

# THE NSW COMMUNITY MANAGED MENTAL HEALTH SECTOR MAPPING REPORT

2010







Working for  
Mental Health

# **THE NSW COMMUNITY MANAGED MENTAL HEALTH SECTOR MAPPING REPORT**

## **2010**

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## ABOUT THE MENTAL HEALTH COORDINATING COUNCIL OF NSW

MHCC is the state peak body for community managed organisations (CMOs) representing the views and interests of over 200 CMOs throughout NSW. Member organisations specialise in the provision of services and support for people with a disability as a consequence of mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community.

Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development. The organisation consults widely in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector, and is a registered training organisation, delivering mental health certified training and professional development to the workforce.

## FUNDED BY NSW HEALTH

## FOREWORD

Traditionally, community organisations formed in response to unmet need in communities. Many started as voluntary organisations and went on to receive government grants to support their activities. The development of the NSW community managed mental health sector has been defined by both organic and strategic growth at different points in its history. Its outcomes have, however, come to be recognised as highly beneficial in supporting people with mental health problems to live, work and participate in community life, complementing the work of the public and private mental health services.

As the value of the sector has become more evident and recognised both the State and Commonwealth have established program funding in NSW for delivery of specific services. At the same time awareness of the impacts of mental health problems and psychiatric disability for the range of individuals accessing diverse community service areas has led to identification of expertise in mental health as a core skill set for people working in non mental health specialist community organisations.

Consequently, understanding what comprises the community managed mental health sector has become very complex with no single source able to provide information on its size, scope of activity, workforce and outcomes. This understanding is needed if the sector is to work with government agencies, the community sector and consumers and carers to provide services that meet the needs of our population.

This report is a start in scoping and defining the NSW community managed mental health sector. It has throughout its development been referred to as the *NSW Community Managed Mental Health Sector Mapping Project* but it is in fact much more than a mapping exercise. In line with the need to understand and define the sector four major outcomes have been achieved. They are designed to enable clear directions for the future growth and development of the sector.

The first achievement is an international *Literature Review* on capacity building in the community managed sector and some of the support structures that have been employed in its development; second - and stemming from the *Literature Review* - is establishment of a capacity building framework for the community managed mental health sector based on four key areas of organisational operation and including creation of a taxonomy of service types; third is a thorough snapshot of the size, location and activity of the sector; and finally eleven clear and actionable recommendations are presented to further the ongoing development of community organisations that work with people recovering from mental health problems.

I commend this report to you with the hope that it will form the basis for ongoing collaboration between all stakeholders in developing the NSW community managed mental health sector.

Best wishes



Jenna Bateman  
Chief Executive Officer  
Mental Health Coordinating Council





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# EXECUTIVE SUMMARY

## SECTOR MAPPING PROJECT BACKGROUND

As the numbers of mental health community managed organisations (CMOs)<sup>1</sup> grow rapidly, the Mental Health Coordinating Council (MHCC) is taking steps to focus efforts on accessible, relevant, high quality and coordinated programs for people who need mental health support.

The NSW mental health sector involves a range of stakeholders including:

- People affected by mental health problems, their families, and advocates;
- Community managed (not-for-profit) organisations;
- For-profit entities (including GPs & private providers); and,
- Governments (local, State and Commonwealth).

The *NSW Mental Health Community Managed Organisation (CMO) Sector Mapping Project* focuses on CMOs providing mental health services for people affected by mental health problems, their families and carers in NSW. Through this project the MHCC seeks to achieve two objectives:

- Develop a current picture of the community managed mental health sector in NSW; and,
- Provide information, using evidence based methodology, to guide in future planning and sector development.

## OUTCOMES OF THE SECTOR MAPPING PROJECT

1. *Literature Review* on CMOs and CMO approaches to mental health support.
2. A community managed mental health *Sector Capacity Framework* incorporating:
  - Client Experience (individual & family)<sup>2</sup>;
  - Service Provision;
  - Policy and Planning; and,
  - Research and Development.
3. *Sector Mapping Project Report* showing a clear snapshot of CMOs providing mental health programs in NSW that responded to the *Sector Mapping Survey*.
4. Actionable *Recommendations* for building community mental health sector capacity.

## SECTOR MAPPING SURVEY METHODOLOGY & RESULTS

A detailed *Literature Review* and an extensive survey of CMOs providing mental health programs were undertaken resulting in well-founded recommendations for future sector development. The *Literature Review* provided a *Sector Capacity Framework* that was used in design of the *Sector Mapping Survey* and analysis of the resulting data. The *Sector Mapping Survey* yielded valid responses from 247 organisations providing information on 350 community managed mental health programs in NSW. The findings of the *Sector Mapping Survey* are extensive and are described in detail in this report. A brief summary of survey findings is attached to this *Executive Summary*, however, a more comprehensive review of all findings is strongly recommended for full contextualisation of results.

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<sup>1</sup> MHCC uses the term "community managed organisation" (CMO) interchangeably with "not-for-profit" (NFP) organisation. These organisational structures have also historically been known as "non-government organisations" (NGOs).

<sup>2</sup> The *Literature Review* uses a broad cross-section of Australian and international health and community sector information in which the terms "consumer", "service user" and "client" are used interchangeably. This report uses the term client to include both mental health service consumers and their carers (ie, family and friends of people with mental illness).

## KEY RECOMMENDATIONS ARISING FROM THE SECTOR MAPPING PROJECT

### Recommendation 1

A clear framework will be produced by NSW Health which will structure its relationship with the mental health CMO sector.

### Recommendation 2

Seven core community-managed mental health service areas (functions) to be accessible within each local area. The amount of support available is population-based with needs based variation parameters.

- Accommodation Support & Outreach;
- Employment & Education;
- Leisure & Recreation;
- Family Support & Carer Programs;
- Self-help & Peer Support;
- Helpline & Counselling Services; and,
- Information, Advocacy & Promotion.

### Recommendation 3

Mental health consumers have access to the range of CMO service types and experience continuity of care between components of the mental health service system.

### Recommendation 4

The CMO sector will: develop a recovery-oriented audit mechanism for CMOs; and, develop a CMO equivalent of MH-CoPES.

### Recommendation 5

CMOs develop and adopt a *Care Coordination Strategy* that will promote pathways and linkages across the mental health sector.

### Recommendation 6

The CMO sector is supported to meet quality standards and build capacity to deliver effective services.

### Recommendation 7

*Workforce Development* continues to be strengthened as a critical factor in sector development.

### Recommendation 8

Streamline procurement processes and introduce outcome focused funding and performance agreements.

### Recommendation 9

An *Agreed Data Set* be adopted by NSW mental health CMOs and government funding bodies. De-identified data is generated from CMOs to:

- Build a clearer picture of the size and functionality of the CMO sector; and,
- Enable CMO sector evaluation and planning.

### Recommendation 10

A broad *Community Mental Health Research Network* be developed.

### Recommendation 11

Evaluate the outcomes of the recommendations arising from the *Sector Mapping Project* and review capacity of the New South Wales mental health CMO sector in 2013.

## BRIEF SUMMARY OF SECTOR MAPPING SURVEY FINDINGS

CMO Type	Type 1	Type 2	Type 3	
	Providing mental health programs only	Providing mental health programs in addition to other programs	Providing mental health support but no specific mental health programs	
	35 CMOs (14%)	102 CMOs (42%)	110 CMOs (45%)	(p.27)
<b>Organisational data</b>	247 CMOs – not including peak bodies – delivering 350 programs.			
Program range	21 program types identified. The three most prevalent are:			
	<ul style="list-style-type: none"> <li>Accommodation</li> <li>Support/self-help groups</li> <li>Psychology/counselling services</li> </ul>	<ul style="list-style-type: none"> <li>51</li> <li>47</li> <li>46</li> </ul>		(p.30)
Core service areas	318/350 programs:			
	<ul style="list-style-type: none"> <li>Employment &amp; Education</li> <li>Accommodation Support &amp; Outreach</li> <li>Self-Help &amp; Peer Support</li> <li>Helpline &amp; Counselling Services</li> <li>Leisure &amp; Recreation</li> <li>Information, Advocacy &amp; Promotion</li> <li>Family Support &amp; Carer Programs</li> </ul>	<ul style="list-style-type: none"> <li>29%</li> <li>18%</li> <li>15%</li> <li>14%</li> <li>10%</li> <li>7%</li> <li>7%</li> </ul>		(p.31)
Program funding sources	26 funding sources identified, including:			
	<ul style="list-style-type: none"> <li>NSW government</li> <li>Federal government</li> <li>Private donation</li> <li>Other</li> <li>Other government</li> </ul>	<ul style="list-style-type: none"> <li>44%</li> <li>22%</li> <li>15%</li> <li>12%</li> <li>7%</li> </ul>		(p.70)
Organisational structure	CMOs are most commonly Incorporated Associations (60%) or Companies Limited by Guarantee (22%).			(p.28)
Referral sources/effectiveness	Self-Referral/Drop-in (77%); Other CMOs (76%); Government Agencies (73%); Family Referral (67%); Hospitals (49%); Government Psychiatric Facilities (36%); Other (19%). Most effective referral source (responded agree/tend to agree) – other CMOs (93%), NSW Government (54%), NSW Health (49%), and GPs (23%).			(p.45)
Partnerships	Average – 2.7 formal agreements; Average no. of partners within each formal agreement – 11 CMOs	Average – 5 formal agreements; Average no. of partners within each formal agreement – 7 CMOs	Average – 3.9 formal agreements; Average no. of partners within each formal agreement – 6 CMOs	(p.47)
Human Resources	Average – 25 FTE, 40 hrs/week volunteers	Average – 13 FTE, 22 hrs/week volunteers	Average – 3 FTE, 7 hrs/week volunteers	(p.49)
Data collection systems	<ul style="list-style-type: none"> <li>Fully computerised data collection</li> <li>Mixture of manual and computerised data collection</li> <li>Manual data collection</li> <li>No data collection</li> </ul>			<ul style="list-style-type: none"> <li>18%</li> <li>60%</li> <li>13%</li> <li>9%</li> </ul>
Types of client data collected	Most CMOs collect many types of client data – client personal information (85%), referral source (82%), type of assistance provided (81%), mental health diagnosis (75%), client circumstances (73%), progress monitoring (70%), consumer functional status (63%), exit details (60%), amount of time assistance provided (59%), and other data (49%).			(p.53)

CMO Type	Type 1	Type 2	Type 3	
Outcome monitoring	Most popular outcome monitoring tools – DASS, K10+, CANSAS, GAF			(p.53)
Use of outcome monitoring tools	60% use outcome monitoring tools. Three tools are used on average.	34% use outcome monitoring tools. Two tools are used on average.	21% use outcome monitoring tools. One tool is used on average.	(p.55)
KPIs	72% of CMOs set Key Performance Indicators.			(p.57)
Accreditation	Accredited – 38%	Accredited – 32%	Accredited – 15%	(p.58)
	<ul style="list-style-type: none"> <li>23% of CMOs are currently externally accredited with QIC, ACHS, ISO, or SAI Global.</li> <li>38% intend to seek accreditation in next two years.</li> <li>Accreditation was more than twice as likely for Companies Limited by Guarantee (41%) than for Incorporated Associations (17%).</li> </ul>			
Other quality reviews	<ul style="list-style-type: none"> <li>58% of CMOs are intending to have an external general service development review in next two years.</li> <li>56% of CMOs have arrangements with external organisations to conduct reviews for general service development.</li> <li>57% of CMOs have developed internal quality standards.</li> <li>52% of CMOs are required to comply with government developed quality systems.</li> </ul>			(p.58)
Key challenges for the mental health sector	<ul style="list-style-type: none"> <li>Lack of funding and growing demand.</li> <li>Low availability of trained and skilled staff.</li> <li>Dependence on government, short-term contracts, and poor communication.</li> <li>Lack of collaboration between providers, especially in relation to referrals.</li> </ul>			(p.59)
Most wanted change	<ul style="list-style-type: none"> <li>More funding.</li> <li>More workforce development.</li> <li>Memoranda of Understanding with Area Health Services including clear role delineation.</li> <li>Reduced red tape in dealing with NSW Health.</li> </ul>			(p.59)
Most important policy initiative in NSW	<ul style="list-style-type: none"> <li>Varied responses - most frequently mentioned are new plans and acts in the NSW Parliament, an increase in accommodation services and increased funding. There were a substantial number of neutral and negative responses.</li> </ul>			(p.73)





# INTRODUCTION

## INTRODUCTION

The *NSW Mental Health Community Managed Organisation Sector Mapping Project* builds on previous work undertaken by the Mental Health Coordinating Council (MHCC) – and funded by NSW Health Mental Health and Drug and Alcohol Office (MHDAO) – to strengthen the capacity of community managed organisations (CMOs) providing mental health services.

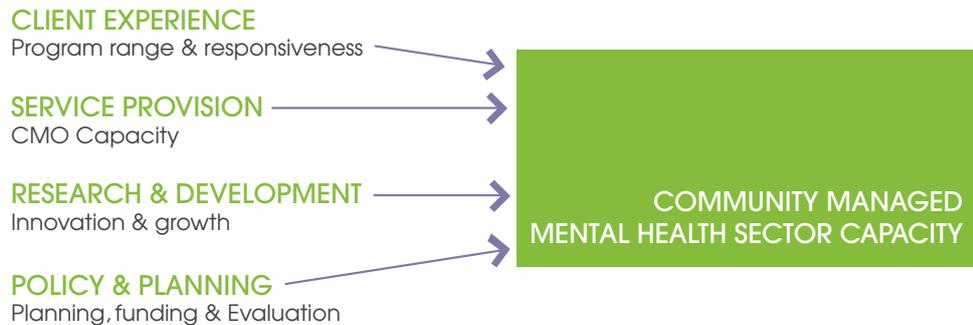
A shift is occurring towards increasingly community based service delivery. It is essential to have a better understanding of the capacity of the NSW community managed mental health sector, and to identify ways in which it can be developed, to effectively anticipate and respond to the needs of people affected by mental illness.

The *Sector Mapping Project* is funded under the *Infrastructure Grants Program (IGP)* – an initiative funded by NSW Health and administered by MHCC. The *Sector Mapping Project* is an early stage in the development of a service planning and resource allocation framework under which CMOs can be systematically supported to enhance their role and function within the mental health service system. Through the *NSW Mental Health CMO Sector Mapping Project* the MHCC seeks to achieve two objectives:

1. **Develop a current picture of the community managed mental health sector in NSW; and,**
2. **Provide information, using evidence based methodology, to guide in future planning and sector development.**

A comprehensive *Literature Review* is attached at the end of this report. The *Literature Review* explored the elements contributing to community managed mental health sector capacity and from these a *Sector Capacity Framework* was developed (Figure 1 & Appendix 1).

**FIGURE 1: NSW COMMUNITY MANAGED MENTAL HEALTH SECTOR CAPACITY FRAMEWORK**



Although there is much literature in regard to CMO capacity, the community managed mental health sector capacity is poorly defined. In the context of government planning and funding of many community managed mental health programs – and drawing on community mental health, Organisation for Economic Cooperation and Development (OECD)<sup>3</sup>, social inclusion, public health system and other concepts – elements were identified in the *Literature Review* which contribute to MHCC's definition of "community managed mental health sector capacity". Each of the sector capacity elements is not, in isolation, enough to bring about effective sector performance and development. It is essential to strengthen all four elements concurrently.

<sup>3</sup> Organisation for Economic Co-Operation and Development (2006)

## DETAILS OF SECTOR CAPACITY FRAMEWORK ELEMENTS

### Client Experience (Program range & responsiveness)

People are informed, educated and empowered about mental health issues and linked with needed personal mental health supports. Accessible, relevant, well-coordinated, recovery oriented mental health programs, using evidence based supports, are available for people with mental health concerns and/or mental illness. Programs are provided; across the spectrum of age groups; in urban, rural and remote areas; and, using culturally and linguistically competent and disability friendly responses. Recovery oriented indicators of wellbeing are used to enable clients to monitor outcomes.

### Service Provision (Organisational capacity)

CMOs are strategically and operationally sound, well resourced, skilled and engage with each other in a streamlined regulatory environment. Community partnerships are mobilised to: identify mental health problems; develop solutions to increase wellbeing; and, to provide accessible, relevant, well-coordinated mental health services. A competent mental health workforce is in place.

### Policy & Planning (Planning, funding and evaluation)

Transparent and consistent sector planning, funding and evaluation mechanisms are in place. Policies and plans that support individual and community mental health programs are developed. Evaluation of the effectiveness, accessibility, and quality of personal and population-based community managed mental health programs leads to progressive change in the sector.

### Research & Development (Innovation & growth)

Transparent, consistent, sector research mechanisms are in place. CMO service delivery models and practices are identified and investigated. New insights and innovative methods to support recovery are evaluated to build an evidence base of good practice.

