Premier’s Department is undertaking a review of the grants programs operating across a range of human service portfolios. The government is interested in identifying issues and gathering views on the relationship between service planning and funding arrangements, accountability and the need for flexibility or change in allocating available funding to meet changing community needs.

2.1.2 Capacity building for NGOs

The Premier's Department is also reviewing ways to enhance the capacity of NGOs, especially smaller ones, to deliver effective, efficient and sustainable services. This review is gathering information on the practical realities of the operating environments of NGOs and ways in which government can assist NGOs to provide cost-effective services.

Consultations with NGOs in NSW for the above three projects were conducted between March and June 2000. A report on the Compact was due for completion in July 2000.

2.2 Review of NSW Health NGOs Grant Program

The overall aim of the Review of the NGOs Grant Program is to improve the partnership and collaboration between NGOs and the NSW health system. The terms of reference for the review are to -

- advise on an appropriate framework to underpin the relationship between non-government organisations and the NSW health system
- advise on an appropriate range and level of health services to be provided by the NGO sector
- advise on appropriate resources to promote viable non-government organisations across differing service types and
- advise on appropriate structures for the management of the NGO Grant Program.

Consultations for this review will be based on the document *NGO Framework - A Discussion Paper* [3], drafted by the Department's NGO Advisory Committee. This review began in June 2000 and is due for completion in October 2000.

2.3 Mental Health Reviews and Projects

2.3.1 Review of Clubhouses in NSW

The aim of the review of Clubhouses in NSW is to assist in future planning and funding decisions related to psycho-social rehabilitation. The reviewers were asked to -

- advise on the nature and effectiveness of the Clubhouse model
- describe the application of the Clubhouse model in NSW
- make comparisons between the Clubhouse model and other approaches to community based rehabilitation services and
- develop recommendations.

This review is being undertaken by independent consultants for the Centre for Mental Health, NSW Health, and was due for completion in July 2000.

2.3.2 Mental Health and Housing Partnerships Project

The aim of the Mental Health and Housing Partnerships Project is to develop a statewide framework on housing and accommodation support for people with a mental illness which identifies partners and strategic directions; supports interagency policy

development and planning; and establishes links to other government policies and initiatives.

This project is being conducted by the Centre for Mental Health, NSW Department of Health and is due for completion in 2001.

2.3.3 Employment Issues Project

The aims of the Employment Issues Project are to -

- improve understanding of the range and scope of employment service models for mental health consumers
- review the literature about outcomes for mental health consumers of each employment service model
- identify gaps in employment services for mental health consumers with complex needs and
- increase insight into funding options for disability employment services and the relationship of these to assessment processes.

This project was conducted by an independent consultant for the Mental Health Coordinating Council and was completed in June 2000.

3. Introduction

Consultations with the mental health NGO sector were organised at the beginning of the MAP Project to develop an understanding of current issues for the sector and explore future directions for the sector. These consultations occurred at the MHCC Review Day and the NGO Forum Day in August 1999. Discussion of current issues focused on attempting to identify those components of NGO services which contribute to improved outcomes for people experiencing mental illness and consumer needs that services were unable to meet. The strengths of the sector were clearly articulated by representatives of services at the consultations. These included the ability of NGOs to be flexible and responsive to the needs of consumers, to include consumers in the planning and development of services and to increase the capacity of the local community to meet the needs of its residents.

Similar strengths were identified in the report *Strengthening Community Management*.

“Community based organisations make an important contribution to the social and economic health of a society, because they strengthen communities, build social capital and provide social justice and client centred services. This is good for society, governments, individuals and the economy.” [4]

The consultations identified that further development of the mental health NGO sector required a clearer understanding of -

- the range of services provided by the sector and the distribution of these services across the state
- the needs of people accessing NGO services and the extent to which these needs are being met
- the interface between the public mental health sector and the NGO sector and
- planning and funding issues for mental health NGOs.

These discussions helped to clarify the parameters of the MAP Project and to identify possible ways to undertake the project.

Following the consultation the MAP Project Steering Committee identified a range of methodologies which would provide a series of snapshots of the sector in the year 2000. The methodologies included -

- telephone interviews with all mental health NGOs and public mental health services to identify services
- written surveys to a sample of mental health NGOs to identify consumer mix, service inputs and capacity
- telephone surveys to a sample of mental health NGOs to identify outcome measures used by different service types
- face to face and telephone interviews with consumers using the Camberwell Assessment of Need (CAN) survey to determine the met and unmet needs of consumers
- face to face and telephone interviews with consumers to determine their range of service use
- consultations with sector representatives and NSW Health to discuss the interface between the mental health NGO sector and the public mental health sector and
- consultations with sector representatives to discuss funding and planning issues for the sector.

Some of the comments made by consumers when they were interviewed for the CAN survey demonstrate the significance of their involvement with mental health NGOs.

Comments from consumers of mental health NGOs
"_____ is my only source of friendship"
"... I don't feel connected, except to _____"
"I feel accepted here"
"I attend a drop-in which is really good. I am treated like an equal"
"The staff are really great to talk to. They really listen"
"I feel I belong to a group that supports me"
"I feel safe here. Staff have helped calm me"
"Sense of belonging and feeling worthwhile from coming to _____"
"Self-esteem is achieved at _____ - a sense of worth and achievement"
"- it's like having an extended family" [5]

The recommendations stemming from this report were informed by the outcomes of the MAP Project, consultation with representatives of the mental health NGO sector and current state and federal policy directions in mental health.

4. Mapping the mental health NGO sector

The mental health NGO sector is a complex web of funded and non-funded organisations and groups. The funded organisations receive funding from one or more sources including the Non Government Organisation Grant Program (NSW Health), Area Health Services (AHSs), Supported Accommodation Assistance Program (NSW Department of Community Services), local councils and federal government departments. Some services such as Aftercare Association and Richmond Fellowship have services in more than one AHS. Others are stand alone and have developed in response to a particular local need. Many of the non-funded services are support or advocacy groups and are linked to funded parent organisations such as the Schizophrenia Fellowship and Association of Relatives and Friends of the Mentally Ill (ARAFMI).

4.1 Methodology

In developing the methodology for the mapping the mental health NGO sector it was decided that the number of services provided by NGOs would be recorded rather than simply the number of NGOs. For example one NGO may provide up to four different services such as support groups, supported residential services, information services and drop in. This was recorded as four services and allowed for services to be categorised into 12 different service types. The categories included -

- Consumer support groups (illness related)
- Community Consultative Committees
- Carer support groups
- Supported residential services
- Advocacy, education and information services
- Open employment services
- Telephone support services
- Drop in centres or Clubhouses
- Supported employment services
- Consumer networks and
- Respite services.
- Outreach services

It should be noted that the data base does not include mental health services provided by the large charities and other community services providing limited services for people with mental health problems.

Collecting the data for mapping of the mental health NGO sector involved the following steps -

1. Each Area Health Service was contacted and asked for a list of mental health services run by NGOs in their catchment area. These lists were entered onto a data base.

2. This data base was cross checked against the services listed in the NSW Association for Mental Health directory *Way Ahead: Your Resource to Better Mental Health in NSW*. This led to further services being added to the data base.
3. Each NGO on the data base was contacted and asked for information about the type of services they provide and contact details. They were also asked what other services they were aware of in their local area. Again this led to further services being added to the data base.
4. Organisations added in Step 3 were also contacted for information about their services and contact details.

The comprehensive methodology used to develop the data base of mental health services provided by NGOs in NSW suggests that the data base was probably close to being a definitive list at the time the data was collected (September 1999 to March 2000). However any large data base of services changes regularly with new services starting and others closing.

4.2 Results

4.2.1 Total number of services provided by NGOs

A total of 372 mental health services provided by NGOs was identified. To some extent the number of services provided by mental health NGOs reflects the population base for the AHS. In June 1999 the population of NSW was 6.4 million people of whom 4.8 million lived in metropolitan areas including Sydney, Newcastle, Wollongong and the Central Coast [6]. This represents 75% of the population. Similarly 72% (269/372) of mental health services provided by NGOs are located in AHSs which are primarily metropolitan. For the purposes of this report the 'metropolitan' AHSs include Northern Sydney Area Health Service (NSAHS), South Eastern Sydney Area Health Service (SESAHS), Central Sydney Area Health Service (CSAHS), Western Sydney Area Health Service (WSAHS), South Western Sydney Area Health Service (SWSAHS), Wentworth Area Health Service (WAHS), Central Coast Area Health Service (CCAHS), Illawarra Area Health Service (IAHS) and Hunter Area Health Service (HAHS).