### The Sector Mapping Survey

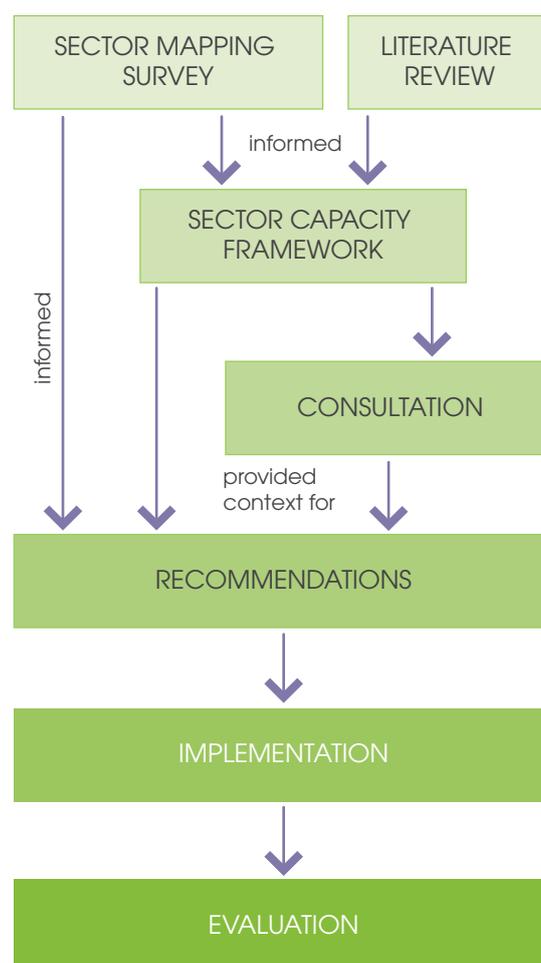
The *Sector Mapping Survey* yielded valid responses from 247 organisations providing information about 350 community managed mental health programs. Analyses of the data occurred in the context of the NSW community managed mental health *Sector Capacity Framework* elements. Results were used to develop recommendations for each framework element and to develop implementation guides upon which to base cross-sector discussions to strengthen the capacity of the NSW community managed mental health sector over the coming years.

## THE SECTOR MAPPING PROJECT

The following diagram provides a visual overview of the approach used in implementation of the *Sector Mapping Project*. The survey and project methodology are discussed in more detail elsewhere in this report:

- Section 3: Sector Mapping Survey Methodology: and,
- Appendix 2: Details of Methodology – Sector Mapping Project.

FIGURE 2: APPROACH OF THE SECTOR MAPPING PROJECT



## LITERATURE REVIEW – SUMMARY

An extensive *Literature Review* was undertaken to explore community managed mental health sector capacity issues and this full document is provided as an Attachment to – and should be read in conjunction with – this *NSW Mental Health CMO Sector Mapping Project Report*. It included a review of research literature and internet-based information as well as related policy and planning documents. The brief summary below highlights key issues arising from the Literature Review that helped to inform the *Sector Mapping Project*.

### PURPOSE

The purpose of the *Literature Review* was to provide a context for the *Sector Mapping Project* and to inform recommendations to develop the capacity of the NSW community managed mental health sector.

### COMMUNITY MANAGED ORGANISATIONS (CMOS)

The MHCC uses “community managed organisation” (CMO) interchangeably with “not-for-profit” (NFP) organisation.

CMOs continually change, progressing through life-cycle stages, each of which has particular needs and challenges. Engagement with CMOs should be underpinned by a sound understanding of particular needs and challenges of CMOs at each life cycle stage.

Australian CMOs receive proportionally less government revenue than those in Canada and Europe. Internationally, governments are devoting considerable resources to ensure CMOs continue in their essential role. The notion that it is appropriate for governments to provide support for building NSW CMO capacity aligns with international practice.

### NATIONAL INFLUENCES ON CMO SECTOR

The Australian government has a national CMO sector reform group and has proposed a national compact between itself and the CMO sector. The Productivity Commission has proposed a regulatory and support framework for the Australian CMO sector. Supports developed at a national level will impact on NSW mental health CMOs.

Implementation of the *National Health and Hospitals Reform Commission* recommendations and the *Fourth National Mental Health Plan* will impact on NSW mental health CMOs in ways that are not yet clear. The NSW mental health CMO sector should position itself to contribute to, and adapt itself to support, changes which are in the best interests of the community.

There is some alignment in State and Territory planning with the principles of the *Fourth National Mental Health Plan*.

### CHANGING RELATIONSHIPS: GOVERNMENTS AND CMOS

There has been a shift from traditional direct government to a contemporary, more networked government. Governments are focusing more on funding and monitoring, and deliver fewer services which are, in turn, delivered by CMOs. The contractual relationship embodies particular areas of the government–CMO relationship. When contracting practices are poor, efficient and effective service delivery is undermined. A common set of core principles should be developed to underpin all government contracts in human services.

There are very few explicit statements clarifying the roles of CMOs and governments in mental health support, highlighting the need to develop clarity regarding the roles of NSW mental health CMOs and governments in funding and providing mental health support.

CMO providers may be approaching coordination of client supports from interdisciplinary or transdisciplinary frameworks while NSW Health, as a service provider, uses a multidisciplinary framework suggesting potential challenges for collaboration. Joint education for CMO and NSW Health employees in contemporary approaches to teamwork should be considered.

### PROPOSED CORE SERVICE AREAS FOR GOVERNMENT FUNDED CMOS

The seven NSW mental health core CMO service areas are:

- Accommodation Support & Outreach;
- Employment & Education;
- Leisure & Recreation;
- Family Support and & Carer Programs;
- Self-help & Peer Support;
- Helpline & Counselling Services; and,
- Information, Advocacy & Promotion.

The NSW mental health core CMO service areas include the following common features:

- Culturally competent and disability friendly responses;
- Prevention & early intervention orientation;
- Rural and remote support;
- Emergency support; and,
- Support across the spectrum of age groups.

## CMO HUMAN RESOURCES

Both training and support for CMO boards in governance and more strategic approaches to attract, utilise, develop and retain CMO volunteers are required. Demand for CMO staff with higher level qualifications is expected to grow and it is recommended that the sector keeps up-to-date opportunities arising from the *National Mental Health Workforce Strategy/Plan* and *National Health Workforce Taskforce NGO Mental Health Workforce Study*. Career paths for CMO employees are not clear and yet it is known that many CMO employees move to the public sector. It is essential that sector-wide career paths for CMO employees are developed. CMO service delivery employees may become CMO managers (without sufficient management skills) necessitating access to training in CMO business management. In addition, leadership skills have been recognised as a critical factor in system and service reorientation to provide community-based and recovery-oriented mental health services<sup>4</sup>.

## CONSUMER-RUN ORGANISATIONS

Internationally, mental health consumers operate or play a major role in providing a wide range of programs. Mental health consumers in NSW are not playing such a major role. In order to ensure that the NSW mental health CMO sector is prepared to meet future demands, workforce development for consumer-providers (ie, consumers employed and/or volunteering in consumer-run organisations and other CMOs) should be firmly on the sector capacity building agenda.

## PARTNERSHIPS

Some partnership mechanisms are in place within the NSW mental health CMO sector. The sector needs to facilitate partnerships focusing on the promotion of recovery and life-transformation.

## PUBLIC ACCESS TO INFORMATION ABOUT COMMUNITY MANAGED MENTAL HEALTH PROGRAMS

Finding information about CMOs providing community managed mental health programs in NSW is difficult. There seems no straightforward way to access mental health programs provided by CMOs. Information about NSW mental health CMOs should be easy to access.

## THE COMMUNITY MENTAL HEALTH SECTOR

The “*Optimal Mix of Services Pyramid*” elaborated upon by The World Health Organisation (WHO) and the World Organisation of Family Doctors (WONCA) depicts: informal mental health services; mental health services through primary care; and, formal community mental health services. Formal community mental health services are specialised mental health services based in community settings with programs delivered by a trained workforce.

The NSW community managed mental health sector should incorporate the underpinning principles of the WHO model for mental health systems. No single service setting can meet all population mental health needs. Support, supervision, collaboration, information-sharing and education are essential components of any mental health system. Individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery.

## FUNDING THE COMMUNITY MANAGED MENTAL HEALTH SECTOR

Funders’ expectations of low CMO running costs can contribute to under-reporting of CMO overheads and low infrastructure investment. Realistic expectations of CMO running costs need to be made by funders. There are no consistent methods for funding NSW mental health CMOs. Linking funding directly to bed occupancy allows little flexibility to develop non-residential community-based mental health services. Diagnosis-related funding leads to inequity in response to disability.

In determining resource allocation to CMOs, governments should consider factors such as: size of local population; relative population needs; and, the local cost of delivering services. Functional need, rather than diagnosis, should be used to determine individual need.

CMO funding risk factors need to be defined, along with a mechanism to indicate how risk factors will impact on CMOs receiving or applying for government funding. CMO age, life cycle stage, size, asset base, and experience with government grants contribute to an understanding of CMO funding risk factors. However, there is little agreement about what constitutes CMO size.

## MEASURING CMO PERFORMANCE

Completion rates of routine outcomes measurements are low and some argue that current tools are not sufficiently service user-oriented. A data collection and outcomes measurement strategy that more strongly reflects a service-user perspective needs to be developed and implemented.

<sup>4</sup> Anthony & Huckshorn, 2008.

## COMMUNITY MANAGED MENTAL HEALTH SECTOR RESEARCH

The Centre for Community Service Effectiveness has been proposed by the Productivity Commission as a means to assemble and disseminate evaluations based on an agreed national measurement framework for CMOs.

Practice-based research networks are underused in mental health services research. In NSW, an *Alcohol & Other Drugs and Mental Health Research Network* is in the stages of early formation. There is no dedicated research network for the broader community managed mental health sector in NSW. There are few approaches of note reported by Australian mental health CMOs. The mental health CMO sector needs to report effective, innovative approaches to mental health support. A broad *Community Mental Health Research Network* should be developed.

## CAPACITY BUILDING FOR CMOS

In Australia, each State/Territory government provides funds to strengthen CMOs and support is provided on a piecemeal basis. A more strategic approach to CMO support is required.

The NSW government sees CMO capacity building as a whole-of-government issue with NSW Health demonstrating its commitment to engage with the CMO sector through a range of initiatives. Building on the investment made by NSW Health in the mental health CMO sector will enhance an efficient, robust and integrated mental health sector.

CMOs have regulatory, strategic and operational capacity needs which can be called "organisational capacity". Capacity grants, intermediaries and structured programs are used to strengthen organisational capacity. Organisational capacity is one element of sector capacity.

## COMMUNITY MANAGED MENTAL HEALTH SECTOR CAPACITY FRAMEWORK

Although CMO organisational capacity has been mentioned frequently in the literature, research on elements essential for strengthening the capacity of the entire community managed mental health sector is lacking. Four elements contributing to community managed mental health sector capacity were synthesised in the *Literature Review*:

1. Client Experience (Program range & responsiveness)
2. Service Provision (Organisational capacity)
3. Policy & Planning (Planning, funding and evaluation)
4. Research & Development (Innovation & growth)

Each of these elements is not, in itself, enough to bring about effective sector performance and development. It is essential to strengthen all four sector capacity elements concurrently.

## CAPACITY FOR WHAT?

When considering community managed mental health sector capacity elements the OECD states that it is important to ask "*Capacity for what?*".

We are focusing on the capacity of the community managed mental health sector to provide accessible, relevant programs so that the people of NSW are supported in their journeys of recovery and wellbeing.

## THE NSW MENTAL HEALTH CMO SECTOR

The CMO sector provides a broad range and choice of programs available to the community. In addition to providing mental health supports: CMOs raise and give resources; design new services; and, encourage empowerment and participation<sup>5</sup>. The work of the government sector in supporting people experiencing mental illness is not just complemented by the CMO sector. CMOs are essential to the mental health system as a whole as they align with the health needs of the community<sup>6</sup> and are flexible, responsive and build social capital.

NSW Health's *NGO Advisory Committee* is committed to developing an overarching policy framework to define the partnership between CMOs and NSW Health. NSW Health's *NGO Program* aims to:

- Support models of health service delivery developed by local communities which maximise access and support community participation;
- Build self-reliance and responsibility for health at a personal and community level by the development of networks and self-help initiatives;
- Ensure a range of complementary health services which provide ease of continuity of care and efficiency in the use of local resources; and,
- Assist CMOs to provide a range of priority health services.

NSW Health excels in providing medical treatment to the most disadvantaged - people who are so unwell they struggle to live in the community during a psychiatric crisis. NSW Health calls on the CMO sector to assist people who require support throughout the experience of mental illness.

CMOs support people to participate fully in community living using a client-centred approach oriented towards supporting each person to create a meaningful life. The mental health CMO sector aims to:

- Provide early intervention and relapse prevention services;
- Support clients to build on their achievements in their recovery journey; and,
- Prevent re-entry to hospital-based treatment, decreasing demand on overburdened medical services.

CMOs bring expertise and a broad range of perspectives through the use of volunteers who provide professional, peer and lay support to clients, Boards, management, administration and employees.

The NSW mental health CMO workforce was quantified by MHCC in a 2006 sector training needs analysis and estimated it to be about 3000 FTE (with recent growth this figure is now thought to now be 5000 FTE). Managers had an average of 14 years industry experience and 96% had a tertiary qualification - 54% had a university level qualification. 70% of direct care staff also had tertiary qualifications, however, 68% of these qualifications were not considered mental health specific.

The valuable contribution of the mental health CMO sector in improving the wellbeing of the people of NSW is slowly gaining long overdue recognition. As the immense benefits of the CMO sector are being realised, governments are devoting considerable resources centrally to ensure CMOs continue in their essential role.

<sup>5</sup> Monteduro, Hinna & Ferrari (2009)

<sup>6</sup> NCOSS (2009a)

*The NSW Community Mental Health Strategy 2007-2012 (2008) and NSW: A New Direction for Mental Health (2006) provide guiding principles on the role of NSW Health and the community managed mental health sector in providing programs for people requiring mental health support. The next step is for NSW Health and the community managed mental health sector to develop and agree on explicit expectations, ways of relating and development of the CMO sector. The CMO Sector Mapping Framework and the recommendations throughout this report are intended to serve as a guide and reference for NSW Health and other stakeholders in this process.*

The carefully considered recommendations by MHCC in the Sector Mapping Report propose changes to the ways in which NSW Health and CMOs relate to each other so that the people of NSW are better supported in their journeys of recovery and wellbeing.

### RECOMMENDATION 1

A clear framework will be produced by NSW Health which will structure its relationship with the mental health CMO sector.

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 1

#### How

The *CMO Sector Capacity Framework* developed by MHCC (Appendix 1) and the recommendations of the *Sector Mapping Project Report* will be considered by NSW Health as a basis for its mental health CMO framework







# SECTOR MAPPING SURVEY METHODOLOGY

## SECTOR MAPPING SURVEY METHODOLOGY

The following is a summary of the methodology undertaken in design and implementation of the *Sector Mapping Survey* including analysis of the data collected. Additional details about the overall methodology of the *Sector Mapping Project*, including acknowledgement of survey limitations, can be found in Appendix 2.

### SECTOR MAPPING SURVEY DEVELOPMENT

MHCC, in collaboration with NSW Health MHDAO and the research firm ARTD Consultants, consulted broadly to develop the *Sector Mapping Survey* to ensure that key areas of relevance were included in the content. This resulted in questions relating to:

- Organisation and program details;
- Funding sources;
- Geographical reach;
- Data collection and analysis;
- Quality improvement activities; and,
- Open questions about the sector.

A full copy of the *Sector Mapping Survey* is provided as Appendix 3.

### DATA COLLECTION

The names of organisations responding to the *Sector Mapping Survey* who gave permission for this information to be shared is provided as Appendix 4.

MHCC collected primary data by surveying the views of CMOs providing mental health services and programs. The research firm ARTD Consultants performed the first and second rounds of automated electronic data collections in late 2008 and early 2009. A third and fourth round of survey data collections were added manually to the initial datasets by a MHCC consultant throughout the first half of 2009.

247 CMOs completed the survey providing information about a total of 350 community mental health programs.

### DATA ANALYSES

Raw data was initially analysed by ARTD Consultants. However, as further data collection was required the final datasets were also cleaned, checked and analysed by a MHCC consultant with expertise in both data analysis and mental health systems.

### CONSULTATION ON EMERGING TRENDS

Consultation on emerging data trends was sought from both MHCC member organisations and NSW Health (MHDAO's Mental Health Program Council, Chronic and Continuing Care Rehabilitation and Recovery Working Group/CCCRRWG and Area Mental Health Service Clinical Partnership Coordinators). A summary of NSW Health consultation comments is provided as Appendix 5.

### REPORTING

The formal reporting process involved a series of interim and draft reports written and distributed to the MHCC executive and the MHCC Board.

### EVALUATION

MHCC will evaluate the effectiveness of the project by considering the responses of consumer groups, carer groups, CMOs, NSW Health and other stakeholders to the recommendations in this report.

## SECTOR CAPACITY FRAMEWORK ELEMENTS

Key sector capacity elements – as identified through the *Literature Review* - were captured in the *Sector Mapping Survey* (as shown in Table 1).