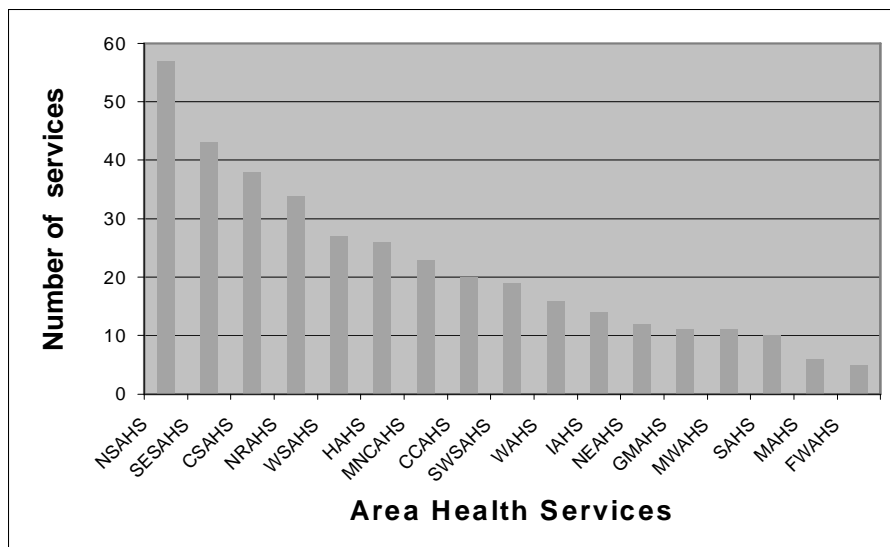
Within the metropolitan areas however there is an uneven distribution of mental health NGO services. The greatest density of mental health NGO services in metropolitan AHSs is in NSAHS, SESAHS and CSAHS where the numbers range from 38 to 57. In contrast the number of NGO services in SWSAHS, WAHS, CCAHS and IAHS range from 14 to 20. In the middle are WSAHS and HAHS with 27 and 30 NGO services respectively.

The greatest density of mental health NGO services in rural AHSs is in Northern Rivers Area Health Service (NRAHS) and Mid North Coast (MNCAHS) where there are 34 and 23 NGO services respectively. The lowest number of mental health NGO services are in Far West Area Health Service (FWAHS) and Macquarie Area Health Service (MAHS) which have five and six mental health NGO services respectively. In the middle are New England Area Health Service (NEAHS), Greater Murray Area Health Service (GMAHS), Mid Western Area Health Service (MWAHS) and Southern Area Health Service (SAHS)

with a range of 10 to 12 NGO services. Photographic maps of the distribution of mental health NGO services in the Sydney metropolitan area and across NSW are attached (Appendices 1 and 2).

Graph 1 below shows the number of mental health services in the non-government sector in each AHS.

Graph 1 Number of mental health services in the non-government sector



4.2.2 Service types

Based on the information received from each NGO the services were categorised into 12 service types listed in Table 1 below. The number and percentage of each service type were calculated.

Table 1. Number and percentage of each category of mental health NGO

Service type	Number	Percentage
Consumer support groups (illness related)	160	43%
Community Consultative Committees	36	10%
Carer support groups	39	10%
Supported residential services	33	9%
Advocacy, education and information services	26	7%
Open employment services	19	5%
Telephone support services	18	5%
Drop in centres or Clubhouses	13	4%
Supported employment services	9	2%
Consumer networks	9	2%
Respite services	6	2%
Outreach services	4	1%
Total	372	

The largest category of mental health NGO services is consumer support groups (illness related). The distribution of mental health support groups is similar to the distribution of all mental health NGOs.

There is an average of two Community Consultative Committees (CCCs) per Area Health Service (AHS) (range of one to five). The distribution of CCCs reflects the structure of mental health services and/or internal geographical boundaries.

There is an average of two carer groups per AHS (range of one to six). The distribution of these groups does not reflect the distribution of the population and indicates that groups have developed in response to identified needs and the availability of local infrastructure support.

All of the metropolitan services have at least one supported residential service. Over half (18/33) of the residential services are located in CSAHS, SESAHS and NSAHS. There are only seven supported residential services in rural areas. Four of these are in NRAHS, two are in MNCAHS and one in NEAHS. Respite NGO services exist in only three areas (WAHS, NRAHS and SAHS). Similarly outreach NGO services are also located in only three areas (SESAHS, NRAHS and MAHS).

Of the 13 drop in services or Clubhouses 12 are in metropolitan areas and one is in a rural area. Most areas have at least one (range 0-4) supported or open employment service for people with mental health problems. Only IAHS, MAHS and SAHS do not have an employment service. Similarly nearly all areas (range 0-11) have a telephone support or advocacy, information and education service. The two areas without these services are SWSAHS and MAHS.

Recommendation

It is recommended that -

1. The data from the mapping of mental health NGOs services be used by NSW Health, AHSs and NGOs for future planning purposes. This includes determining the minimum range and number of mental health NGO services required in each AHS to meet the needs of the population.

5. Consumer mix, service inputs and capacity

In addition to mapping the NGO sector the MAP Project was interested to obtain more detailed information about consumer mix, service inputs and capacity from a sample of mental health NGOs.

5.1 Methodology

The Steering Committee for the MAP Project developed a survey requesting information about service inputs, capacity and consumer mix. A copy of the survey is attached (Appendix 1). The surveys were sent to a sample of 75 mental health NGOs and an additional 35 support groups for completion. Services were given three weeks to

complete the survey. As the surveys were received telephone calls were made, where required, to clarify the information received. Those who did not respond were reminded by a letter after five weeks.

The surveys asked for information about the age range of clients, client mix, inputs and service capacity.

The age range of clients attending the service during one month was collected. The age ranges included 0-15, 16-25, 26-40, 41-64 and 65+.

Consumer mix was determined by asking service providers to determine the frequency of different clients groups who may access the service. They were asked to complete a five point Likert scale for each client group anchored at each end with “less than expected” and “more than expected”.

The client groups included -

- Non English Speaking Background (NESB)
- Aboriginal and Torres Strait Islanders (ATSI)
- gays and lesbians
- women
- people with substance abuse problems
- people with an intellectual disability and
- people with a physical disability.

An average score out of five (“less than expected” = 1, “as expected” =3, “more than expected” =5) was calculated for each client group.

The service input data included staff and volunteer hours per week, and funding and income per annum. Funding included grants from government departments and income included moneys generated by the service from membership fees, fund raising activities, luncheon clubs and board (residential services only). The service capacity data included the number of clients seen in a month and the number of beds provided by residential services.

The large variations in the input and capacity data meant that calculations of measures of central tendency such as means and medians were meaningless. It was decided that reporting the range of data for each service type provided the most useful information. The statewide services responding to the survey were listed separately.

Summarising the data was further complicated in that -

- some of the supported residential services responding to the survey provide additional services but were not able to separate the input data for each service type. These services were categorised as “supported residential plus at least one other service”.

- some of the larger organisations provide services across a number of AHSs and the data collected was for the whole organisation.

5.2 Results

Data was obtained on 52 services. The age range of clients data showed that most clients were in the 26-40 group (37%) or the 41-64 group (31%). The next biggest group was the 16-25 group (23%) and the smallest groups were 0-15 and 65+ (4% and 7% respectively).

The data from the Likert scales indicated that most client groups (NESB, ATSI, gay and lesbian, intellectual disability, physical disability) identified were seen “less than expected” (range 1.77 to 2.10). Only two of the client groups (women and people with substance abuse problems) were seen “as expected” (3.02 and 2.65 respectively). None of the client groups were seen “more than expected”.

The range of inputs and service capacity from a sample of NGOs is summarised in Table 2.

Table 2. Range of inputs and service capacity from a sample of NGOs

Service type	Number of surveys	Staff hrs/wk (range)	Volunteer hrs/wk (range)	NSW Health or AHS funding (range)	Total funding (range)	Total income (range)	No. clients in Sept 1999 (range)	No. of beds (range)
Support groups (illness related)	7	0-16	0-100	0	0-42,000	0-17,300	10-250	
Organisation of support groups (statewide service)	1	334	170	395,600	416,254	65,463	500	
Community Consultative Committees	7	0-5	0-15	0-15,000	0-15,000	0	6-30	
Carer support and helpline (statewide service)	1	312	258	341,400	434,729	158,126	1178	
Supported residential services	9	10-494	0-12	0-516,300	29,600-785,093	14,756-147,940	12-38	10-32
Supported residential plus at least one other service	6	121-1,035	0-41	113,251-1,061,873	113,251-210,128	1,930-3,514,771	29-1,600	18-65
Drop in or Clubhouse	6	20-190	36-305	10,000-178,202	10,000-178,202	0-21,086	50-1,782	
Advocacy, education and information services	4	0-174	0-40	12,500-220,505	12,500-220,505	0-10,000	20-95	
Advocacy, education and information services and support groups (statewide services)	2	177-376	350-1,000	184,000-401,000	207,000-505,000	108,000-108,854	1,200-2,000	
Open employment services	7	91-789	0-40	0	121,500-1,265,000	0-1,060,000	20-598	

The above table shows that there are large variations in the size of services and thus little consistency in the level of funding and capacity of mental health NGOs in the sample. Some of the organisations have up to 10 facilities and provide more than one service type. For example six of the supported residential services provided between one and four additional service types. The substantial involvement of volunteers in many NGO strengthens the capacity of the local community to care for their residents.

Recommendation

It is recommended that –

2. Mental health NGOs, in collaboration with the AHS planning units, identify the demographic features of the area they are serving and ensure their services are

accessible to the main client groups identified. The demographic data should be reviewed at least every three years and prior to any service planning activities.

6. Measuring consumer outcomes and service use

6.1 Consumer outcomes

In the past decade there has been an increasing emphasis on evidence based health care in the western world. In Australia there has been extensive research into suitable consumer outcome measurements and field testing of a range of measures to test their suitability for the public mental health sector since 1994 (5, 6). As a result of this research and field testing NSW Health is preparing to develop training for all clinical staff (n>5,000) in NSW public mental health services in the use of two outcome measures - Health of the Nation Outcome Scales (HoNOS) (7) and Life Skills Profile (LSP) (8). The training will ensure valid and reliable use and reporting of the measures. The HoNOS was developed for use as a routine measure of consumer outcomes in the United Kingdom. The LSP was developed by researchers in NSW and has been used primarily in formal evaluation studies of mental health services both in Australia and overseas. Both instruments measure a consumer's level of functioning. There are also plans to introduce a consumer rated outcome measure in the public mental health sector. The measure to be adopted is currently being considered.

There has been no similar level of research and field testing of consumer outcome measures suitable for the non-government mental health sector. As in the public sector there has been little or no formal training of NGO staff in the use of outcome measures. Without adequate research and field testing of outcome measures it is difficult for the non-government mental health sector to know which instruments provide the best measures of outcomes for their clients. A range of formal and informal outcome measures, however, is used in a number of mental health NGOs.

A survey was conducted on a small sample (n=11) of mental health NGOs to ascertain how they measured outcomes for clients of their service. Service providers were asked to identify formal measures of client outcomes and informal measures and observations.

Information was obtained from five supported residential services, four supported or open employment services and two drop in services or Clubhouses. The range of measures used by each service type is summarised in Table 3 below.

Table 3. Formal and informal outcome measures

Service type	Formal measures	Informal measures
Supported residential	Review of Individual Personalised Plans (Appendix 4) six monthly	File notes on each client contact include information on behavioural indicators (such as appearance, outlook, communication skills, social skills and contacts, level of independence), health status (such as changes in medication, acute psychiatric symptoms, hospital admissions, physical health changes) and referrals to other services
	Review of Individual Support Programs every six months	Regular meetings with key service providers and family members to discuss client's progress (if client consents)
	Review of Individual Service Plans and Role Functioning Scale (Appendix 5) every six months	Review of client's mental status by external mental health staff
	Client Needs Identification and Service Requirements survey reviewed yearly	Staff observe behaviour of clients at social events such as barbeques and golf days
	Resident Satisfaction Questionnaire (currently being developed)	Anecdotal feedback on client from peers and neighbours
	Support Plan (Appendix 6) – provides guidelines for the development and review of a support plan for residents	
	Life Skills Profile	
Feedback Survey for clients leaving the service (currently being developed)		
Open and supported employment	Disability Employment National Information System (DENIS) computerised data base. Records changes and progress made by client.	File notes following each client contact include information on behavioural indicators (such as appearance, outlook, communication skills, social skills and contacts, level of independence), health status (such as changes in medication, acute psychiatric symptoms, hospital admissions, physical health changes) and referrals to other services
	Record of move to mainstream employment	Communication with other service providers to monitor client's progress (if client consents) Feedback from employers regarding issues or problems at work (if client consents)
Drop in, outreach and Clubhouse	Number of attendances (output data)	Monthly reports by managers and workers note any changes in clients
	Client Action Plan constructed on an individual basis and reviewed as required.	Informal file notes include information on client's level of involvement in programs, contributions at "Open Forum" meetings of members and staff, and involvement with other services. An Activities Form keeps track of the services provided to clients Anecdotal feedback on client from peers and staff

Services also collect data, for initial assessment purposes, on some or all of the following items -

- level of education
- work experience
- current mental status
- major illnesses
- living arrangements
- cultural background and
- involvement with other services.

When clients left a supported residential or employment service, information on their living arrangements or type of employment was recorded where possible.

While most of the surveyed services regularly reviewed their clients' progress, there is little or no consistency in the type of measures or procedures used.

6.2 Service use

Similarly there is no consistent method of collecting data on service use and consumer throughput in mental health NGOs. In some residential services there may be little or no throughput in a 12 month period as the services have policies or philosophies which include providing a client with housing for life or for as long as the client wants to stay. To some extent this policy has evolved due to the lack of affordable and suitable alternative housing for people with psychiatric disabilities. The lack of throughput, however, is of concern to service funders who want supported residential services to be accessible to a greater number of clients.

One way of increasing throughput is to attach residential support hours to individual clients based on their needs rather than to houses based on the collective needs of the resident clients. As clients require less support, support hours are freed up for other clients who may also be living in the supported residential service or in other accommodation. However NGOs have found that this model is not always cost effective especially for clients with high support needs. Greater economies of scale are achieved when people with high support needs reside in the same house and are jointly supported by the service.

Most day programs provided through Clubhouses or Drop-in Centres are generally open to all consumers who want to access them. They provide opportunities for important social networks to develop between consumers and thereby reduce the risk of social isolation. The programs provided by these services range from social activities to pre-vocational programs.

As with the supported residential services there is no consistent method of collecting service use and throughput data in Clubhouses and Drop-in Centres. Most services collect some service use data but it is often difficult to determine the number of different clients using the service and the range of individual programs they access. Consistent

data on the number of different clients accessing each program within these services over 12 months would provide valuable throughput data for future service planning and funding bodies.

Recommendations

It is recommended that -

3. NSW Health in collaboration with mental health NGOs research and field test suitable outcome measures for the various types of services provided by the mental health NGO sector. Common outcome measures would provide for some consistency across the state and allow for the collation of data on a wider scale if required.
4. The mental health NGO sector is adequately resourced to train staff in the use of outcome measures.
5. NSW Health in collaboration with mental health NGOs identify service use and throughput data for each mental health NGO service type.
6. Residential support services review their policies and procedures with a view to improving their throughput and ensuring their services are accessible to as many people as possible in need of supported residential services.
7. Residential support services explore the option of attaching support hours to individual clients rather than to houses wherever feasible.

7. Needs of NGO consumers

A study titled *MAP Project: Report on Needs of NGO Consumers* [9] provides a profile of NGO consumers in rural and metropolitan areas and identifies the main areas of met and unmet needs from the perspective of consumers accessing mental health NGOs in rural and metropolitan areas. A summary of the report appears below.