TABLE 1: SECTOR CAPACITY ELEMENTS CAPTURED IN THE SURVEY

Client Experience:		
<b>A) PROGRAMS</b> <ol style="list-style-type: none"> <li>1. Range</li> <li>2. Access</li> <li>3. Geographic availability</li> <li>4. Services clients need</li> </ol>	<b>B) CLIENT CHARACTERISTICS:</b> <ol style="list-style-type: none"> <li>1. Gender</li> <li>2. Age</li> <li>3. Complex needs</li> <li>4. Experiencing Mental Illness</li> <li>5. Hospitalisation</li> </ol>	
Service Provision:		
<b>A) REGULATORY ENVIRONMENT</b> <ol style="list-style-type: none"> <li>i. Corporate Structure</li> </ol>	<b>B) STRATEGIC CAPACITY</b> <ol style="list-style-type: none"> <li>i. Service Type</li> <li>ii. Partnerships</li> </ol>	<b>C) OPERATIONAL CAPACITY</b> <ol style="list-style-type: none"> <li>i. Service to Clients               <ul style="list-style-type: none"> <li>● Referral Sources &amp; Systems</li> </ul> </li> <li>ii. Human Resources:               <ul style="list-style-type: none"> <li>● FTE Mental Health staff</li> <li>● Volunteer hrs per week</li> </ul> </li> <li>iii. Information Management:               <ul style="list-style-type: none"> <li>● Data Collection Systems</li> <li>● Software</li> </ul> </li> <li>iv. Measuring Process, Outcomes &amp; Impact               <ul style="list-style-type: none"> <li>● Types of Client Data</li> <li>● Outcome Monitoring</li> <li>● KPIs</li> </ul> </li> <li>v. Systems improvement:               <ul style="list-style-type: none"> <li>● Accreditation</li> </ul> </li> </ol>
Policy & Planning:		
<b>A) PROGRAM FUNDING</b>	<b>B) POLICY PERSPECTIVES</b>	
Research & Development		
<i>Results from other sections relevant to inform research &amp; innovation</i>		

The *Sector Mapping Survey* results, follow up consultation and *Literature Review* findings are presented and discussed in the following sections. All of these information sources were used to inform *Sector Mapping Project* recommendations on how the NSW community managed mental health sector can strengthen its capacity.





# SECTOR MAPPING PROJECT RESULTS

## SECTOR MAPPING PROJECT RESULTS

The *Sector Mapping Survey* results presented in this report also describe and discuss key findings and recommendations arising from the project.

Some broad observations regarding mental health CMO types and corporate structures are provided first and then more detailed survey results are presented and discussed in the context of the four NSW community managed mental health *Sector Capacity Framework Elements* (Appendix 1) as identified in the accompanying *Literature Review*:

- Client Experience;
- Service Provision;
- Policy and Planning; and,
- Research and Development.

### RESULTS

For each sector capacity element, survey results are reported initially with minimal interpretation or comment on the data other than some contextualising narrative. “*Discussion & Recommendations*” then follow.

Some additional and more detailed results are presented as Appendices to this report as follows:

- Appendix 6 – Extended Responses to Open questions;
- Appendix 7 – NSW Health Funded Programs;
- Appendix 8 – Data Sheets for Each NSW Health Area Health Service;
- Appendix 9 – Quality Review Processes; and,
- Appendix 10 – Funding Sources of NSW Mental Health CMOs.

This approach has been used to make the *Sector Mapping Survey* data more accessible for a variety of stakeholders. This data will also be useful for future implementation of some recommendations (eg, CMO population planning and sector development, strengthening care coordination practice, enhancing sector quality and outcomes, etc).

### DISCUSSION & RECOMMENDATIONS

Recommendations arising from the *Sector Mapping Project* are made in response to key issues identified and some early guidance on implementation of these recommendations is provided. The recommendations are also summarised at the end of this section including an overview of their relationship to the *Sector Capacity Framework*.

## MENTAL HEALTH CMO TYPES 1, 2 & 3

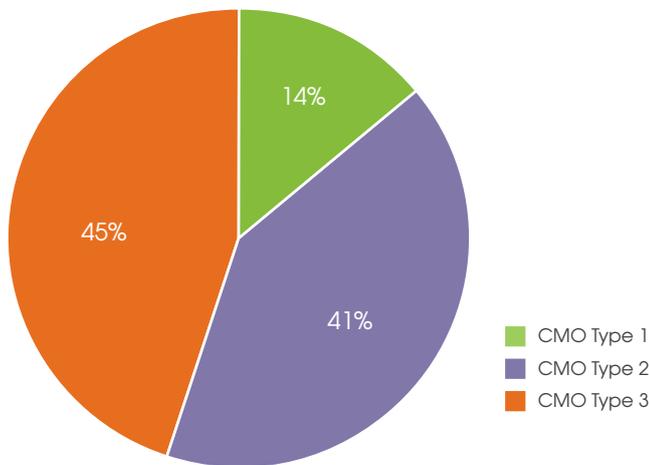
CMOs were categorised into three groups intended to represent the range of mental health CMOs from most specialised to most generalised as follows:

- **Type 1** – providing mental health programs only;
- **Type 2** – providing mental health programs in addition to other programs; and,
- **Type 3** – providing mental health support but no specific mental health programs.

*Sector Mapping Survey* respondents included:

- 35 Type 1 CMOs (14.2%);
- 102 Type 2 CMOs (41.3%); and,
- 110 Type 3 CMOs (44.5%).

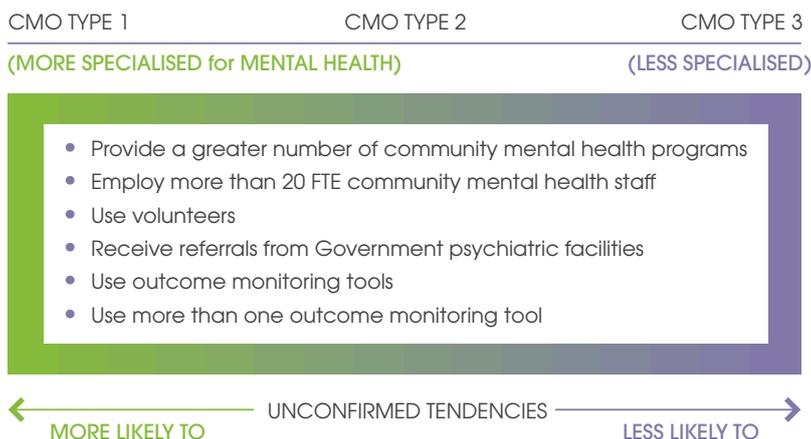
FIGURE 3: CMO TYPES IN MAPPING SAMPLE



Although more research needs to be done to establish clear findings the *Sector Mapping Survey* results suggest that specialised mental health CMOs are more likely to:

- Provide a greater number of community mental health programs;
- Employ more than 20 FTE community mental health staff;
- Receive referrals from government psychiatric facilities; and,
- Be accredited;
- Use volunteers;
- Use outcome monitoring tools.

FIGURE 4: TENDENCIES OF CMO TYPES OBSERVED IN THE *SECTOR MAPPING SURVEY* SAMPLE



## ORGANISATIONAL STRUCTURE OF NSW MENTAL HEALTH CMOs

The bulk of CMOs in the Australian sector consists of small, unincorporated organisations which have no employees and rely on volunteer contributions.<sup>7</sup>

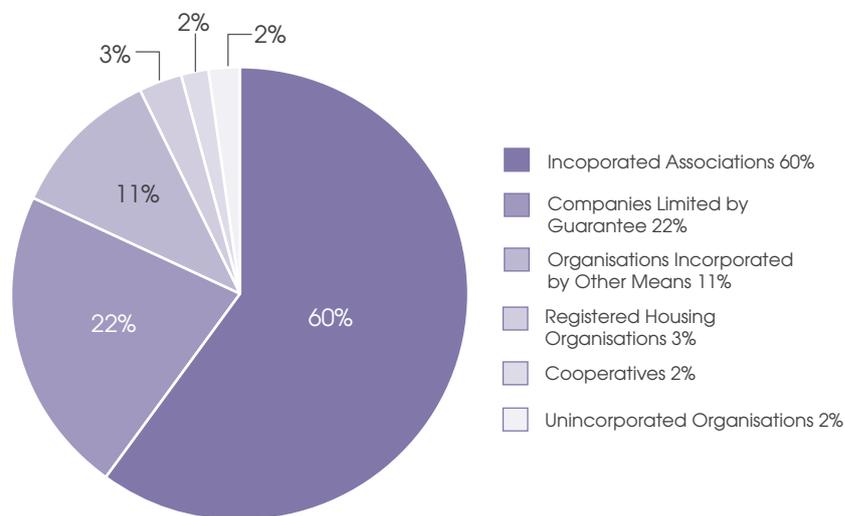
In NSW, associations are incorporated under the Associations Incorporation Act 1984 and from early 2010 will be subject to the Associations Incorporation Act 2009 which requires tighter controls over finances for larger associations. A Company Limited by Guarantee is subject to financial reporting and auditing obligations applicable to public companies under the Corporations Act 2001 and, as such, the administrative requirements are more rigorous than for Incorporated Associations.

The Productivity Commission proposes a regulatory and support framework for the NFP sector including an Office for NFP Sector Engagement (in the Department of the Prime Minister & Cabinet), local infrastructure support hubs and social intermediaries for NFP development in financial skills, business skills, governance & other training services.

Of the 247 *Sector Mapping Survey* respondents:

- More than half are Incorporated Associations (60%, n=148);
- Around one-fifth are Companies Limited by Guarantee (22%, n=54);
- 3% are registered housing organisations (n=8);
- 2% are cooperatives (n=5);
- 2% are unincorporated associations (n=5); and,
- 11% are incorporated by other methods (n=27).

FIGURE 5: CORPORATION TYPES OF CMOs



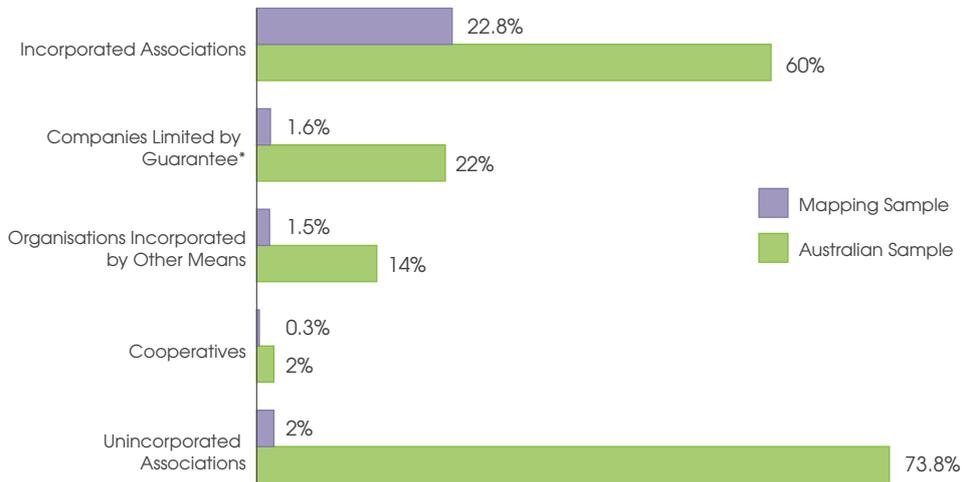
This last category included: indigenous corporations; organisations formed by Royal Charter organisations formed by a special Act of Parliament; and, religious organisations.

The large numbers of responding CMOs that are Incorporated Associations will need to consider how the Associations Incorporation Act 2009 will impact on them. All responding CMOs will potentially be affected by implementation of the Productivity Commission's recommendations.

<sup>7</sup> Productivity Commission, 2009

The *Sector Mapping Survey* sample organisational structure results were compared with those of the Australian NFP sector provided by the Productivity Commission (Figure 6). The NSW mental health CMO sector has a very high representation of incorporated entities compared to the Australian sample.

**FIGURE 6: PROPORTION OF ORGANISATION STRUCTURE TYPES IN MHCC SECTOR MAPPING SURVEY SAMPLE COMPARED TO AUSTRALIAN NOT-FOR-PROFITS**



\* Australian sector Incorporated Associations n= 136,000; Companies Limited by Guarantee n=9,700 (Productivity Commission figures with 2,000 finance and insurance mutuals removed)

Proportionally, the mapping sample has fewer unincorporated associations (2%) than the Australian sector (73.8%). There are three Incorporated Associations for every Company Limited by Guarantee in the mapping sample, whereas in the Australian sector there are fifteen Incorporated Associations for every Company Limited by Guarantee.

# CLIENT EXPERIENCE

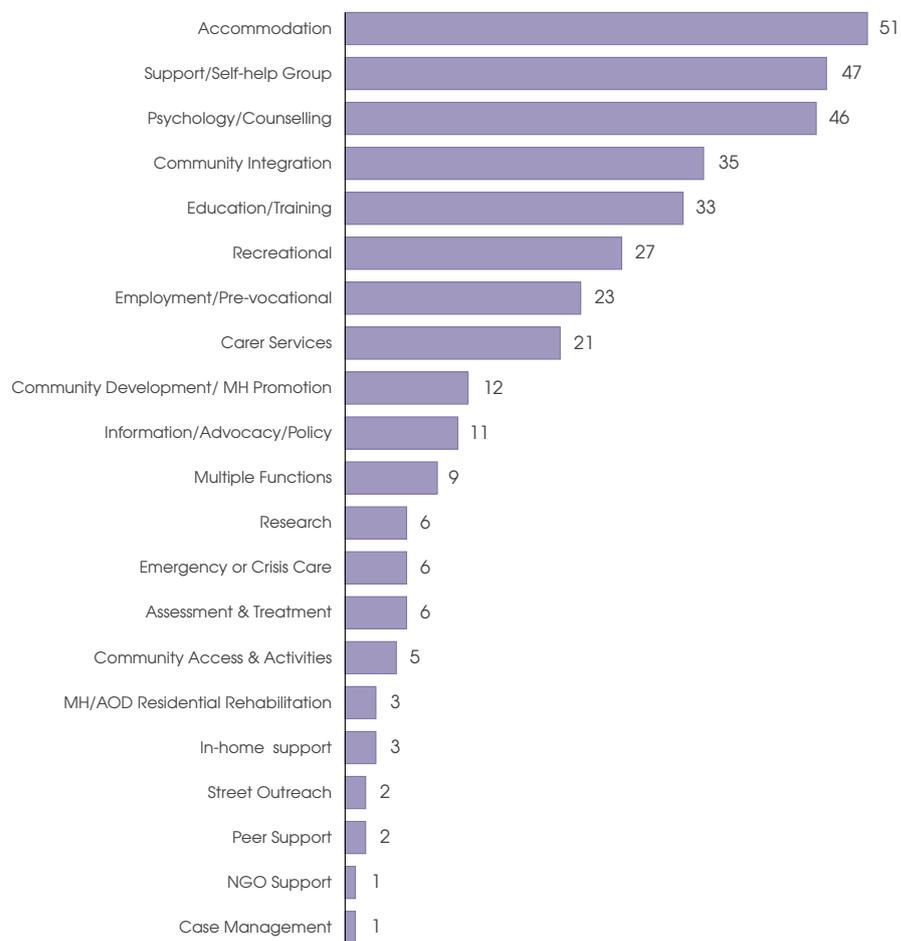
## Results of the Sector Mapping Survey

### PROGRAM RANGE

CMOs provide a broad range of specialised community mental health programs. 350 programs were reported in the *Sector Mapping Survey*. Overall, 21 program types were identified. The three highest responding program types were:

- Accommodation (51);
- Support/Self-help Groups (47); and,
- Psychology/Counselling services (46).

FIGURE 7: NUMBER OF CMO PROGRAMS REPORTED IN THE MAPPING SURVEY



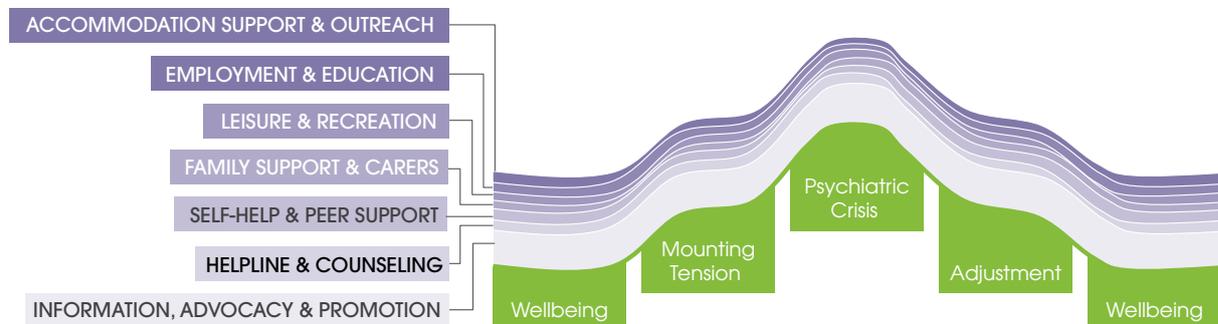
Programs reported in the *Sector Mapping Survey* were categorised into seven necessary core service areas ("core services") as identified in the Literature Review and shown in Figure 8.

FIGURE 8: CATEGORISATION OF PROGRAM TYPES INTO CORE SERVICES



All core services should have the skills, resources and flexibility to increase or change the nature of supports according to individual client need. Flexibly supporting people to remain where they live and work will result in movement towards wellbeing rather than crisis.

FIGURE 9: CORE SERVICES SHOULD BE AVAILABLE THROUGH DIFFERENT PHASES OF THE CLIENT JOURNEY<sup>8</sup>

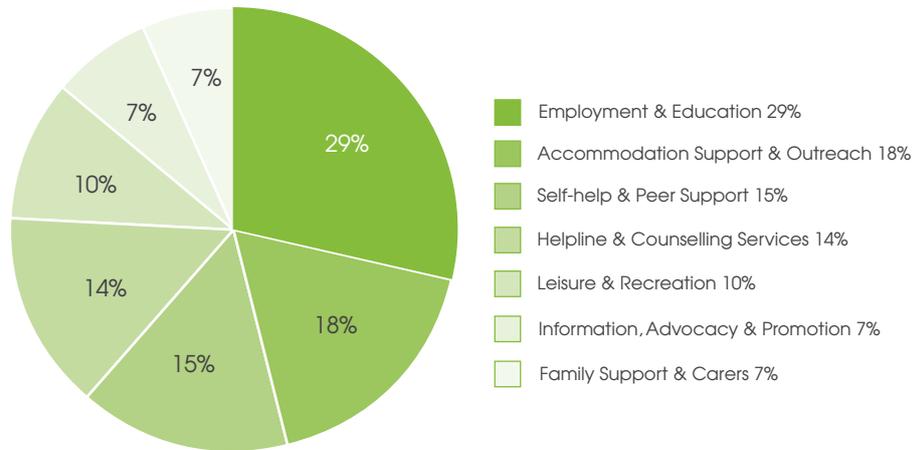


318 programs reported in the *Sector Mapping Survey* fell within the seven core service areas (91%). The numbers of programs reported in each core service area are:

- Employment & Education (n=91);
- Accommodation Support & Outreach (n=56);
- Self-help & Peer Support (n=49);
- Helpline & Counselling Services (n=46);
- Leisure & Recreation (n=32);
- Information, Advocacy & Promotion (n=23); and,
- Family Support & Carer Programs (n=21).

<sup>8</sup> Adapted from Rosen, 1998

FIGURE 10: CORE NSW COMMUNITY MANAGED MENTAL HEALTH PROGRAMS REPORTED IN THE MAPPING SURVEY



### NSW HEALTH FUNDED PROGRAMS

The *Sector Mapping Survey* identified 33 organisations delivering 109 programs (excluding peak bodies) with funding received from NSW Health through a specific and identifiable stream. The four identified program funding streams were:

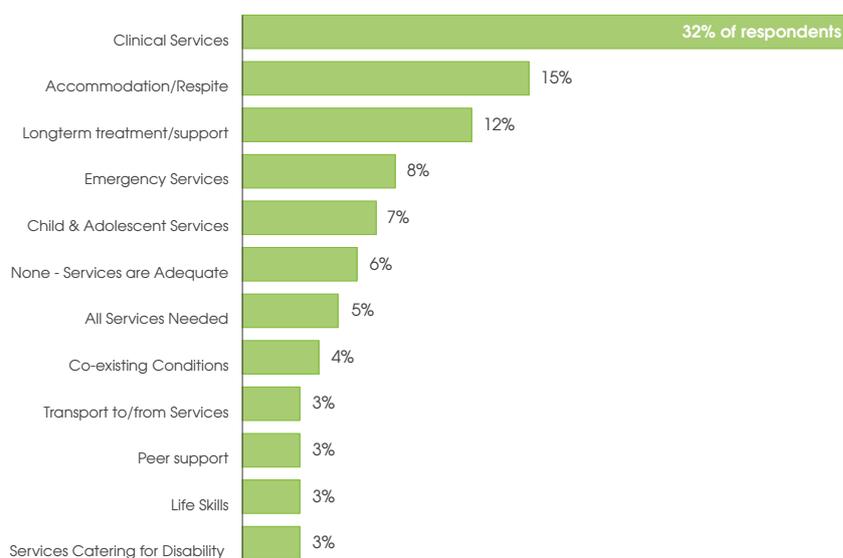
1. NGO Grant Program;
2. Housing and Accommodation Support Initiative (HASI);
3. Family & Carer Support Program; and,
4. Resource & Recovery Services Program.

More detailed information about these NSW Health funded programs is provided throughout this document as well as in Appendix 7 (ie, program numbers; core service numbers; corporate structure; organisational type; referral sources; staffing; use of volunteers; and use of outcome measures).

## EXPLORING PROGRAM GAPS

Extended responses to the open ended questions included in the *Sector Mapping Survey* are provided as Appendix 6. In response to the open question “What mental health services do your clients require that they are unable to obtain?” the majority of respondents stated that clients need better access to clinical services (Figure 11).

FIGURE 11 : CATEGORISED RESPONSES TO OPEN QUESTION OF SERVICE NEED IN THE NSW MENTAL HEALTH SECTOR



When further explored it is apparent that access to and quality of clinical services are by far the largest concern for CMOs without direct FTE mental health staff (see Appendix 6). While “Clinical Services” is still generally the highest area of perceived need for CMOs with direct mental health staff there was almost as high a perceived need for more “Accommodation”, “Longterm Treatment”, “Child & Adolescent” and “Emergency” Services.

## GEOGRAPHIC REACH

NSW Health is divided into eight Area Health Services (AHS). Four AHS contain predominantly rural populations and four AHS contain predominantly urban populations as follows:

Rural	Urban
Greater Southern (GSAHS)	Northern Sydney/Central Coast (NSCCAHS)
Greater Western (GWAHS)	South Eastern Sydney/Illawarra (SESIAHS)
Hunter/New England (HNEAHS)	Sydney South West (SSWAHS)
North Coast (NCAHS)	Sydney West (SWAHS)

Data sheets summarising the range of CMO programs identified within each AHS are provided as Appendix 8. These identify the number of program types within each local government area (LGA) of the AHS and the number of core services within the AHS.

Analysis of *core services* for each AHS is indicative rather than exhaustive (Figure 12 & Table 2). Data relating to programs reported by organisations responding to the *Sector Mapping Survey* provide the basis for the analysis.

FIGURE 12: NUMBER OF CMO CORE SERVICES REPORTED OPERATING IN EACH AHS

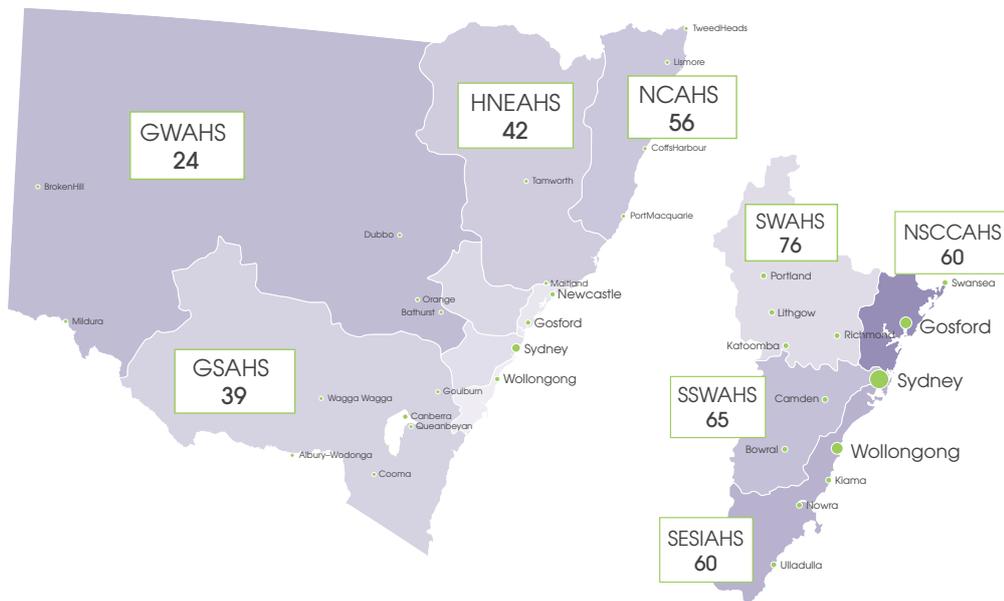


TABLE 2: NUMBER OF RESPONDING CMO CORE SERVICES OPERATING IN EACH AHS

CORE SERVICE	RURAL AHS				URBAN AHS			
	GS	GW	HNE	NC	NSCC	SESI	SSW	SW
Accommodation Support & Outreach	9	7	9	10	11	12	17	13
Employment & Education	12	9	13	23	15	19	19	19
Leisure & Recreation	7	0	2	2	0	7	5	12
Family Support & Carer Programs	4	2	2	0	6	3	4	5
Self-help & Peer Support	4	1	3	4	11	9	8	15
Helpline & Counselling services	1	2	13	10	7	8	9	7
Information, Advocacy & Promotion	2	3	0	1	1	2	3	5
Total	39	24	42	50	51	60	65	76

NOTE: Programs reported as operating in more than one AHS are counted in each AHS

■ AHS with lowest reported programs    
 ■ AHS with highest reported programs

The findings show that:

- There are more core services reported in the four urban AHS regions;
- The highest number of core services (n=76) is reported in SWAHS; and,
- The lowest number of core services (n=24) is reported in GWAHS.

Population projections (Table 3) were used to calculate population-based comparisons for core service availability between each AHS (Table 4 & Figure 13). With the exception of HNEAHS, the rural AHS regions have a higher number of reported core services per 100,000 people. NCAHS has the greatest number of reported core services (10.4 per 100,000 people) while SSWAHS, SESIAHS, NSCCAHS and HNEAHS all reported around five core services per 100,000 people.

TABLE 3: POPULATION PROJECTIONS FOR EACH NSW AHS<sup>9</sup>

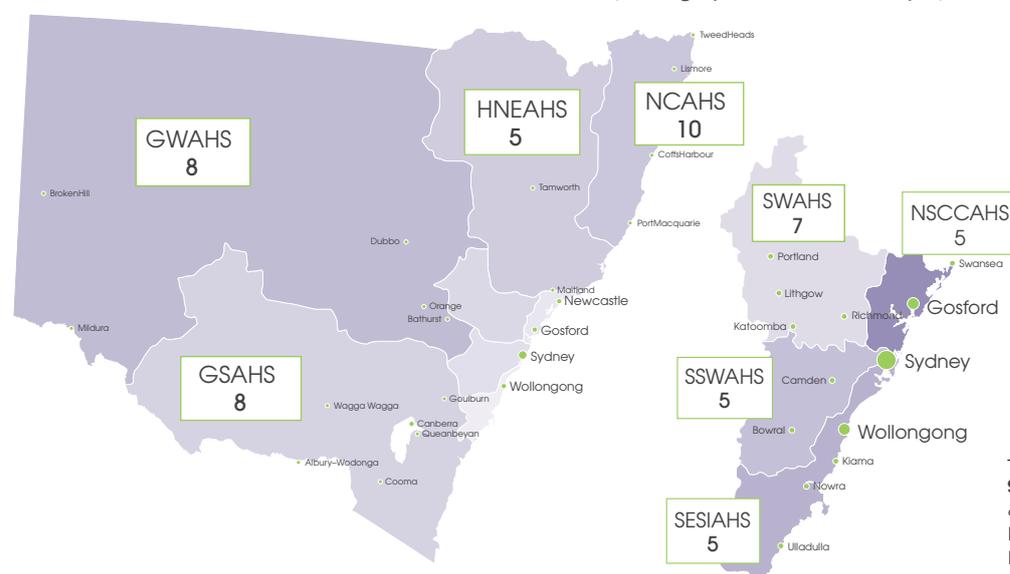
		2006	2011	2016	2021	2026	2031	2036
RURAL	GS	473,578	492,985	512,259	531,000	548,531	564,271	577,201
	GW	300,528	301,560	302,331	302,441	301,524	299,329	295,362
	HNE	844,765	880,812	915,938	950,598	983,644	1,014,003	1,039,730
	NC	479,544	511,146	542,696	573,694	603,478	631,316	655,886
RURAL TOTAL		2,098,415	2,186,503	2,273,224	2,357,733	2,437,177	2,508,919	2,568,179
URBAN	NSCC	1,104,624	1,158,068	1,203,417	1,259,046	1,309,712	1,364,906	1,422,717
	SESI	1,173,593	1,237,286	1,282,555	1,325,406	1,363,523	1,403,669	1,443,448
	SSW	1,342,316	1,447,390	1,559,596	1,687,266	1,828,119	1,974,196	2,117,735
	SW	1,097,139	1,178,394	1,284,710	1,378,848	1,476,655	1,565,332	1,643,887
URBAN TOTAL		4,717,672	5,021,138	5,330,278	5,650,566	5,978,009	6,308,103	6,627,787
TOTAL NSW		6,816,087	7,207,642	7,603,502	8,008,299	8,415,186	8,817,022	9,195,966

TABLE 4: NUMBER OF RESPONDING CMO CORE PROGRAMS OPERATING IN EACH AHS PER 100,000 PEOPLE

	RURAL AHS				URBAN AHS			
	GS	GW	HNE	NC	NSCC	SESI	SSW	SW
Accommodation Support & Outreach	1.9	2.3	1.1	2.1	1.0	1.0	1.3	1.2
Employment & Education	2.5	3.0	1.5	4.8	1.4	1.6	1.4	1.7
Leisure & Recreation	1.5	0.0	0.2	0.4	0.0	0.6	0.4	1.1
Family Support & Carers	0.8	0.7	0.2	0.0	0.5	0.3	0.3	0.5
Self-help & Peer Support	0.4	1.0	0.0	0.2	0.1	0.2	0.2	0.5
Helpline & Counselling services	0.2	0.7	1.5	2.1	0.6	0.7	0.7	0.6
Information, Advocacy & Promotion	0.8	0.3	0.4	0.8	1.0	0.8	0.6	1.4
Total	8.2	8.0	5.0	10.4	4.6	5.1	4.8	6.9

■ AHS with lowest reported programs    
■ AHS with highest reported programs

FIGURE 13: NUMBER OF CMO CORE SERVICES REPORTED OPERATING IN EACH AHS (Average per 100,000 People)

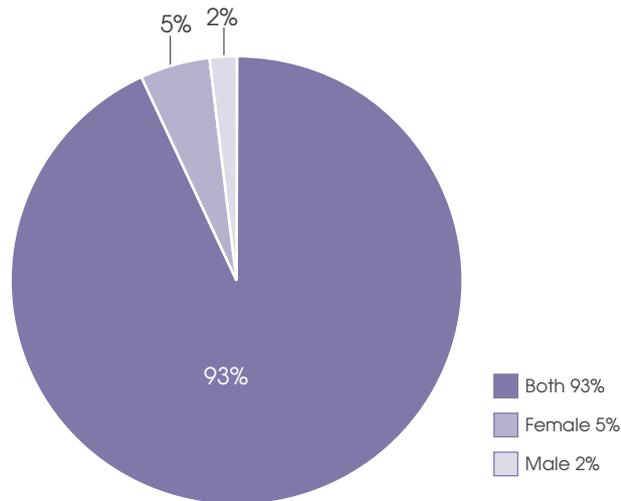


<sup>9</sup> Department of Planning & State-wide Services Development Branch, NSW Health (2009)

## CLIENT CHARACTERISTICS

*Sector Mapping Survey* respondents reported that the majority of programs cater for: both men and women; people with complex needs; and are targeted towards the adult age range (18 to 65 yrs). The results relating to consumers experiencing specific mental illness and “recent hospitalisation” suggest that CMOs support people with a broad range of needs, including people with high levels of mental illness and specific diagnoses, and those with varying levels of hospitalisation.

FIGURE 14: PROPORTION OF RESPONDING PROGRAMS TARGETING GENDER



### CLIENT CHARACTERISTICS: Gender

Few programs target a specific gender:

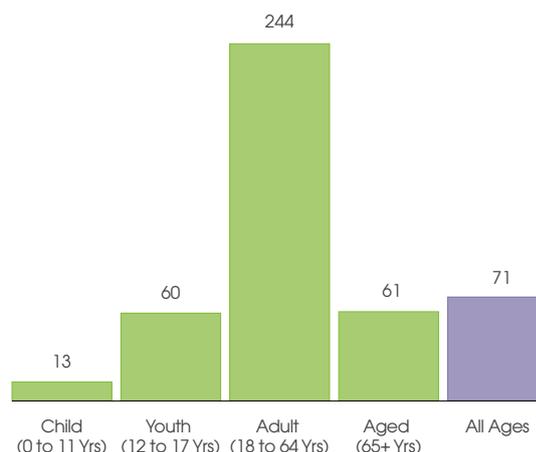
- 93% of programs cater for both men and women.

It is not known how many, if any, programs cater for people who identify as gay, lesbian, bisexual or transgender.

### CLIENT CHARACTERISTICS: Age

The majority of responding programs target the adult age range (18 to 64). The least targeted group was the child age range (0 to 11). However, some of the adult range programs may include young-adult targeted services as many youth programs target up to and including 25 years of age.<sup>10</sup>

FIGURE 15: PROPORTION OF RESPONDING PROGRAMS TARGETING SPECIFIC AGE RANGES



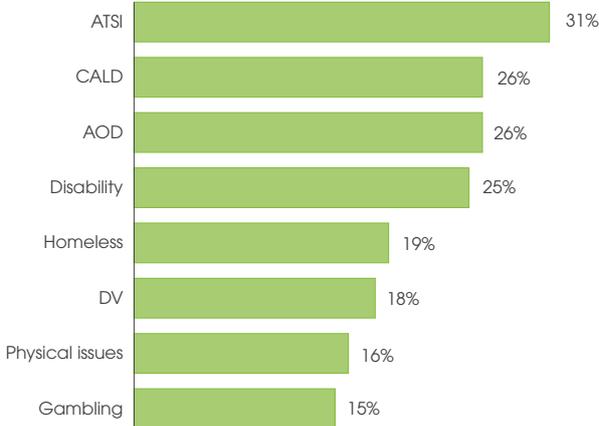
<sup>10</sup> See data limitations in Appendix 2.