7.1 Description of survey and methods

7.1.1 Sample

Mental health NGOs in NSW were divided into the following categories -

- Support groups
- Supported residential services
- Drop-in Centres/Clubhouses
- Open employment services and
- Supported employment services.

Two organisations were selected from each service type – one from a metropolitan and one from a rural area. Ten to fifteen consumers were randomly selected for interview from each organisation.

7.1.2 Measures

Needs were assessed using the Camberwell Assessment of Need (CAN) [5]. The CAN is a semi-structured interview designed for use with both consumers and clinicians. It covers 22 areas of need and in each area asks about met and unmet need, informal care from friends and relatives, formal care from health and other services and overall satisfaction with care received. It has been widely used overseas and has also been trialed in Australia [6].

The areas of need assessed in the CAN are presented below -

- Accommodation
- Food
- Self care
- Household skills
- Daytime activities
- Physical health
- Symptoms of mental illness/medication
- Information about mental illness and its treatments
- Psychological distress
- Self harm
- Harm to others
- Alcohol
- Drugs
- Company of others
- Intimate relationships
- Sexual expression
- Child care
- Basic education
- Use of a telephone
- Use of public transport
- Money management and
- Welfare or benefits.

Two additional areas of need were assessed for this survey. They were-

- Sense of community and
- Advocacy.

Disability was assessed using the SF-12, a shortened form of the SF-36 [9]. The SF-12 is a measure of disablement or health status. It measures physical and social functioning and role limitations due to physical and mental health in the four weeks prior to assessment. It has two scales, a physical and a mental health scale and has been widely used both overseas and in Australia [10,11,12]. In the general population both scales have a mean of 50 and a standard deviation of 10.

7.1.3 Interview procedures

Interviews were conducted by either the project officer for the MAP Project or a consumer researcher, in person or by telephone. Interviewers were trained by one of the MAP committee members who has extensive experience in both training of interviewers and in the use of the CAN.

A standardised description of the project purpose was written on the cover of each interview and the project was explained to consumers when they were approached for the interview. The identity of consumers was not recorded as part of the survey.

7.2 Summary of results

7.2.1 Description of consumers who participated in the survey

All Consumers

- A total of 133 consumers participated in the survey, 71 from metropolitan areas and 62 from rural areas.
- Consumers reported levels of physical health disability in the mild range and levels of mental health disability in the moderate to severe range [10].
- Levels of need reported were similar to other clinical samples in Australia and overseas [8,13,14] with the level of need reported by rural consumers slightly higher than the averages reported by other samples. (NB The two additional areas of need were not included for this comparison.)

Rural and Metropolitan Consumers

- There were no significant differences in the level of disability reported by consumers in rural compared with metropolitan regions, or in the age and sex distribution in these two groups ($p > 0.05$).
- Despite the fact that the total number of needs reported by consumers of rural areas was slightly higher than reported by metropolitan consumers, this difference was not significant ($p > 0.05$).

Table 4. Age, sex, disability and level of need for consumers participating in the survey by region

	Region	
	Metropolitan	Rural
Sex	n = 71	n = 62
	%	%
Female	38	31
	\bar{X} (sd)	\bar{X} (sd)
Age in years	41 (12)	38 (12)
Disability¹		
Mental health scale	36.3 (5.6)	37.6 (6.2)
Physical health scale	45.9 (8.6)	42.3 (8.8)
Need		
Number of Needs	5.9 (3.7)	8.2 (4.2)

n=number, X=mean, sd=standard deviation. The SF-12 has a mean of 50 in general population samples.

Consumers from different NGO types

- The numbers of males and females in the sample did differ across NGO types ($p < 0.02$). The highest numbers of males were sampled from supported residential services and the highest numbers of females from supported employment services.
- Levels of disability reported by consumers did not differ according to the type of NGO that they accessed ($p > 0.05$).
- Levels of need did, however, differ significantly across groups. Consumers of both supported and open employment services consistently reported fewer needs compared to consumers of other NGO types ($p < 0.004$ for all comparisons, Scheffe’s post-hoc test).

Table 5. Age, sex, disability and level of need for consumers participating in the survey by type of NGO

NGO type	Support Group	Supported Residential	Drop-in or Clubhouse	Open Employment	Supported Employment
	n = 26	n = 29	n = 26	n = 21	n = 30
Sex	%	%	%	%	%
Female	39	17	46	57	23
	\bar{X} (sd)	\bar{X} (sd)	\bar{X} (sd)	\bar{X} (sd)	\bar{X} (sd)
Age in years	48 (12)	43 (11)	39 (10)	34 (10)	33 (10)
Disability¹					
Mental health scale	37.3 (5.7)	36.4 (4.9)	37.9 (5.8)	36.6 (6.8)	36.2 (6.6)
Physical health scale	45.2 (8.9)	43.4 (7.9)	43.7 (9.2)	46.2 (12.0)	44.0 (7.5)
Need					
Number of Needs	7.3 (3.7)	9.6 (3.2)	8.9 (4.3)	3.1 (2.7)	5.1 (3.0)

n=number, X=mean, sd=standard deviation.
 1. The SF-12 has a mean of 50 in general population samples.

7.2.2 Met and unmet needs of consumers

All Consumers

- More than half the consumers surveyed reported a need in the areas of psychiatric symptoms (81%), psychological distress (71%), sense of community (67%), information about mental illness and its treatments (62%), company of others (57%), daytime activities (56%) and advocacy (54%).
- One third to a half of consumers surveyed reported needs in the areas of physical health (45%), accommodation (40%), intimate relationships (38%) and safety to self (33%).
- The most commonly reported need was in the area of psychiatric symptoms. Although just over half of the consumers sampled reported a met need in the area of psychiatric symptoms, one third reported it as an area of unmet need. Many consumers commented on the negative impact the side-effects of medication had on

their lives and reported that they needed *less* help with symptoms than they were currently receiving. The findings suggest that consumers are asking for help, other than medication, for their symptoms.

- Basic needs such as accommodation and daytime activities were reported as areas of met need, where consumers received moderate to high help from local services and reported satisfaction with help received.
- Similarly, in the areas of sense of community and advocacy, consumers reported met needs, moderate to high levels of help from friends, relatives and local services and satisfaction with help received.
- Serious unmet need was more likely to be reported for social or emotional needs. One quarter to one third of consumers reported serious unmet need in the areas of psychological distress, company of others and intimate relationships. These were areas where consumers were likely to be receiving some help from friends and relatives as well as local services. However, consumers reported that they needed more help with intimate relationships and were least satisfied with the help received for this area of need.
- Information about mental illness and its treatments was commonly reported as a met need and consumers were more likely to be receiving help from local services for this need compared with help from family or friends. However, a significant proportion of consumers reported that they would like more help in this area and they were not satisfied with the help they were receiving.

Rural and Metropolitan Consumers

- Overall levels of disability and need were similar for metropolitan compared with rural consumers.
- Consumers from both areas were likely to report unmet needs in the areas of social or emotional need (company of others, intimate relationships, sexual expression, psychological distress).
- For almost all of the 24 areas of need examined consumers from rural NGOs reported higher levels of met need than did metropolitan consumers, although this difference was not significant.
- The notable exception to this was in the area of company of others, where twice as many metropolitan compared to rural consumers reported a met need and more than one third of consumers from rural areas reported an unmet need.
- Similarly, almost twice as many consumers in rural compared with metropolitan areas reported a serious unmet need in the area of psychiatric symptoms.

Consumers from different NGO types

- While levels of disability did not differ across different NGO types, levels and patterns of need did differ.
- Most notably, consumers from open and supported employment services reported lower levels of need (both met and unmet) than consumers from the other NGO types.
- Consumers from residential and drop-in services reported the highest levels of met need. Consumers from residential services reported high levels of met need in the areas of basic needs (accommodation, food, self care), as well as company of others

and sense of community, while consumers of Drop-in Centres reported met need in the areas of daytime activities, information, community and advocacy.

- With the exception of the two employment services, patterns of unmet need were more similar across NGO types. Once again social or emotional needs were more likely to be reported as areas of unmet need (company of others, relationships, psychological distress).

Recommendation

It is recommended that -

8. In all future planning activities mental health NGOs, in collaboration with consumers of their services, consider the needs of consumers identified in the study *MAP Project: Report on Needs of NGO Consumers* and develop ways of addressing the unmet needs of consumers of their services.