### CLIENT CHARACTERISTICS: Complex Needs

Approximately a quarter of responding programs cater for individuals with specific needs including: indigenous; other culturally diverse backgrounds; substance misuse; domestic violence; gambling issues; physical disability; and, homelessness.

*Note: Respondents could choose multiple items for this question.*

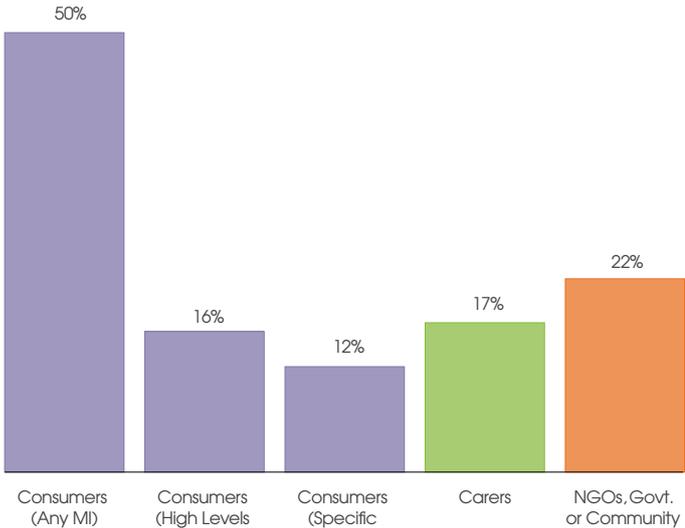
FIGURE 16: PROPORTION OF PROGRAMS TARGETING SPECIFIC GROUPS



### CLIENT CHARACTERISTICS: Experiencing Mental Illness

More than half of responding programs were broadly targeted towards people with any mental illness (50%). Almost all programs were also marked as targeting "Other" with a diverse range of target groups written in comments. *Note: Respondents could choose multiple items for this question.*

FIGURE 17: PROPORTION OF RESPONDING PROGRAMS TARGETING MENTAL HEALTH STAKEHOLDERS



## CLIENT CHARACTERISTICS: Hospitalisation

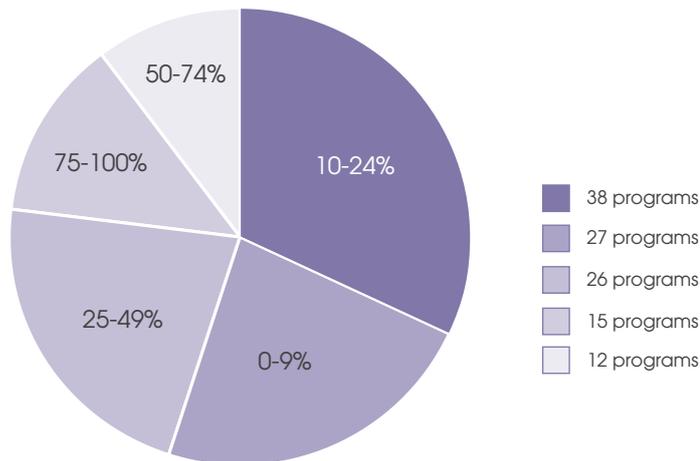
A third of responding CMO programs provided hospitalisation data (see Table 5, Figure 18). Of these, 91 programs (77%) stated that less than half of their clients had been hospitalised in the previous 12 months.

The hospitalisation data suggests that more than half of people participating in community managed programs had been supported to remain out of hospital in the previous 12 months. This is likely to mean that many are experiencing early intervention or relapse prevention, reducing demand for hospitalisation.

TABLE 5. PROGRAM PERCENTAGES OF CLIENT HOSPITALISATION IN LAST 12 MONTHS

% of clients hospitalised in last 12 months	0-9%	10-24%	25-49%	50-74%	75-100%	Total
No. of programs	27	38	26	12	15	118

FIGURE 18: PROGRAM PERCENTAGES OF CLIENT HOSPITALISATION IN LAST 12 MONTHS



## DISCUSSION & RECOMMENDATIONS

### CLIENT EXPERIENCE

There have been calls for a more strategic approach to mental health care delivery whereby individual countries define 'core' mental health services and set evidence-based, country-specific resource targets related to these<sup>11</sup>. The *Literature Review* proposed seven NSW mental health core CMO service areas and these were validated through analysis of the *Sector Mapping Survey* program results:

- Accommodation Support & Outreach;
- Employment & Education;
- Leisure & Recreation;
- Family Support & Carer Programs;
- Self-help & Peer Support;
- Helpline & Counselling Services;
- Information, Advocacy & Promotion.

The NSW mental health core CMO service areas include the following common features:

- Culturally competent and disability friendly responses;
- Prevention & early intervention orientation;
- Rural and remote support;
- Emergency support; and,
- Support across the spectrum of age groups.

The *Sector Mapping Survey* results indicate the number of responding core services per 100,000 people. The lowest number of programs is 5 per 100,000 (in HNEAHS, SSWAHS, SESIAHS & NSCCAHS) and the highest was in NCAHS with 12 per 100,000. The number of clients supported by each program, intensity of supports being provided and unmet needs in the area are not clear. More detailed local mapping needs to be undertaken to ascertain a comprehensive picture of the CMO sector.

### A CONSISTENT RANGE OF CORE SERVICES ACROSS NSW

The NSW Health Mental Health Clinical Care and Prevention (MH-CCP) Model's ten year forward service planning process is based on the generic needs of a nominal town with a population of 100,000 people with a certain number of hospitals and also supported accommodation beds per 100,000 people. At this stage, prevention, promotion and early intervention and community-based programs are not comprehensively included in the MH-CCP process – they are planned and funded in an ad-hoc manner. A related concern with the process is that it does not take into account the unique socio-demographic characteristics or existing resource and infrastructure issues that exist for local communities.

Population based service planning needs to be clearly informed by known evidence-based practice. Community based approaches and the funding mechanisms that support mental health CMOs are not easily incorporated into the MH-CCP structure other than for bed based contracted programs such as the HASI. However, population based planning approaches can be extensively used and include participation of all key stakeholders including consumers and carers. This could occur at state-wide, AHS, regional and/or LGA levels.

An approach in which necessary community managed mental health programs are planned on a population basis (for example, per 100,000 people) – and taking into account the unique socio-demographic characteristics and existing resource and infrastructure capabilities for local communities – would improve the way community managed mental health services are planned and increase likelihood of program access and equity across NSW.

<sup>11</sup> Pirkis, Harris, Buckingham, Whiteford & Townsend-White (2007)

#### VARIATION PARAMETERS:

**Socio-demographic:** The *Fourth National Mental Health Plan* states that the determinants of mental health status include factors such as: income; education; employment; and, access to community resources. As a guiding principle, the socio-demographic variations to a standard number of places per 100,000 people for the mental health CMO core service range may be based on Australian Bureau of Statistics (ABS) and/or local government data relating to local community income, age, cultural background, educational level, and employment status.

Existing resources & infrastructure of local communities and mental health service systems should also be considered.

**General community resources:** Access to community resources includes transport, housing, employment, education, leisure and recreational facilities.

#### Existing Mental Health Infrastructure

The range of available and accessible government, private and community based mental health infrastructure must also be considered in population planning. The history of hospital-based mental health services in NSW can further complicate such mapping.

Many people experiencing mental illness in the 20th century were placed in large psychiatric institutions located in places such as Rozelle, Gladesville, Goulburn, Newcastle, Peat Island, Morisset, Parramatta and Rydalmere. Downsizing of large psychiatric institutions commenced within Australia's public mental health system in the mid-1960s, when the number of beds peaked at 30,000<sup>12</sup>. The reduction in size of hospitals prior to the 1990s was driven by new discoveries in treatment and a growing concern for human rights. Unfortunately, the policy environment provided few safeguards to ensure that alternative community services were developed to replace the functions of shrinking institutions. As beds were closed, the freed resources were usually re-directed back to the hospitals to improve staffing levels and rarely used to open new community services or inpatient services elsewhere<sup>13</sup>. It is possible that local communities in which deinstitutionalisation occurred will have resources and infrastructure in place which are beneficial for CMOs to facilitate the delivery of supports, such as nominal rent, administration facilities, government contract rates for purchase of goods and services, and a well developed workforce.

The existing resources & infrastructure variations to a standard number of places per 100,000 people for the core service range could be influenced by *local community* transport, housing, employment, education, leisure and recreational facilities; and *provider infrastructure* (in-kind operating support, and developed workforce).

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<sup>12</sup> Department of Health and Ageing (2007), page 36

<sup>13</sup> Department of Health and Ageing (2007), page 37

## RECOMMENDATION 2

Seven core community-managed mental health service areas (functions) to be accessible within each local area. The amount of support available is population-based with needs-based variation parameters.

- Accommodation Support & Outreach;
- Employment & Education;
- Leisure & Recreation;
- Family Support & Carers Programs;
- Self-help & Peer Support;
- Helpline & Counselling Services; and
- Information, Advocacy & Promotion.

The amount of support available will be population-based with needs-based variation parameters.

## IMPLEMENTATION GUIDE FOR RECOMMENDATION 2

Develop benchmarks for **Core Service Areas**, including:

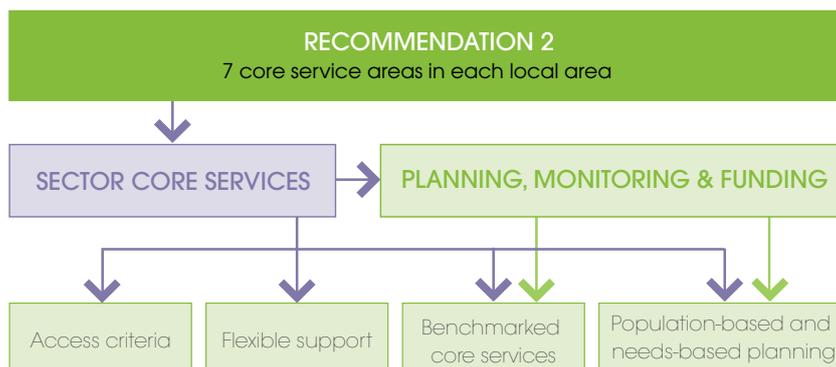
- Client places per core service area for each AHS (or other defined local area);
- Access criteria, emphasising functional need, for each core service;
- Mechanisms to enable flexible levels of support to clients during different phases of the personal journey.

For each core service area, population-based core support and needs-based variation parameters will be defined:

- **Level of support:** the amount of client support per 100,000 people
- **Variation parameters:** how local adjustments to core support will be made, based on each area's unique characteristics.

People invited to be involved in this work may include representatives such as: CMOs, consumers; carer; academics; GPs; AHS; and, government departments.

## IMPLEMENTATION GUIDE FOR RECOMMENDATION 2



## ACCESS TO COMMUNITY MANAGED MENTAL HEALTH PROGRAMS

The *Fourth National Mental Health Plan*<sup>14</sup> has commitment by all Australian State/Territory governments to "... a mental health system that ... ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community."

In order to meet the requirements of the *Fourth National Mental Health Plan* CMOs will have systems in place which centre on the client's needs and ensure:

- Flexibility – to meet the specific needs of different groups with different needs;
- A holistic response to mental health problems and mental illness (community support services, accommodation, and expert & appropriate clinical services);
- Interventions which are: evidence based, comprehensive and complementary; cover the spectrum from prevention, to relapse prevention and recovery; and, recognise the importance of self-determination, self-care, and self-help.

*"... we need clear referral pathways between NSW Health mental health services and the (CMO) sector"*

*Sector Mapping Survey respondent*

Client access to programs is a key challenge and major gap in the community managed health sector. The Mental Health Council of Australia states that "*successful services demonstrate some common characteristics and features including strong partnerships between NGOs and other mental health services and good access to acute and sub-acute services as part of the recovery process for people at crucial points in their lives*"<sup>15</sup>. NSW Health states that timely access for individuals, their families and carers to appropriate mental health care is central to its *Community Mental Health Strategy 2007-2012*<sup>16</sup>.

Access to services was stated as an issue of concern in the NSW Health consultation comments (Appendix 5) and a high number of *Sector Mapping Survey* respondents indicated clients needed better access to clinical, accommodation and respite services (Appendix 6). When asked "*How can the sector be improved (apart from more funding)?*", coordination of services was the second highest response (Appendix 6). This is a strong indication that continuity of care is in need of improvement.

### Supporting clients to transition between NSW Health treatment and community managed mental health programs

The transition between hospital-based treatment and community managed mental health programs is of concern to survey respondents and those involved in consultation feedback. In particular, coordinated discharge and entry planning processes were identified as crucial to the smooth transfer of care and support.

CMO clients with complex needs gaining access to NSW Health services was an issue raised in the NSW Health consultation comments, resonating with the concerns of *Sector Mapping Survey* respondents who state that the greatest area of need for their clients is access to clinical services, with key challenges in the sector being coordination of services and role delineation.

<sup>14</sup> Fourth National Mental Health Plan Working Group (2009b)

<sup>15</sup> MHCA (2006, p18)

<sup>16</sup> NSW Health (2008, p10)

**RECOMMENDATION 3**

Mental health consumers have access to the range of service types and experience continuity of care between components of the mental health service system.

**IMPLEMENTATION GUIDE FOR RECOMMENDATION 3**

*See Recommendation 5 Implementation Guide  
– The Care Coordination Strategy -*

**Recovery Oriented Practice**

The term recovery has many different meanings. In the mental health sector, it could be interpreted as being either “recovery from” or “recovery in” the experience of mental illness.<sup>17</sup> The *US Consensus Statement on Recovery* states that:

*“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential”<sup>18</sup>*

According to Slade (2009), in the *Personal Recovery Framework* the person experiences recovery through undertaking recovery tasks such as: developing a positive identity outside of being a person with a mental illness; developing a personally satisfactory meaning to frame the experience which professionals would understand as mental illness; taking personal responsibility through self-management; and, acquiring previous, modified or new valued social roles.

A view emerging from people who use mental health services is that “the mental health system is commandeering the user-developed concept of recovery: incorporating the term without undergoing the fundamental transformation it requires”<sup>19</sup>. MHCC<sup>20</sup> asserts that it is essential to ensure that services are practically, rather than just philosophically, recovery-oriented. Further, “a positive culture that reflects and demonstrates the principles of recovery means individuals will feel supported as they attempt to develop new meaning and purpose as they move beyond the effects of mental health problems” (MHCC, 2008).

Recovery-focused support attempts to develop service provision for people experiencing mental illness into a system which is innovative and life-enhancing, focusing on life transformation<sup>21</sup>. This view is supported by Slade (2009) who holds that mental health professionals should be oriented around the following recovery support tasks: fostering relationships; promoting wellbeing; offering treatments; and, improving social inclusion.

A recovery-oriented CMO audit mechanism may enable CMOs to ascertain areas of strengths and weakness in implementation of recovery oriented practice throughout the organisation. The Recovery Promotion Fidelity Scale (RPFS) was developed to evaluate the extent to which public mental health agencies in Hawaii incorporate recovery principles into their services and operations<sup>22</sup>. MH-CoPES (Mental Health Consumer Perceptions and Experiences of Services) involves consumer feedback about their experiences of inpatient and NSW Health community mental health services in order to guide service improvement. The areas in which feedback is sought for NSW Health community mental health services include: Access to Care; Treatment and Care Received; Information Provided; Privacy; and, Choice of Treatment. An MH-CoPES equivalent or adaptation could contribute to client driven change to CMO services.

<sup>17</sup> MHCC (2008)  
<sup>18</sup> SAMSHA (2004)

<sup>19</sup> Slade (2009, p367)  
<sup>20</sup> MHCC (2008)

### RECOMMENDATION 4

The CMO Sector will develop a:

- CMO equivalent of MH-CoPES; and
- Recovery-oriented audit tool

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 4

#### How

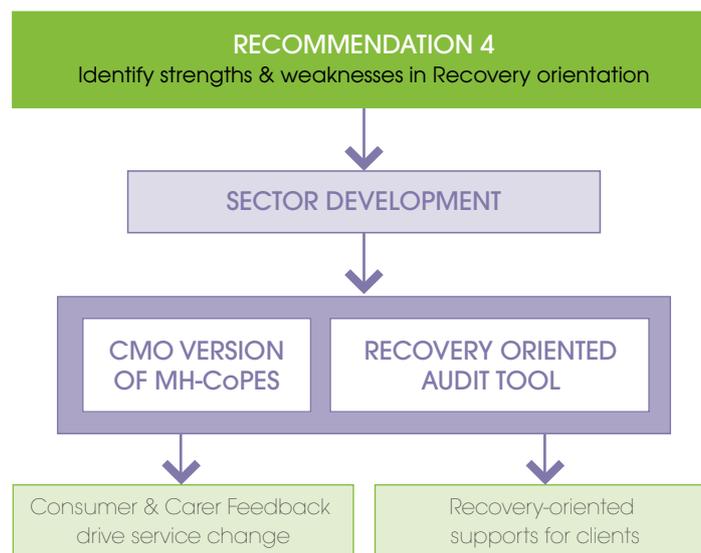
The CMO sector will:

- Develop a recovery-oriented audit mechanism for CMOs; and,
- Develop a CMO equivalent of MH-CoPES.

**Recovery audit mechanism** will be developed in order to determine whether recovery-oriented practice (including cultural competence, professional development and knowledge management) is applied consistently throughout the CMO. This will take the form of self-assessment with provision for external evaluation for independent verification of results.

**Service responsiveness and service satisfaction from the perspectives of consumers and carers** will be ascertained by implementation of a CMO equivalent of MH-CoPES.

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 4



21 Sterling, von Esenwein, Tucker, Fricks & Druss (2009).

22 Armstrong & Steffan (2009)

## SERVICE PROVISION

### Results of the Sector Mapping Survey

#### SERVICE TO CLIENTS: Referral Sources and Systems

Respondents were asked: "Please indicate the extent to which you agree with the following. In the last three months the client referral system has been effective between our organisation and ..."

- NSW Health,
- Other NGOs (Note: Now CMOs),
- Government Departments (Note: now NSW Human Services) or
- General Practitioners?"

A four-point Likert scale enabled respondents to rate the degree to which they agreed that the referral system was effective (and we note very few "Don't know" responses.). The level of agreement was: highest for other CMOs; second highest for NSW Human Services; third highest for NSW Health; and, lowest for GPs.

FIGURE 19: EXTENT TO WHICH RESPONDENTS AGREED THAT THE CLIENT REFERRAL SYSTEM WAS EFFECTIVE (OVER THE LAST THREE MONTHS)

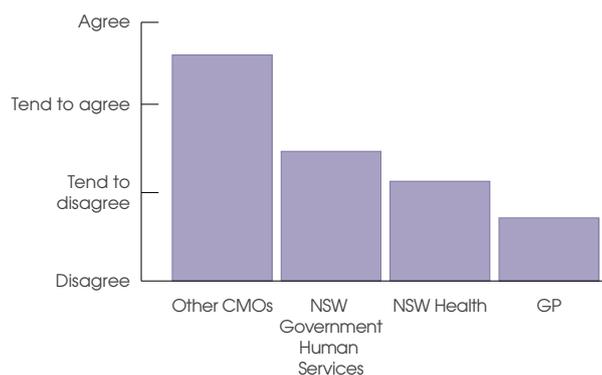
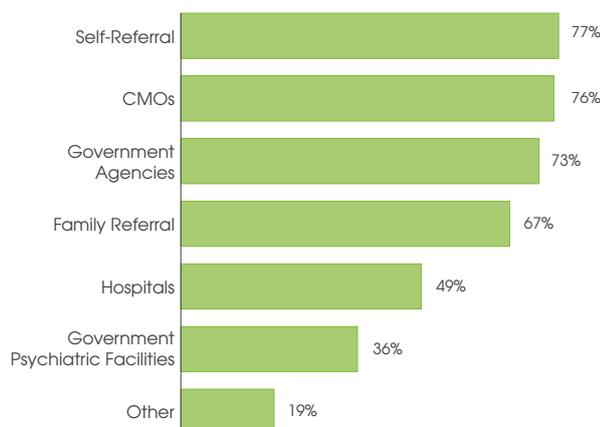


FIGURE 20: PERCENTAGE OF ALL CMOs RECEIVING REFERRALS IN THE PREVIOUS 3 MONTHS



Of the 82% of respondents collecting data about client referral sources, the highest referral source for clients was reported as "self-referral" (77%). That is, the person requiring support made contact with the CMO directly. The lowest source of referrals was from government/NSW Health psychiatric facilities (36%). Reasons why this may be the case include that self-referrals may not have disclosed their actual referral source or CMOs services may hold less stigma/be less intimidating than more formal clinical options.

**TABLE 6: SOURCE OF REFERRALS TO DIFFERENT CMO TYPES (OVER THE LAST 3 MONTHS).**

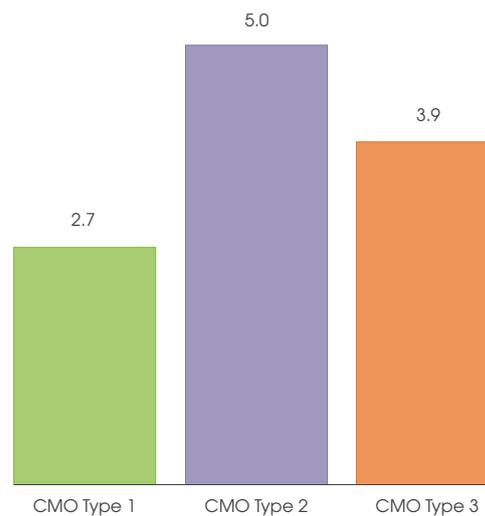
	Type 1	Type 2	Type 3
Self-Referral	77%	78%	75%
CMOs	74%	80%	73%
Government Agencies (e.g. DADHC)	63%	77%	72%
Family Referral	66%	67%	67%
Hospitals	54%	50%	45%
Government Psychiatric Facilities	49%	41%	26%
Other	23%	22%	15%

- Lowest percentage to Type 1, much higher to Type 2 and Type 3
- Highest percentage to Type 1, second highest to Type 2, lowest to Type 3

Client referrals were categorised by CMO Type where Type 1 CMOs are more specialised (mental health programs only) and Type 3 CMOs are more generalised (no specific mental health programs). The results in Table 6 indicate that Government/NSW Health Psychiatric Facilities were reported to be the referral source of 49% of clients using Type 1 CMOs; 41% of clients using Type 2 CMOs; and 26% of clients using Type 3 CMOs, indicating that mental health specialised Type 1 CMOs reported receiving more referrals from Government/NSW Health Psychiatric Facilities than less specialised CMOs (Types 2 & 3).

Conversely, Government Agencies/NSW Human Services were reported to be the referral source of: 63% of clients using Type 1 CMOs; 77% of clients using Type 2 CMOs; and 72% of clients using Type 3 CMOs, indicating that generalised CMOs without specific mental health programs (Types 2 & 3) reported receiving more referrals from Government Agencies (e.g. DADHC, etc).

**FIGURE 21: AVERAGE NUMBER OF FORMAL AGREEMENTS IN WHICH CMOs PARTICIPATE**



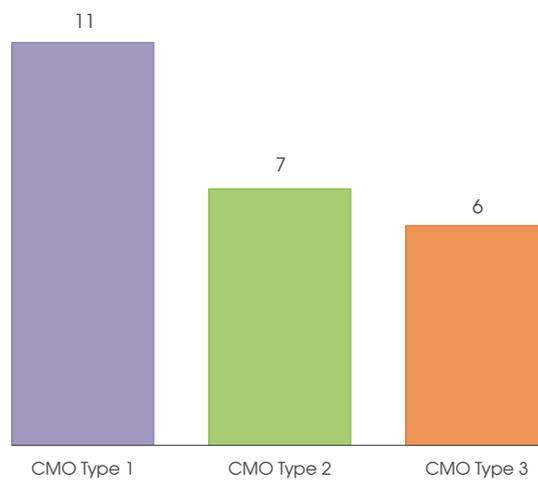
## Partnerships

The purpose, number of agreements between, and number of organisations involved within agreements were measured. For example, in order to apply for funding, four CMOs may form a consortium. This would count as one agreement, involving three other CMO partners. Another example is coordination of client supports where five CMOs may each have particular accountabilities. This would count as a CMO having one agreement involving four other CMO partners.

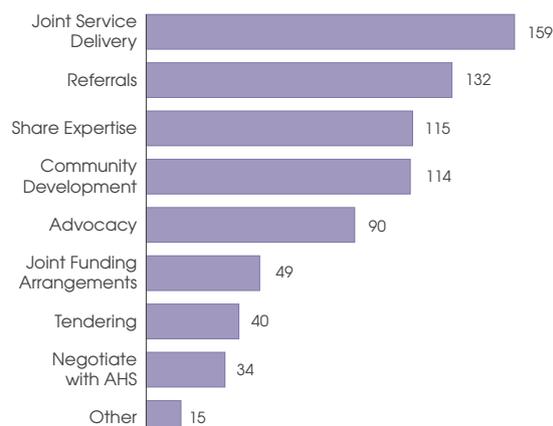
The average number of formal agreements in which CMOs participate is 4.2. The average number of CMO partners involved within agreements is 7.7.

On average, Type 1 CMOs have fewer formal agreements (average is 2.7) than Type 2 & 3 CMOs (average is 4.5). However, Type 1 CMOs have more partners (average is 11) within each formal agreement than Type 2 & 3 CMOs (average is 6.5).

**FIGURE 22: AVERAGE NUMBER OF CMO PARTNERS INCLUDED WITHIN FORMAL AGREEMENTS**



**FIGURE 23: NUMBER OF CMOs REPORTING THE MAIN PURPOSE OF PARTNERSHIP AGREEMENTS**



### Purpose of Partnerships

159 CMOs stated that the main purpose of partnership agreements between CMOs is for joint service delivery. 132 CMOs stated that the main purpose is for referrals.

TABLE 7: MAIN PURPOSE OF PARTNERSHIPS BY CMO TYPE

	Type 1	Type 2	Type 3	All
Joint Service Delivery	19	68	72	159
Referrals	17	60	55	132
Share Expertise	19	52	44	115
Community Development	13	56	45	114
Advocacy	14	38	38	90
Joint Funding Arrangements	7	20	22	49
Tendering	4	21	15	40
Negotiate with AHS	7	20	7	34
Other	3	6	6	15

Lowest number identifying main purpose for CMO Type

Highest number identifying main purpose for CMO Type

A closer look at the data relating to the main purpose of partnerships indicated that the primary purpose of partnership agreements for Type 2 & 3 CMOs was joint service delivery, and the primary purpose of partnership agreements for Type 1 CMOs was to share expertise.

Views on strength and quality of partnerships were polled through responses to the following questions and using a four-point Likert scale (Agree, Tend to Agree, Tend to Disagree or Disagree):

- “There is a clear goal for the partnership”;
- “This goal is realistic”;
- “Each partner’s areas of responsibility are clear and understood”;
- “The action is adding value (rather than duplicating services) for clients”;
- “The partnership can demonstrate or document the outcomes of its collective work”; and
- “There are clear arrangements to ensure the partnership is reviewed to ensure it continues to meet its objectives”.

Most respondents selected Tend to Agree or Agree on all items. This confirms that CMOs generally find value in partnerships and understand that partnerships require investment in policy development and resources.

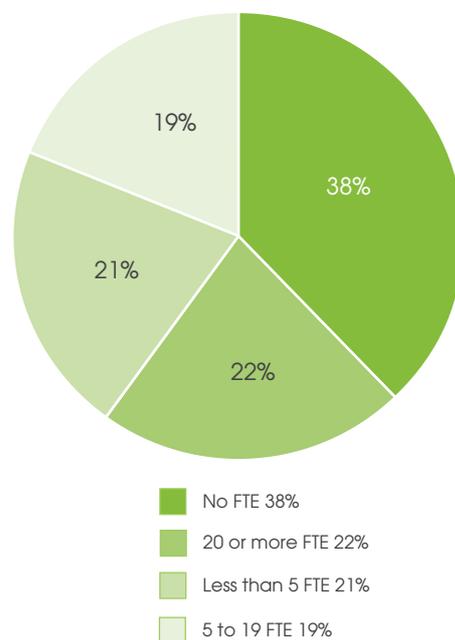
## HUMAN RESOURCES: CMO Full Time Equivalent (FTE) Mental Health Staff

38% of CMOs reported having no FTE mental health staff. 22% of CMOs reported having 20 or more FTE mental health employees.

There is a clear difference in average numbers of FTE mental health staff between CMO Types (Figure 25). CMOs providing mental health services only have a substantially higher average number of FTE mental health staff, and Type 3 CMOs have the lowest.

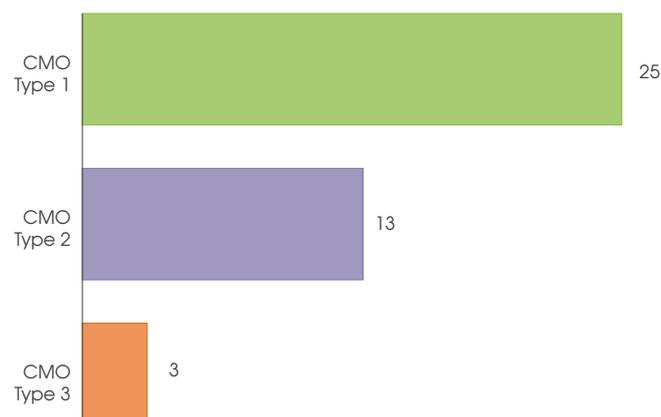
It is not surprising that Type 1 CMOs have significantly more FTE mental health staff given that they are specialised (delivering mental health programs only) and, on average, provide more mental health programs per organisation.

FIGURE 24: PERCENTAGE OF CMOS WITH FTE MENTAL HEALTH EMPLOYEES



When asked the open question “*What do you think is the key challenge currently facing the mental health sector in NSW?*” survey respondents overwhelmingly stated the need for more funding and resources. When asked the open question “*How can mental health services be improved, apart from ‘more funding’?*” most survey respondents indicated an increase in the provision of regular free or heavily subsidised mental health related training for CMOs.

FIGURE 25: AVERAGE FTE STAFF EMPLOYED BY CMOS FOR MENTAL HEALTH SERVICES



## HUMAN RESOURCES: Volunteers

Respondents were asked to provide an estimate of the number of volunteer hours provided to their organisation per week. There is a clear difference in the average number of hours volunteered to organisations depending on CMO Type.

FIGURE 26: PERCENTAGE OF CMOs REPORTING ANY VOLUNTEER HOURS PER WEEK

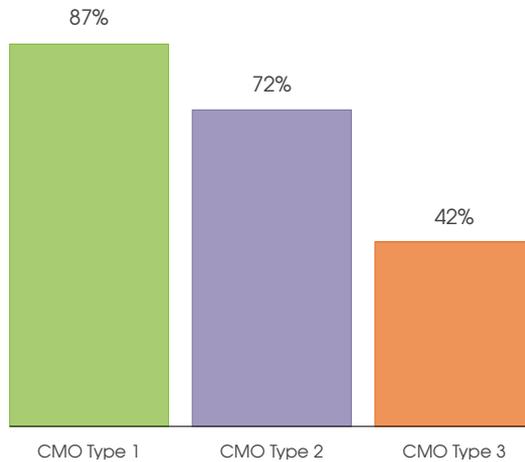
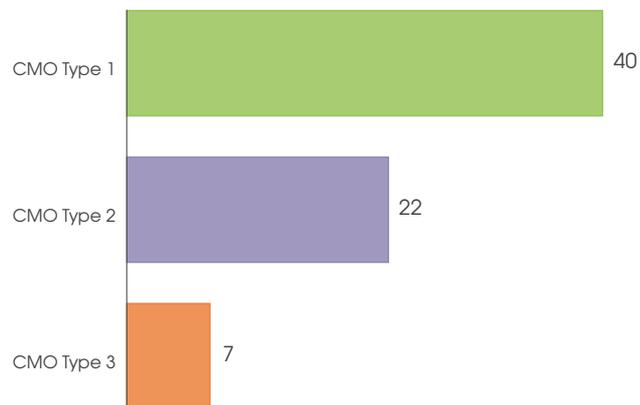


FIGURE 27: AVERAGE NUMBER OF VOLUNTEER HOURS PER WEEK BY CMO TYPE



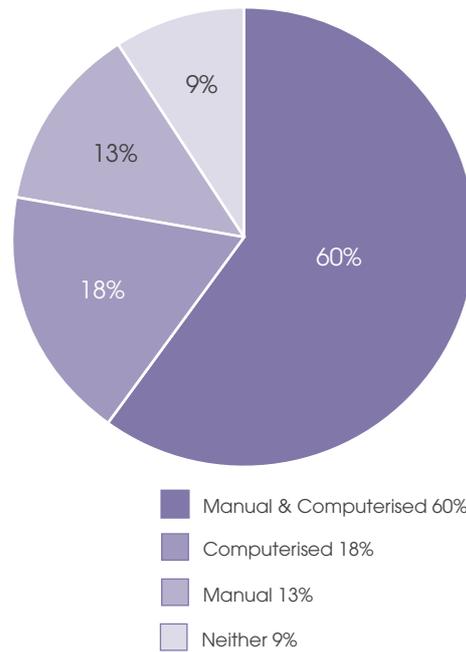
More specialised CMOs (Type 1 & 2) declared a far higher level of volunteerism both in use of volunteers (Figure 26) and in average number of hours (Figure 27).

## INFORMATION MANAGEMENT: Data Collection Systems

Data collection systems relate to how CMOs collect and use information about consumers, workforce and services to inform planning, monitoring and evaluation activities. Nearly all mental health specialised Type 1 & 2 CMOs reported having data collection systems.

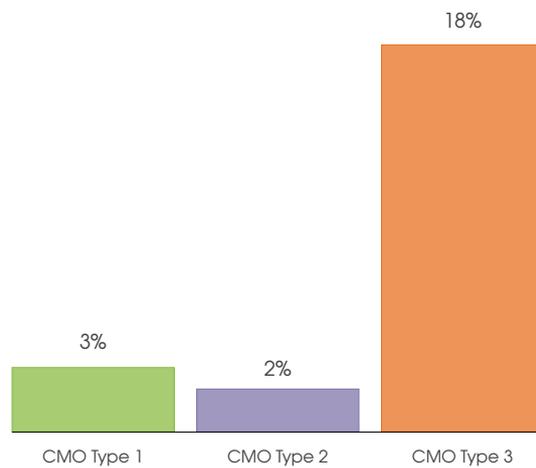
78% of responding CMOs use computers in their data collection system. However, only 18% of responding CMOs have a fully computerised data collection system, with 60% having a combined manual and computerised system.