8. Service use by consumers of mental health NGOs

The same 10 NGOs whose clients were surveyed for the *MAP Project: Needs of NGO Consumers* study, were asked to interview 15 consumers of their service about the range of services accessed by the consumer.

8.1 Methodology

The 10 NGOs included a rural and metropolitan service from the following service types

- Support groups
- Supported residential services
- Drop-in centres/clubhouses
- Open employment services and
- Supported employment services.

As with the *MAP Project: Needs of NGO Consumers* study the interviews were conducted by consumer researchers either in person or by telephone. Interviewers were trained by one of the MAP committee members with extensive experience in the training of interviewers.

Clients were asked to estimate how much time per month they spent with the following services -

- Community health rehabilitation program or group
- Community mental health case manager
- Community health service
- General practitioner
- Psychiatrist
- Charity or church organisation
- Other services or groups and
- Identified NGO.

The mean time spent per month with all non-NGO services was added together and compared with the mean time spent at the identified NGO.

Up to 15 consumers were interviewed from nine of the 10 NGOs identified from rural and metropolitan areas. The interviewer for the metropolitan ‘open employment’ NGO was not able to interview consumers at the time of the survey.

8.2 Results

A total of 118 interviews with consumers was conducted. Table 6 below shows that where consumers are accessing a mental health NGO they access few other services. The only exception to this was for consumers accessing the rural ‘open employment’ service. These clients spent most of their service use time with community mental health services (rehabilitation and case management).

Table 6. Proportion of consumers service use time at identified NGO

Location	Service type	No. of interviews	Non NGO services mean hrs/mnth	NGO service mean hrs/mnth	% of consumers' service use time at NGO
Rural services	Support group	11	2.08	13.78	86.90
	Drop in centre or Clubhouse	15	10.35	97.00	90.36
	Supported residential	15	2.93	110.00	97.4
	Supported employment	15	11.24	54.40	82.88
	Open employment	6	22.04	2.67	10.79
Metropolitan services	Support group	15	4.88	26.07	84.24
	Drop in centre or Clubhouse	11	31.63	40.82	56.34
	Supported residential	15	6.53	70.20	91.49
	Supported employment	15	6.17	26.43	81.08
	Open employment	0			

The above table shows that when consumers in the survey were accessing a support group, Drop-in Centre or Clubhouses, supported residential service or supported employment service the percentage of their service use time with the NGO was over 80% for seven of the eight services. In the eighth service consumers spent 56% of their service use time with the NGO. This data indicates that NGO services need to encourage consumers to access a range of services to reduce their dependency on one service.

Recommendation

It is recommended that -

9. Staff of mental health NGOs encourage clients to access a range of mental health and mainstream services to reduce their dependency on one service.

9. Interface between NGOs and public mental health services

The interface between public mental health services and mental health NGOs was discussed at a forum in April 2000 comprising over 20 representatives of the non government sector. It was further discussed at a meeting with the Director of Mental Health, NSW Health.

The interface between public mental health services and mental health NGOs is not clearly defined in NSW. The core public mental health services are hospital and community based acute care services, case management services and hospital based residential rehabilitation for people with severe mental disorders. Other services include community based rehabilitation and supported residential services.

The MAP Project described in section three of this report identified 12 service types in the mental health non-government sector. These are -

- Consumer support groups (illness related)
- Community Consultative Committees
- Carer support groups
- Supported residential services
- Advocacy, education and information services
- Open employment services
- Telephone support services
- Drop in centres or Clubhouses
- Supported employment services
- Consumer networks
- Respite services and
- Outreach services.

The main areas of overlap between the two sectors are in rehabilitation and supported residential services. Historically most of the rehabilitation services and some of the supported residential services were managed and supported by public mental health services. In the past decade new supported residential services have been established mainly by the non-government sector. The NGO sector has a long history of running supported residential services for people with psychiatric disabilities. Aftercare have been providing such services for nearly 100 years and Richmond Fellowship for almost 30 years. In recent years there has been an increased focus on NGO based psycho-social rehabilitation services with the emergence of the Clubhouse model and supported employment services.

In determining those services most suitable for the NGO sector and those best managed by the public health sector it is useful to consider the International Classification of Impairments, Disabilities and Handicaps [15] and apply it to people accessing psychiatric services. Impairments relate directly to the symptoms of mental disorder or illness. Disabilities are the consequence of a mental illness and affect a person's ability to perform the activities and tasks of everyday living and develop and maintain fulfilling personal and social relationships. Handicaps are the social disadvantages which limit or prevent a person with a mental illness or psychiatric disability fulfilling their desired social roles. As disability and handicap often co-exist for people with a mental illness they are collectively referred to as psychiatric disability for the purposes of this report.

In broad terms it can be argued that acute care services and those requiring a high level of clinical expertise should remain in the public mental health sector and those providing services for people with psychiatric disabilities should primarily be provided in the non-government sector. This distinction is clearly made in Victorian Mental Health Services where the role of the public mental health sector is clearly defined and focuses on acute clinical care. The mental health NGO sector comes under the broad category of Psychiatric Disability Support Services (PDSS). The service types provided by PDSS include self help and mutual support groups, day programs including employment and recreational programs, home based outreach, residential rehabilitation and planned respite services. There are strong links and partnerships between the two sectors [16].

In NSW many of the services for people with a psychiatric disability continue to be managed and supported by the public sector mental health services. A telephone survey of Mental Health Directors (or their delegates) of each Area Health Service asked for information about supported residential services and Living Skills Centres in their area. Table 7 below shows the number of beds in supported residential services and Living Skills Centres managed by Area Health Services in NSW, and the staff resources attached to these services.

Table 7. Number of beds in supported residential services and number of Living Skills Centres in NSW

Area Health Service	Supported residential services		Living Skills Centres	
	No. of beds	No. of staff (FTE)	No. of facilities	No. of staff (FTE)
Northern Sydney	127	38.5	3	10.0
Central Sydney	9	2	4	10.5
South Eastern Sydney	0	0	0	0
Western Sydney	68	20	1	5.0
South Western Sydney	87	17	1	2.63
Wentworth	2	6.5	2	4.0
Central Coast	20	4.5	2	9.5
Hunter	38	10.0	0	11.0
Illawarra	54	8.3	3	7.0
Mid Western	51	30	0	0
Macquarie	14	10.5	0	0
Northern Rivers	10	7.2	4	6.4
Mid North Coast	14	NS	5	8.3
New England	27	8.0	6	6.5
Southern	29	7.3	0	0
Greater Murray	11	3.0	2	2.5
Far West	0	0	0	0
Total	561	172.8	33	83.3

NS – Not Specified

The two main areas of overlap between the public and NGO mental health sectors – supported residential services and non-residential rehabilitation services – are discussed below.

9.1 Supported residential services

Based on the World Health Organisation (WHO) distinction between impairments and disabilities, supported residential services in community settings are clearly for people with psychiatric disabilities and could be provided by the NGO sector. The feasibility of these services being transferred to the NGO sector would depend on the availability of suitable local NGOs capable of providing the service.

The above table shows that there are at least 491 beds in supported residential services in NSW managed and staffed by the public mental health sector. A total of at least 167.5 full time equivalent staff positions support these services. The supported residential services referred to in this section do not include the long term and extended care services

(also referred to as rehabilitation services) provided by the large psychiatric hospitals (Rozelle, Cumberland, Bloomfield, Kenmore and Morisset) for people with severe psychiatric disabilities.

There are two main types of supported residential services in the NGO sector.

9.1.1 Provision of housing and support services

In this model the NGO usually owns the property and acts as landlord for the property. The organisation employs staff who provide outreach services on a regular basis or are based on the premises. In the latter instance houses are often categorised as high, medium or low support houses and a set number of hours of support per week is allocated to each house.

As residents' support needs change they move to a house with a different level of support or to independent housing. The more disabled clients often become long term residents of the service.

9.1.2 Partnership between health, housing and NGO services

In this model the houses are owned by NSW Department of Housing and the support services are contracted out to an NGO by an Area Health Service. In some instances the NGO also provides the landlord function and in others a Community Housing Association (a housing NGO) is the landlord. Separation of the landlord and support functions eliminates the potential conflict of interest between these two roles.