FIGURE 28: COMPUTERISATION OF DATA COLLECTION SYSTEMS



A very surprising and somewhat alarming result is that only 18% of responding CMOs have a fully computerised data collection system. Computerised systems are essential for CMOs to effectively administer resources, plan strategically and to report to many government funding bodies.

FIGURE 29: PERCENTAGE OF CMOs STATING NO DATA COLLECTION SYSTEM

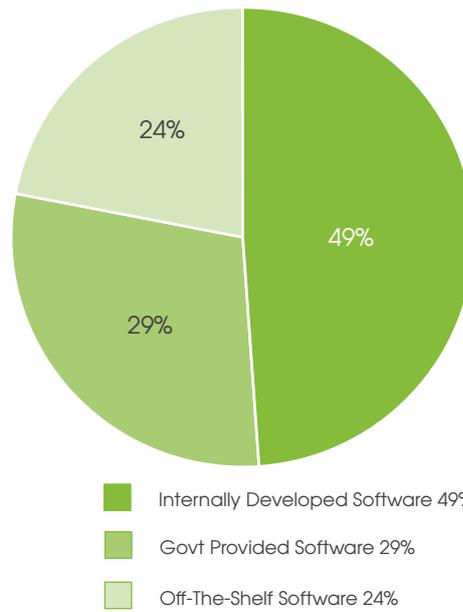


## INFORMATION MANAGEMENT: Software

CMOs reported that in order to collect data:

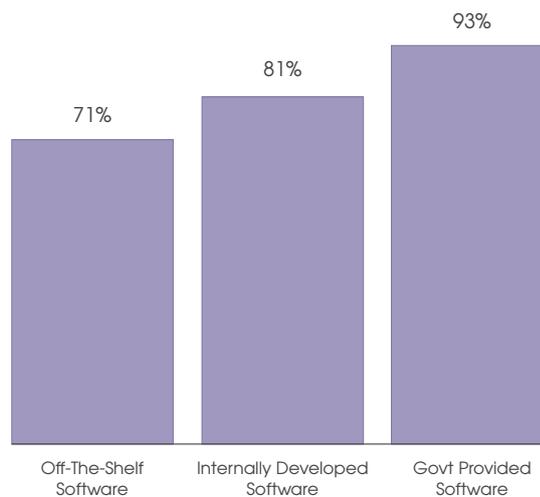
- 24% use off-the-shelf software;
- 29% use government provided software; and,
- 47% use internally developed software.

FIGURE 30: ORIGIN OF DATA SYSTEM SOFTWARE



Government provided software is associated with more data collection relating to clients than off-the-shelf and customised software.

FIGURE 31: PERCENTAGE OF CLIENT DATA COLLECTED USING TYPES OF SOFTWARE

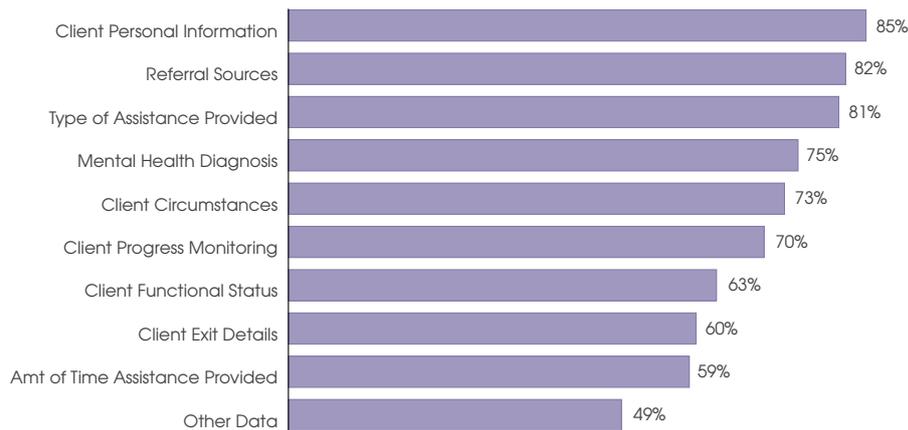


## MEASURING PROCESS, OUTCOMES AND IMPACT: Types of Client Data Collected

More than 80% of responding CMOs collect data about:

- Client personal information (85%);
- Client referral sources (82%); and,
- The type of assistance provided (81%).

FIGURE 32: PERCENTAGE OF RESPONDING CMOs COLLECTING CLIENT RELATED DATA

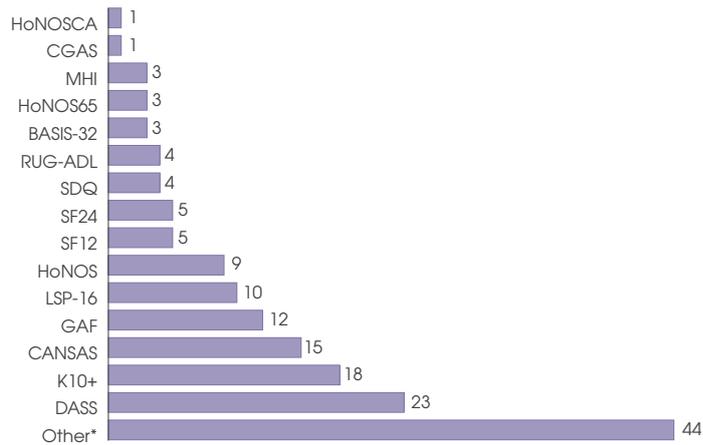


## MEASURING PROCESS, OUTCOMES AND IMPACT: Outcome Monitoring

Participants were asked to indicate which of the following tools they used for monitoring outcomes and organisational responses are provided in Figure 33:

- Health of the Nation Outcome Scales (HoNOS)
- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)
- Health of the Nation Outcome Scales 65+ (HoNOS65+)
- Life Skills Profile 16 (LSP-16)
- Kessler-10 Plus (K-10+)
- Camberwell Assessment of Need - Short Appraisal Schedule (CANSAS)
- The 24-Item Short Form Health Survey (SF24)
- Depression Anxiety Stress Scales (DASS)
- Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL)
- Children’s Global Assessment Scale (CGAS)
- Mental Health Inventory (MHI)
- Behaviour and Symptom Identification Scale 32 (BASIS-32®)
- Strengths and Difficulties Questionnaire (SDQ)
- The 12-Item Short Form Health Survey (SF12)
- Global Assessment of Functioning Scale (GAF)

FIGURE 33: NUMBER OF NGOS USING SPECIFIC OUTCOME MONITORING TOOLS



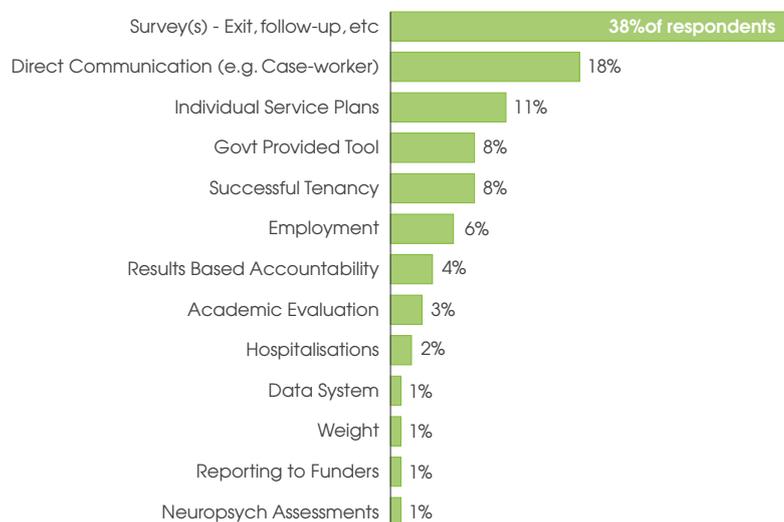
\* The 48 “other” outcome monitoring tools include: the Department of Employment & Workplace Relations IT platform for employment outcomes (EA3000); the Beck Depression Inventory (BDI); the Beck Scale for Suicidal Ideation (BSI); Brief Treatment Outcome Measure (AOD); Satisfaction with Life Scale; and, a variety of other tools including some internally developed measures.

The four most common outcome monitoring tools in use are DASS, K10+, CANSAS & GAF. Custom made in-house outcome monitoring tools are also quite prevalent. There are many possible reasons for this, such as: popular outcome monitoring tools may not be appropriate for community mental health CMO activity; there is not enough awareness of the availability and evidence base of specific outcome monitoring tools; and, differing funding sources require different outcome monitoring tools.

Type 1 organisations are well ahead in use, and best-practice application of, outcome monitoring tools (i.e., using more than 1 standardised measure), however, the highest penetration of any single tool is only 13%. This is a poor level of standardisation, and will have implications for performance monitoring within and between CMOs, different service types and different geographic areas for performance reporting to funding bodies and supporting consumers to see what works for them over time.

When asked how else outcomes were measured, the Surveys response was the most frequent (Figure 34). Direct Communication with other service providers was the second most frequent response followed by Government provided tools, successful client tenancy, and ongoing employment of clients.

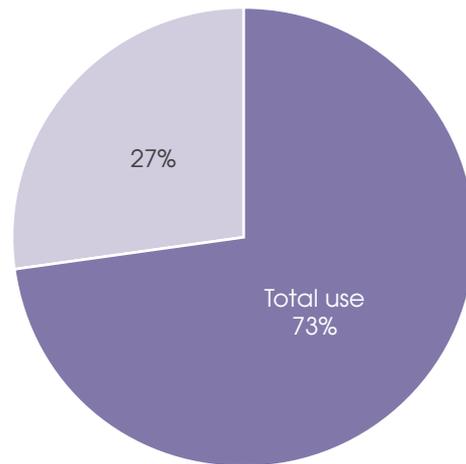
FIGURE 34: THEMES OF QUALITATIVE RESPONSES TO “HOW ELSE DO YOU MEASURE OUTCOMES?”



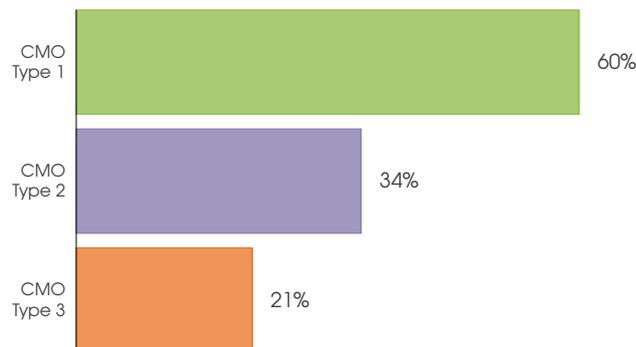
To evaluate the percentage of CMOs that use any form of client evaluation, responses were compared between the open question above (Figure 34) and the number of CMOs using outcome measurement tools. In total, it was found that 73% of CMOs use some form of client evaluation or outcome measurement tools (Figure 35).

Type 1 CMOs are more likely to be able to demonstrate the efficacy of their service provision with 60% reporting use of outcome measures (Figure 36).

**FIGURE 35: TOTAL PERCENTAGE OF CMOs USING ANY FORM OF CLIENT EVALUATION (INCLUDING OUTCOME MEASUREMENT TOOLS)**

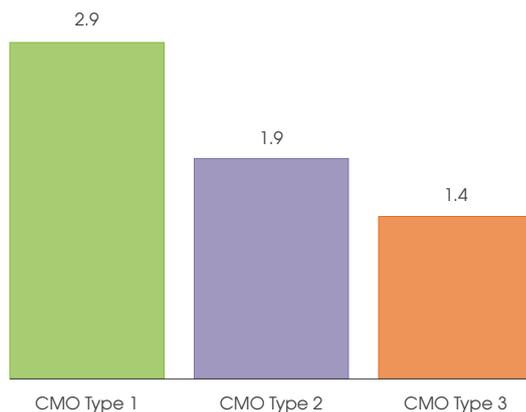


**FIGURE 36: PROPORTION OF CMOs USING OUTCOME MONITORING TOOLS**



Specialized mental health Type 1 CMOs are more likely to use multiple outcome monitoring tools (average 2.9, Figure 37).

**FIGURE 37: AVERAGE NUMBER OF OUTCOME MONITORING TOOLS USED BY CMOs**



Respondents were asked: “Thinking about the monitoring data you may collect, to what degree is this data being utilised for each of the following”? and a three-point Likert scale enabled respondents to rate the degree of utilisation of data (Figure 38).

The results support the notion that outcome monitoring tools may be more likely to be utilised to:

- Monitor key performance indicators (KPIs)/Report to funders;
- Provide evidence in funding applications; and,
- Use in program planning or development.

Outcome monitoring tools are least likely to be used to identify unmet need or manage change.

Specialised mental health Type 1 & 2 organisations report they are most likely to use data to Monitor KPIs/Report to Funders. This provides government departments, such as NSW Health, with valuable planning and evaluation information. However, these CMOs are also least likely to use data to identify unmet need. The results suggest that CMOs could use data more strategically. For example, using collected data to identify changes in client need over time and detect opportunities for service development and innovation.

FIGURE 38: USE OF OUTCOME MONITORING DATA BY RESPONDING CMOs

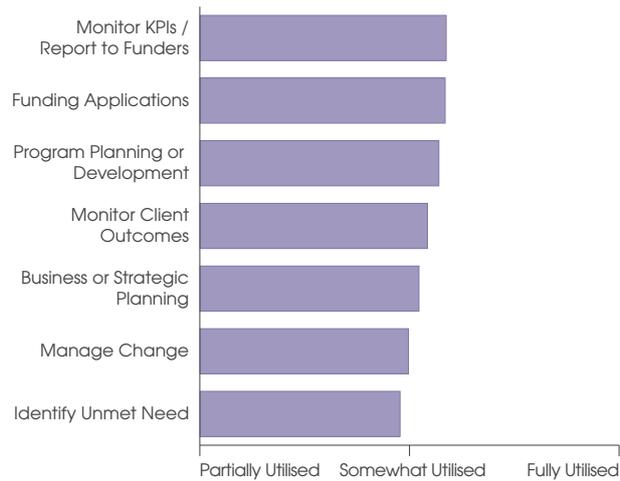
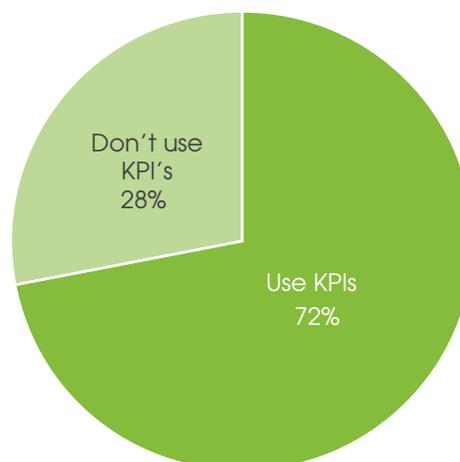


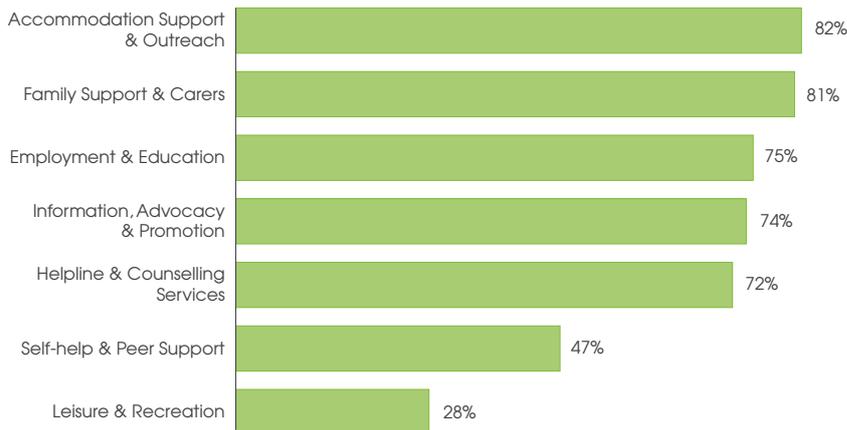
FIGURE 39: PERCENTAGE OF PROGRAMS WITH KEY PERFORMANCE INDICATORS



## MEASURING PROCESS, OUTCOMES AND IMPACT: Key Performance Indicators (KPIs)

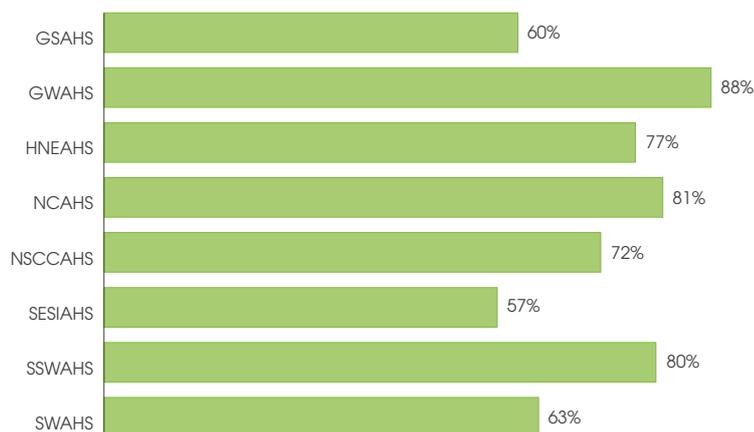
Almost three quarters (72%) of responding CMOs reported that they used KPIs. Most core services contained programs which averaged above 70% KPI use, however, "Self-help & Peer Support" and "Leisure & Recreation" both display significantly low levels of KPI usage at 47% and 27% respectively (Figure 40).