The housing, health and the NGO services involved in this partnership are coordinated by a committee which meets regularly to accept clients to the service and discharge clients from the service. As in the above model the houses are often categorised as high, medium or low support houses.

9.1.3 Key workers in supported residential services

In both the above models the public mental health services, in theory, provide the residents with case management or clinical care services. In practice, however, mental health NGOs report that case managers or similar staff rarely see clients living in supported residential services and that NGO key workers provide the case management service. The survey of *Service Use by Consumers of Mental Health NGOs* (reported in Section 7 of this report) similarly shows that consumers of NGO supported residential services receive nearly all of their services from the NGO. This has probably developed due to staff in the public sector giving priority to clients with acute mental health problems and those with little or no other support.

9.2 Rehabilitation services

9.2.1 Outreach support services

The MAP Project showed that there were only four outreach services run by mental health NGOs in NSW. In contrast 'home based outreach support' services are a major component of services provided by the mental health NGO sector in Victoria.

In outreach support services the level of support is determined on the basis of each person's need and provided to the client wherever they reside. For example the client may live in public or private housing or housing provided by a community organisation. Many of the services provided by public sector case managers or care coordinators are similar to the services provided by outreach workers in the NGO sector. With the increasing emphasis on the regular review of the clinical needs of clients, and discharge of clients from case management when their acute clinical needs have resolved, there is potential for outreach support services in the NGO sector to increase significantly to address clients' disability related needs. A client's ongoing clinical needs would be met by their general practitioner or psychiatrist.

In SESAHS a Rehabilitation Services Framework which identifies the services and programs provided by the public sector and those provided by the NGO sector was developed for the SESAHS Rehabilitation Plan [17]. The Plan also distinguishes between 'clinical rehabilitation' and 'specialist disability support'. 'Clinical rehabilitation' is provided on an individual basis in the client's residence by the public sector. These services include assessment, early intervention and targeted, time limited treatment. 'Specialist disability support' services provide psychosocial rehabilitation and support for people with long term disabling mental health conditions and, where they exist, are provided by NGOs. These latter services may be time limited or ongoing depending on the needs of the client. In other AHSs intensive case management services or Mobile Community Treatment (MCT) teams provide individual rehabilitation services in a client's residence.

Which of the outreach support or rehabilitation services should be provided by the public sector and which rehabilitation services could be provided by the NGO sector depends to a large extent on the clinical needs of the client. If some of these 'one on one' rehabilitation services were provided by the mental health NGO services they may require access to clinical expertise from the public sector from time to time. A partnership model for the provision of individual clinical rehabilitation services needs to be developed following joint planning by the two sectors for a catchment area. This would take account of the particular needs of clients in that area.

9.2.2 Centre-based rehabilitation services or day programs

In recent years there has been a reduction in the number of Living Skills Centres provided by public mental health services and greater emphasis on assisting clients to access mainstream social and recreational activities. Some AHSs have closed all of their Living Skills Centres while others have at least one centre in each geographical sector of their catchment area. Table 7 above shows there are 42 Living Skills Centres managed and staffed by the public mental health sector. A total of 116.5 full time equivalent staff positions support these services.

In the AHSs where Living Skills Centres have closed the staff have usually been replaced by staff providing home-based clinical rehabilitation on an individual basis as described in 9.2.1 above. While there has been a small increase in centre based rehabilitation

services in the non government sector since the emergence of five Clubhouses in recent years there are only 14 Drop-in Centres or Clubhouses in NSW.

The policy of assisting clients to access leisure and recreational mainstream services is praiseworthy and has been successfully implemented for higher functioning clients. However, many of the more disabled clients do not access mainstream services as they feel uncomfortable with people who do not understand their disability. These clients tend to become increasingly isolated if they are not able to find 'user friendly' services. A community education program aimed at raising the awareness of individual service providers to the needs of people with psychiatric disabilities may assist to improve the accessibility of services.

It appears however that a diversity of day programs offering social and recreational activities is required to meet the varying needs of mental health consumers living in the community. Services specifically for people with a psychiatric disability should clearly be run by the non-government mental health sector. These can be run in a defined centre, in a variety of community centres or a combination of both. The Clovelly Aftercare Support Service runs programs for mental health consumers in a range of community centres.

In Victoria Psychosocial Rehabilitation Day Programs are run by the non-government mental health sector and are distributed throughout the state. They have a central base but also run programs in community centres. They offer both formally structured programs aimed at improving the social and pre-vocational skills of clients and informal drop-in programs that include social and recreational activities. Clients of the service are called members and are actively involved in planning the activities and programs provided. In addition the service encourages clients to access mainstream community activities and provides outreach support to members of the service. The services encourage members using drop in, where possible, to move onto more structured, goal orientated programs.

Recommendations

It is recommended that -

10. Partnership models of care are developed between the public mental health and the NGO mental health sectors that clearly define the roles and responsibilities of each sector and the level of integration between the two sectors. These partnership models of care need to be developed at a broad statewide policy level and at a local operational level.
11. Consideration is given to transferring or tendering out community based supported residential services, currently managed by the public mental health sector, to the NGO mental health sector wherever possible.
12. AHSs acknowledge the case management role of staff of supported residential services and ensure they are adequately resourced to fulfil this role.

13. Mental health NGOs providing supported residential services consider transferring the landlord component of the service to a Community Housing Association or other suitable organisation to separate the support and landlord functions.
14. A community education program aimed at making mainstream services more 'user friendly' for people with psychiatric disabilities is developed. The education program would be directed to a broad range of service providers including educational institutions, local councils, government departments, police services and non government community services and groups. Topics covered would include -
 - recognition of early signs and symptoms of mental illness
 - what to do if someone they know becomes unwell
 - consumers' and carers' perspectives of mental illness and
 - community perspectives of mental illness and ways of overcoming stigma.
15. A statewide rehabilitation plan is developed by NSW Health in collaboration with the Mental Health Coordinating Council and consumer representatives. The plan should clearly identify the 'disability support' rehabilitation services to be provided by the mental health NGO sector and the type of rehabilitation services to be provided by public mental health rehabilitation services and partnerships between the two sectors.
16. AHS rehabilitation services, mental health NGOs and consumers develop locally based partnerships to identify the rehabilitation needs of consumers and jointly plan services to meet those needs.

10. Planning and funding issues for mental health NGOs

The planning and funding of mental health NGOs were discussed with over 20 representatives of mental health NGOs in NSW at the forum in April 2000 and with the Map Project Steering Committee in June 2000.

10.1 Joint planning of health services for a catchment area

The development of working partnerships between NGOs and the public health system to share the responsibility for improving the health of the community requires joint planning processes. The relationship between NGOs and the health system has been articulated in legislation. Under the Health Services Act 1997, Area Health Services are to consult and cooperate (as considered appropriate) with organisations concerned with the promotion, protection and maintenance of health. The requirement to plan jointly with these organisations (as appropriate) is also articulated [2].

In most areas there is a bi-annual meeting between all health funded NGOs and representatives of the AHS to discuss issues for non-government services. In some areas joint planning activities between AHSs and mental health NGOs have been established. For example the manager of New Horizons, a mental health NGO in NSAHS, is a member of the Strategic Planning Committee for Mental Health Services, the

Rehabilitation Working Party and the Northern Sydney Community Consultative Committee.

In Northern Rivers extensive joint planning and partnerships have developed between health funded NGOs and the AHS in the past two years. The outcome of the planning process was a commitment of funding to the Non Government Organisations' Development Program by Northern Rivers Area Health Service. This Program is funded for three years to 2002 to assist NGOs in the areas of -

- Governance
- Management practice
- Quality systems
- Planning
- Asset management
- Volunteer recruitment
- Training and development and
- Networking and representation.

The Northern Rivers Area Health Service made funds of \$90,000 available in 1999-2000. In the following two years the Program will receive \$180,000 per annum. As the Program is targeted to organisational requirements of existing services, funding cannot be used for new or enhanced NGO services or major capital works.

Further to this planning the Tweed River Valley Fellowship (TRVF) and the Northern Cluster Mental Health Service established a joint integration planning committee to discuss strategic issues on a monthly basis. This led to the development of an annual planning strategy which includes joint service mapping and planning, and joint funding applications to NRAHS for projects under the National Mental Health Strategy.

The non-government sector sees joint planning with AHSs and consumers as critical to determine the needs of the area and the services best placed to meet those needs. Many mental health NGOs report however that they have limited input into AHS planning processes. It would seem that representatives from the Community Consultative Committees should be ideally placed to participate in AHS planning activities.

10.2 Funding of mental health NGOs in NSW

The mental health NGO sector in NSW is concerned about the proportion of mental health funding spent on NGO services. Table 8 below shows that NSW consistently spends a lower proportion of its total mental health service expenditure on NGOs than the comparable expenditures of its neighbouring states and the national average [18,19,20]. The NGO sector is hopeful that a proportion of the additional \$107.5 million dollars for mental health services per annum announced by the Minister in April 2000 will be allocated to the NGO sector to bring its total funding into line with, at least, the national average.

Table 8. Percentage of total mental health service expenditure on mental health NGOs

	92/93	95/96	96/97
NSW	1.1%	1.5%	1.9%
Queensland	1.3%	2.5%	3.8%
Victoria	2.9%	4.9%	7.2%
National average	1.8%	3.2%	4.2%

[Figures for 93/94 and 94/95 were not published. Figures for 97/98 and 98/99 are not yet available.]

10.3 Administration of NGO funding by Area Health Services

There is a perception that mental health NGOs have been disadvantaged, from a funding perspective, since the administration of funds moved from NSW Health to AHSs in 1996. There appears to be a conflict of interest with AHSs being both funders and providers of services. Representatives from the mental health non-government sector firmly believe they have not had a fair share of new mental health funds, under the National Mental Health Strategy, since the administration of NGO funding moved to AHSs.

A possible solution to the conflict embedded in AHSs being both funders and providers of services is for funding to be clearly identified as NGO or public health service funding before it leaves head office. The Mental Health Coordinating Council should also be informed of all new funding for mental health NGOs so they can inform their members and monitor the use of the funding.

In other government grant programs the funder/provider conflict is avoided as there is a clear separation between the responsibilities of funders and providers.

10.4 Funding and Performance Agreements

All funded NGO services should be party to a Funding and Performance Agreement as set out in Appendix 2 of the *Non Government Organisation Grant Program Operational Guidelines* [17]. The Funding and Performance Agreement includes five parts - a funding agreement (part 1), a performance agreement (part 2), details of the budget (part 3), conditions of the grant (part 4) and dispute resolution procedures (part 5). The Conditions of Grant are detailed in Appendix 1 of the *Operational Guidelines*.

10.4.1 Performance indicators and evaluation

The performance agreement section has headings for performance indicators and evaluation. The Conditions of Grant includes a requirement for an Annual Program Report in which NGOs must report against performance indicators, numbers of major users of the service and health outcomes (point 6.1.4).

The experience of NGOs with services in more than one AHS is that the requirements for reporting of performance indicators and health outcomes varies greatly from AHS to AHS with some having minimal requirements while others have onerous requirements.

The lack of consistency across the state makes it difficult for NGOs operating in a number of areas to collect routine data that meets the requirements of the various AHSs.

10.4.2 Accreditation

The Conditions of Grant (point 5.1) state that organisations “must be willing to undergo an ongoing formal accreditation process that is mutually negotiated and agreed to....”.

Following proclamation of the NSW Disability Services Act 1993 many mental health NGOs, especially the supported residential services, undertook an accreditation review based on the Disability Services Standards. The review was funded and managed by the NSW Department of Community Services. A number of organizations achieved a three year accreditation while other organizations were reviewed and asked to complete transition plans.

However as there was no ongoing funding for accreditation under the Disability Services Standards there have been no follow up reviews since the first three year accreditations expired. The services which developed transition plans were advised by NSW Health to note on the bottom of all funding applications that they were in the process of transition or “working towards accreditation under the NSW Disability Services Act 1993.....” (as stated in point 4.4.3 of Operational Guidelines).

Quality Management Services (QMS), an accreditation organisation, has recently received funding from NSW Health to assist mental health NGOs to implement an ongoing accreditation process. The standards used by QMS for mental health NGOs include a core module developed for all services and a mental health module. The mental health module incorporates both the National Mental Health Standards and the Disability Services Standards.

10.5 Role of NGO Contact Officers in AHSs

There appears to be little consistency on the role of NGO Contact Officers in AHSs. With the devolving of the administration of NGO grants to AHSs, an NGO Contact Officer was appointed in each AHS. The duties of the NGO Contact Officer were added to existing positions in all but one AHS. The positions of the NGO Contact Officers range from accountants to health service planners to managers of community health programs.

NGOs in some areas have regular contact with the NGO Contact Officer while NGOs in other areas have little or no contact. In some AHSs the NGO Contact Officer delegates contact with a mental health NGO to a manager from mental health services who is often unaware of the *Non Government Organisation Grant Program Operational Guidelines* (1996) and the Funding and Performance Agreement or contract.

While all NGOs should receive a Funding and Performance Agreement as detailed in the *Non Government Organisation Grant Program Operational Guidelines* (1996) a number of NGOs funded through the Grant Program report that they did not receive a Funding and Performance Agreement for 1999/2000. Some AHSs now provide three years

Funding and Performance Agreements while other AHSs are still providing yearly Agreements.

10.6 Tendering of services

There has been an increasing trend for AHSs to tender out new NGO services especially in urban areas where there is more than one potential service provider. However, there have been a number of problems with competitive tendering which are discussed below.

10.6.1 Competitive tendering

The use of competitive tendering by governments for services in the non-government and charitable sector has been a subject of debate in the human services field. The Australian Council of Social Service (ACOSS), a national peak body for non-government and charitable organisations, has explored the implications of competition policy and tendering in some detail. They argue that human services are fundamentally different from other types of business and production and this needs to be reflected in the way in which governments fund and deliver human services.

“Inappropriate use of competition in the selection of agencies is likely to result in efficiency taking precedence over quality and equity, unnecessary closure of services and loss of community infrastructure.....Forced competition will also undermine interagency cooperation and collaboration at a time when much of the reform agenda at state and national level is directed towards achieving better coordination and integration between services.” [16]

The experience of the mental health NGO sector in NSW has been that competitive tendering has disadvantaged the smaller specialist mental health NGOs as they do not have the infrastructure of larger NGOs and charities to defray operating costs. It has also led to tensions between services when, for example, a service wins a tender based on lower costs but is then unable to deliver a quality service. While competitive tendering does not necessarily mean the cheapest service wins the tender there is a perception that this happens, and thus larger organisations have an advantage.

10.6.2 Fixed price tendering

In fixed price tendering the emphasis is on the best quality service proposal for a fixed price rather than the lowest cost service proposal. Due to the problems with competitive tendering the Victorian Department of Human Services currently supports fixed price tendering for contracts with the non-government sector.

Psychiatric Disability Services of Victoria (VICSERV), the peak organisation for mental health NGO service providers in Victoria reports that the Victorian Government’s adoption of fixed price tendering in the human services field has overcome most of the problems with competitive tendering [17]. While competition between services still causes some tensions it is seen as a fairer competitive environment.

Recommendations

It is recommended that -

17. Mental health NGOs and consumer representatives are integrally involved in all mental health planning activities in an Area Health Service. This should include funding for the Mental Health Coordinating Council to review the operation of Community Consultative Committees and provide training to consumer and NGO representatives. The aim of the training would be to assist these representatives to actively participate in the planning of mental health services and development of partnerships between services.
18. The planning partnership developed between the public mental health sector and NGO mental health sector in the Northern Rivers is explored by services in other areas.
19. The proportion of funding provided to the mental health NGO sector in NSW is increased to at least the national average.
20. Mechanisms are developed to clearly identify new funds for the mental health NGO sector before they are sent to AHSs to reduce the funder/provider conflict of interest.
21. All mental health NGOs funded by AHSs or the NSW Health make arrangements with Quality Management Services for their service to be involved in an ongoing accreditation process.
22. NSW Health and AHSs clearly identify the role and responsibilities of NGO Contact Officers in Area Health Services and provide this information to NGOs funded by NSW Health or an AHS.
23. NSW Health and AHSs clearly identify the role and responsibilities of NGO Contact Officers in Area Health Services and provide this information to NGOs funded by NSW Health or an AHS.
24. AHSs provide all funded mental health NGOs with three year Funding and Performance Agreements.
25. AHSs adopt fixed price rather than competitive tendering when tendering is used for the funding of new services.

11. Conclusion

The mapping of the mental health NGO sector in NSW has provided the sector and the government with useful data for defining the sector and future planning of mental health NGOs. The data shows the range of service types within the sector and the distribution of NGOs across AHSs. Some areas are well served by mental health NGOs and have a

range of service types while others areas are poorly served and do not have some of the key service types such as supported residential services or employment services.

The detailed survey of the inputs and capacity of a sample of 52 NGOs shows that the size and function of services varies widely. Some mental health NGOs are small unfunded support groups while others are large funded organisations with 10 or more facilities offering up to four service types. Some organisations are located within one AHS while others have facilities in three or four AHSs or have a statewide brief. The substantial involvement of volunteers in many NGO strengthens their capacity of the local community to care for its residents.

The Camberwell Assessment of Need survey of 133 consumers from rural and metropolitan areas provides a profile of mental health consumers accessing NGOs and consumer perspectives of met and unmet needs. The survey showed that consumers of mental health NGOs in NSW experience significant disability related to their mental health and report significant levels of need. While many consumers report their physical and medication needs are being met by government services, it is the NGOs as well as family and friends who play a crucial role in providing help with daytime activities, company of others, sense of community and advocacy. Despite the help provided by both sectors, consumers still report significant unmet need in the areas of psychological distress, company of others and intimate relationships.

A service use survey of 118 consumers found that where consumers are accessing a mental health NGO they access few other services. The only exception to this was clients accessing an open employment service. These clients spent most of their service use time with community mental health services. It is important that NGO services encourage consumers to access a range of services to reduce their dependency on one service.

The survey of outcomes measures used by mental health NGOs indicated that services were using a range of formal and informal outcome indicators to measure the effectiveness of their services. Greater consistency with the measures used for each service type would allow for the collation of outcome data on a wider scale.

The data collected for the MAP Project also provides valuable information for defining the interface between the mental health NGO and public mental health sectors. In broad terms it can be argued that acute care services and those requiring a high level of clinical expertise should remain in the public mental health sector and those providing services for people with psychiatric disabilities should be provided in the non-government sector. This distinction is clearly made in Victorian Mental Health Services where the mental health NGO sector comes under the broad category of Psychiatric Disability Support Services (PDSS).

In NSW the main areas of overlap between the two sectors are in rehabilitation and supported residential services. While most new supported residential services have been established in the NGO sector in the last decade there is still a substantial number of these services managed by AHSs. In rehabilitation services the distinction between the roles

and responsibilities of two sectors in NSW is less clearly defined. Wherever feasible it seems that centre-based rehabilitation services for people with a psychiatric disability and day programs focussed on linking consumers into mainstream community activities and support should be run by the non-government mental health sector. Further with the increasing emphasis on the regular review of clients, and discharge of clients from case management when their acute clinical needs have resolved, there is potential for outreach support services in the NGO sector to increase significantly to address clients' disability related needs.

Finally there are a number of planning and funding issues to be resolved for the mental health NGO sector. The NGO sector would like greater consistency between AHSs in relation to reporting requirements, and greater transparency and fairness in funding decision making processes. Fixed price tendering is seen by the sector to be a fairer process than competitive tendering.

The mental health NGO sector is keen to make a greater contribution to the overall planning and provision of mental health services in their area and look forward to increased funding to the sector following the Minister's announcement of an overall increase in the mental health budget for NSW. Better resourcing of the mental health NGO sector will increase the capacity of communities to contribute to service provision and care for their residents with psychiatric disabilities. The flexible and responsive nature of NGOs means they are ideally placed to provide a range of services that best meets the needs of their communities.

References

1. NSW Health. *Caring for Mental Health. A Framework for Mental Health Care in NSW*, NSW Health Department, 1998.
2. Success Works. *Relationships Between the NSW Government and Non Government Organisations*. Consultation Discussion Paper. May 2000.
3. NGO Advisory Committee of NSW Department of Health. *NGO Framework - A Discussion Paper*. May 2000.
4. Bradfield J and Nyland J. *Strengthening Community Management*. Prepared for the Stronger Community Management Consortium, 1997.
5. Issakidis C and Bateman J. *MAP Project: Report on the Needs of NGO Consumers*, May 2000.
6. NSW Health Council. *Report of the NSW Health Council - A Better Health System for NSW*, March 2000.
7. Andrews G, Peters L and Teesson M. *The Measurement of Consumer Outcome in Mental Health*. Mental Health Branch, Commonwealth Department of Human Services and Health, 1994.
8. Stedman T, Yellowlees P, Mellisop G, Clarke R and Drake S. *Measuring Consumer Outcomes in Mental Health. Field Testing of Selected Measures of Consumer Outcomes in Mental Health*. Mental Health Branch, Commonwealth Department of Health and Family Services, 1997.
9. Wing J, Curtis R, and Beevor A. *Health of the Nation Outcome Scales: Report on Research*. Royal College of Psychiatrists, London, 1996.
10. Parker G, Rosen A, Emdur N, and Hadzi-Pavlovic D. The Life Skills Profile: psychometric properties of a measure of function and disability in schizophrenia. *Acta Psychiatrica Scandinavica* 1991, 83: 145-152.
11. Phelan M, Slade M, Thornicroft G, Dunn G, Holloway F, Wykes T, et al. The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry* 1995, 167: 589-595.
12. Issakidis C and Teesson M. Measurement of need for care: A trial of the Camberwell Assessment of Need and the Health of the Nation Outcome Scales. *Australian and New Zealand Journal of Psychiatry* 1999, 33(5): 754-759.
13. Ware JE, Kosinski M, Keller SD. *How to score the SF-12 physical and mental health summary scales*, 3rd ed. Lincoln, RI: Quality Metric Incorporated, 1998.
14. Sanderson K and Andrews G. Mental health related disability in the community: prevalence, severity and relationship to diagnosis, Clinical Research Unit for Anxiety Disorders, Sydney, working paper 2000/1.
15. Henderson S, Andrews G, Hall W. Australia's mental health: an overview of the general population survey. *Australian and New Zealand Journal of Psychiatry* 1999, 34(2): 197-213.
16. Hodder T, Teesson M, Buhrich N. *Prevalence of mental disorders, disability and health service use among homeless people in inner Sydney*. Research Group in Mental Health and Homelessness and Sydney City Mission, Sydney, 1998.

17. Hansson L, Bjorkman T, Svensson B. The assessment of needs in psychiatric patients: inter-rater reliability of the Swedish version of the Camberwell Assessment of Needs instrument and the results from a cross-sectional study. *Acta Psychiatrica Scandinavica*, 1995, 92: 285-293.
18. Slade M, Phelan M, Thornicroft G. A comparison of needs assessed by staff and needs assessed by an epidemiologically representative sample of patients. *Psychological Medicine* 1998, 28: 543-550.
19. World Health Organisation. International Classification of Illness, Disability and Handicap, WHO, Geneva 1980.
20. Victorian Mental Health Services. *Psychiatric Disability Support Services*. Draft Working Paper for Discussion at VICSERV Forum, 1996.
21. South Eastern Sydney Area Health Service. *Rehabilitation Plan*, October 1999.
22. Mental Health Branch, Commonwealth Department of Human services and Health. *First National Mental Health Report 1993. Monitoring Progress Towards National Mental Health Policy*, 1994.
23. Mental Health Branch, Commonwealth Department of Health and Family services. *National Mental Health Report 1996. Fourth Annual Report. Changes in Australia's Mental Health Services under the National Mental Health Strategy 1995-96*, 1998.
24. Mental Health Branch. Commonwealth Department of Health and Aged Care. *National Mental Health Report 1997. Fifth Annual Report. Changes in Australia's Mental Health Services under the National Mental Health Strategy 1996-7*, 1998.
25. Policy Development Division, NSW Department of Health. *Non Government Organisation Grant Program. Operational Guidelines*, 1996.