**FIGURE 40: PERCENTAGE OF CORE PROGRAMS WITH KEY PERFORMANCE INDICATORS**



Program KPI usage rates varied only moderately across the AHSs (Figure 41). Programs in the GWAHS reported the highest level of KPI usage (87%). Those in SESIAHS and SWAHS reported the lowest levels of KPI usage.

**FIGURE 41: PERCENTAGE OF PROGRAMS WITH KEY PERFORMANCE INDICATORS IN EACH AREA HEALTH SERVICE REGION**



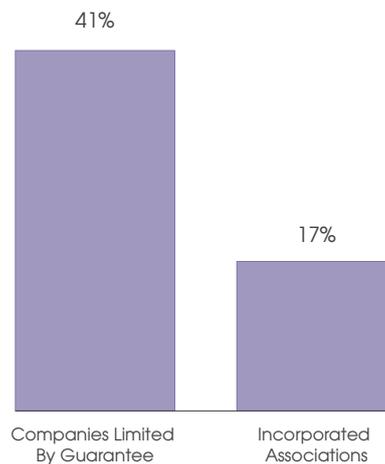
## SYSTEMS IMPROVEMENT: Accreditation

Respondents were asked if they were accredited by any of the following: Quality Improvement Council; ISO; The Australian Council on Health Care Standards; and, AI Global (Business Excellence Framework). 23% of CMOs were accredited with at least one of the four nominated accreditation bodies. The *Sector Mapping Survey* identified an additional 21 quality review processes with which the mental health CMO sector is engaged. The 25 quality review processes identified by responding organisations are listed in Appendix 9.

Respondents were asked the following questions about accreditation:

- *“Is your organisation intending to seek accreditation to any of the above external quality standards in the next two years”?*
  - 38% said YES
- *“Do you have any arrangements/ contracts with external organisations for them to conduct reviews of your organisation for the purposes of accreditation or for more general service development”?*
  - 56% said YES
- *“Are you intending to have a general ‘service development’ review in the next two years conducted by an external organisation”?*
  - 58% said YES
- *“Is the organisation, or any of its mental health services/programs, required to comply with quality systems developed by government”?*
  - 52% said YES
- *“Does your organisation have internally developed quality standards that new programs are required to comply with”?*
  - 57% said YES

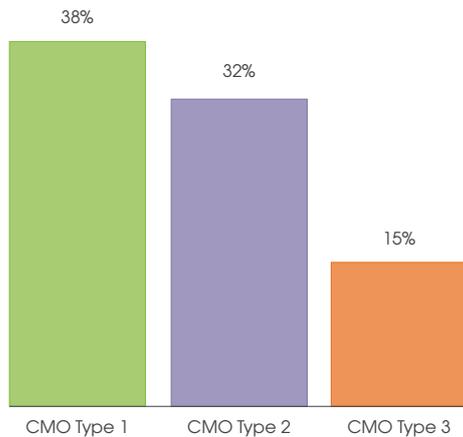
FIGURE 42: PERCENTAGE OF CMO ACCREDITATION (CORPORATE STRUCTURE)



When organisational structure was taken into account, almost half of Companies Limited by Guarantee held accreditation with the nominated bodies whereas only 17% of Incorporated Associations were accredited as shown in Figure 42.

CMO Types 1 and 2 had more than twice the level of accreditation than CMO Type 3 (Figure 43).

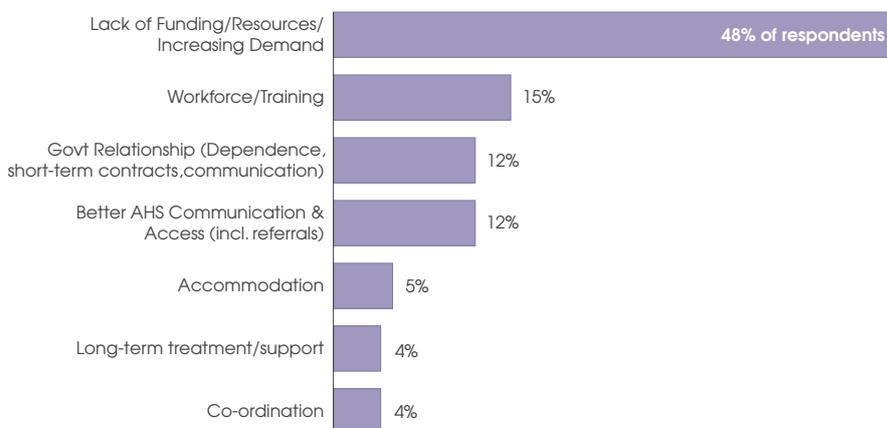
FIGURE 43: PERCENTAGE OF CMO ACCREDITATION (CMO TYPE)



## KEY CHALLENGES FROM THE CMO PERSPECTIVE

Respondents were asked the open question “*What do you think is the main challenge currently facing the NGO mental health sector in NSW?*”? The largest proportion of CMOs declared either insufficient funding, a lack of resources or increasing service demand to be the main challenges currently facing the sector (Figure 44).

FIGURE 44: RESPONSE THEMES TO OPEN QUESTION ON THE MAIN CHALLENGE FOR THE SECTOR

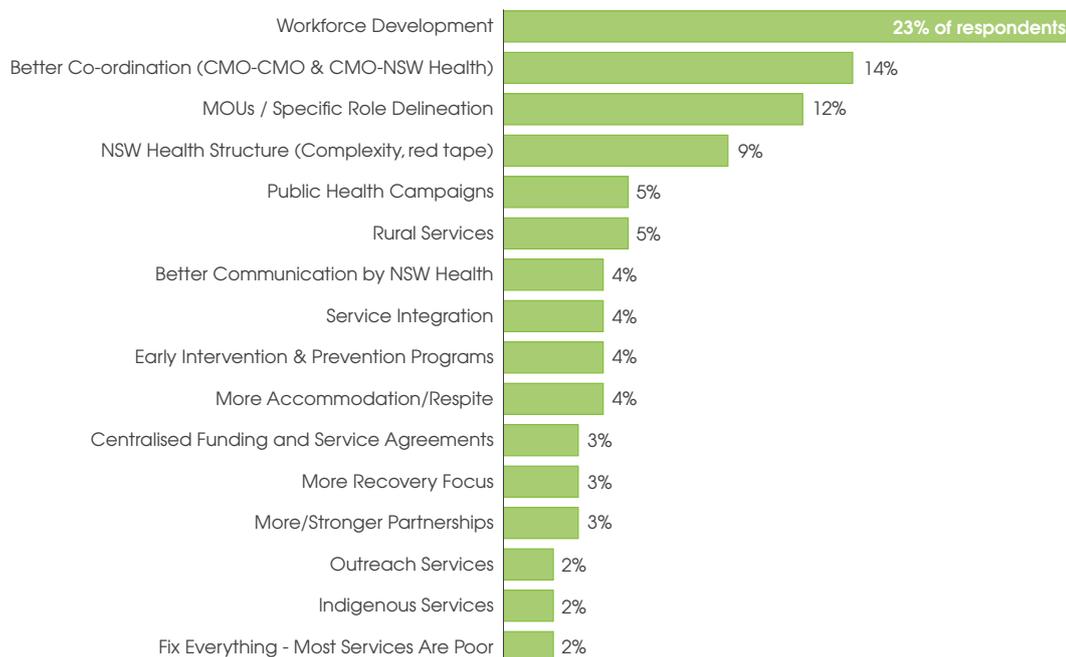


Anticipating this result, respondents were then asked “*How can mental health services be improved apart from more funding?*”? Responses to this question were more diverse (Figure 45). The most common themes emerging were:

- Workforce Development (23% of respondents);
- Better Co-ordination (of services, 14%);
- Memoranda of Understanding/Role Delineation (12%); and,
- Reduction of complexity and red tape in dealing with NSW Health (9%).

More details regarding responses to this question are provided in Appendix 6.

FIGURE 45: RESPONSE THEMES TO THE OPEN QUESTION ON HOW THE SECTOR COULD BE IMPROVED APART FROM "MORE FUNDING".



# DISCUSSION & RECOMMENDATIONS

## SERVICE PROVISION

### PARTNERSHIPS

The nature of partnerships contributes to an understanding of CMO engagement. Strategic alliances within and between sectors may enable growth in perspective taking, smarter use of resources, and more innovative solutions. However partnering will not magically produce cost-effective solutions to complex problems or reduce the necessity of making hard choices about accomplishing priorities with finite resources<sup>23</sup>.

Agreements centred on providing coordinated support for clients can be an effective contribution to meaningful client outcomes. The partnership results indicate this is a strong focus area for CMOs, with overall client support being the main motivator for partnerships. This aligns well with the principles underlying client-centred support and effective care coordination.

However, more work needs to be done to improve partnerships focusing on coordination of client support, given that coordination is an area of high concern to CMOs and NSW Health. One of the key challenges faced by CMOs is their relationship with government, including NSW Health, in a provider role.

The *consultation comments* from NSW Health (see Appendix 5) indicate the need for:

- *“Rules of engagement, clear protocols on shared care and management plans”;*
- *“Role delineation and coordinated care”;*
- *“Better collaboration between NSW Health and NGOs when catering for complex needs”;*
- *“Interagency Forums”;*
- *“A feeling of trust between NSW Health and the NGO staff about shared values”;*  
*and,*
- *“A framework on how NSW Health links with the NGO sector, including dealing with differences”.*

Survey respondents stated that government–CMO relationships, AHS communication, and client support coordination are key challenges facing the community managed health sector and frequently stated that workforce development, better coordination, and clearer role delineation will improve mental health services.

Factors identified for successful health partnerships include a history of collaboration, mutual respect and trust, open and frequent communication, a shared vision, attainable goals, adequately paid staff and skilled leadership<sup>24</sup>.

### WORKING ON LOCAL PARTNERSHIPS TO PROMOTE RECOVERY

NSW Health has Clinical (Mental Health) Partnership Coordinators in AHS, the role of which is to *“provide leadership and direction in the strategic planning and development of key partnerships between mental health services and other agencies and in ensuring the clinical effectiveness of planned-coordinated service delivery”*<sup>25</sup>. Facilitation of partnerships to improve care coordination is a positive and much needed step towards cross-sector collaboration. In the CMO sector MHCC has the *“Meet Your Neighbour”* program<sup>26</sup>, the aim of which is to encourage organisations to meet, learn more about each other and find ways to work better together. These mechanisms are in place to support NSW mental health CMOs to work collaboratively with each other.

Proper care coordination requires localised partnerships and localised partnerships require localised knowledge of service resources, linkages and demographics. There remains a vast area of unknown requirement in the specifics of coordination at regional levels. The distinct characteristics of urban, rural and remote regions require differing

<sup>23</sup> (Ostrower, 2005).

<sup>24</sup> Cheadle, Senter, Solomon, Beery, and Schwartz (2005)

<sup>25</sup> NSW Health (2006)

<sup>26</sup> MHCC (2009)

service delivery models, partnerships, role delineation, workforce strategies and contractual arrangements. Collaboration and care coordination at regional levels would be strengthened through a targeted research agenda.

In order to effectively engage and support CMO interaction with NSW Health, it is envisaged that localised research findings will lay the groundwork for properly coordinated regional and population-based planning.

State and Commonwealth approaches to community mental health planning have targeted programs with little reference to the development of a balanced and coordinated sector. CoAG programs such as Personal Helpers and Mentors (PHAMS), Mental Health Carer Respite, Community Based Programs and Day to Day Living have enabled substantial improvements in access to support for many individuals. The interface between these programs and NSW Health services needs to be addressed.

## ROLE DELINEATION

HNEAHS has developed, in the form of a working paper to be evaluated, *“HNEMH Clinical & NGO Non-clinical Roles: A Guide for Working Together to More Efficiently and Effectively Coordinate Care for Consumers”* (2009). The document was developed by CMO and HNEMH staff coming together through a series of workshops over three years.

Eleven issues are considered with the roles and expectations shown as: clinical (HNEAHS staff); NGO (CMO staff); and, shared. For example, “Exit/Transitioning from Hospital” has the roles and expectations shown in Table 8. Since the delineations in this document have not yet been independently evaluated it would be worthwhile reviewing, modifying and building on the work of HNEAHS to develop an expansive role delineation framework which incorporates day to day working expectations and risk management protocols around critical incident prevention, management, and adaptation/recovery. The framework would be piloted and thoroughly evaluated prior to broad usage.

**TABLE 8: HNEAHS DELINEATION OF ROLES AND EXPECTATIONS FOR “EXIT/TRANSITIONING FROM HOSPITAL”**

Clinical	Shared	NGO (CMO)
<ul style="list-style-type: none"> <li>● Assess consumers’ readiness for return to community and inform NGO of impending discharge</li> <li>● Facilitate involvement in ward rounds or case conference as appropriate</li> <li>● Ensure medication compliance of consumer</li> <li>● Ensure legal requirements are met</li> <li>● Liaise with the following stakeholders on discharge:                             <ul style="list-style-type: none"> <li>● Consumer’s General Practitioner</li> <li>● Mental Health Medical Officer</li> <li>● Family/carer</li> <li>● CMOs</li> </ul> </li> <li>● Coordinate discharge transition plan to either:                             <ul style="list-style-type: none"> <li>● Community Mental Health Service</li> <li>● Psychiatry Rehabilitation Service</li> </ul> </li> <li>● Consult CMOs regarding discharge plan</li> <li>● Follow up on discharge report in a timely manner</li> </ul>	<ul style="list-style-type: none"> <li>● Develop a coordinated discharge plan</li> <li>● Provide support to family/carer</li> <li>● Liaise with inpatient staff</li> <li>● Liaise with consumer’s General Practitioner</li> <li>● Ensure availability of medication</li> </ul>	<ul style="list-style-type: none"> <li>● Visit consumer as appropriate</li> <li>● Participate in joint reviews</li> <li>● Advocate on behalf of consumer and family/carer</li> <li>● Refer family/carer to support services as required</li> <li>● Upon invitation, attend ward rounds and/or case conferences</li> <li>● Provide consumer with transport home and assist in the set-up of home if necessary (e.g. domestic organisation, food available)</li> <li>● Provide consumer and family/carer with support</li> </ul>

## REFERRAL SYSTEMS

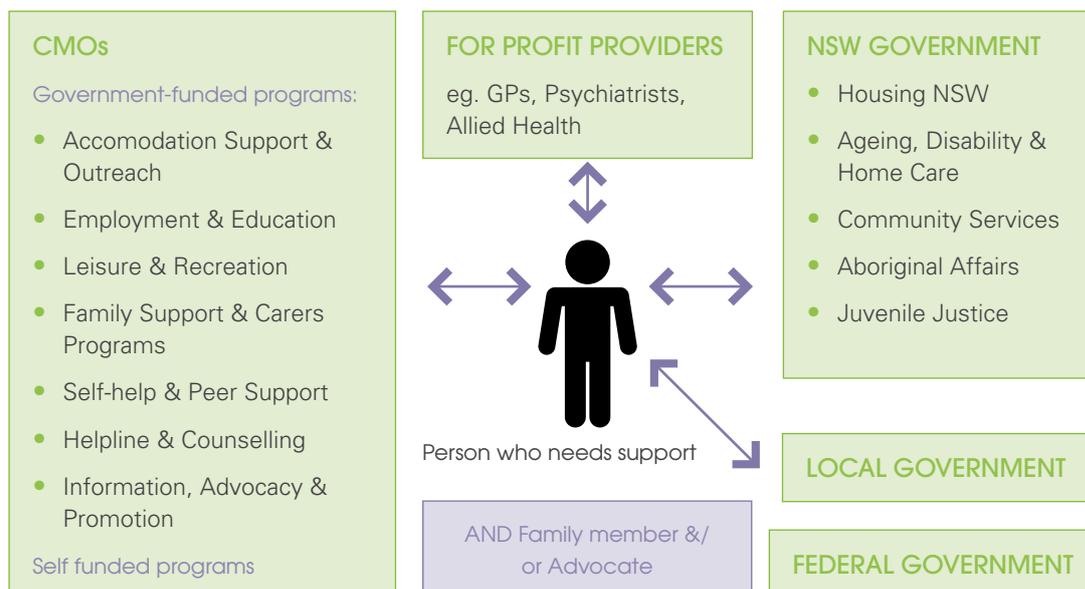
It is essential that CMOs provide accessible, relevant, timely, well-coordinated, recovery-focused programs. Currently, supports are available and referral processes may involve entities such as those in Figure 46.

GPs have difficulty knowing about mental health CMO programs. Local divisions of GPs have developed service directories in the past but do not have the capacity to continually update them as CMOs change and new programs emerge<sup>27</sup>. The results of the *Sector Mapping Survey* add weight to the claim that GPs have difficulty accessing information about CMOs with the referral system between CMOs and GPs being rated as least effective. The rating of the referral system from GPs as the least effective is a cause for concern if access to community managed mental health programs are to become more coordinated through primary health services.

Developing methods to interface more effectively with GPs – through a single point of contact – would contribute to a more coordinated experience for people experiencing mental illness. Updating NSW Health’s Health Services Directory or adapting a system such as HS Net - incorporating details of community mental health CMOs - may meet that need. This item also relates to a need - identified in the NSW Health consultation comments (Appendix 5) – to know more about which CMOs exist.

Researching the nature of CMO referral sources and systems will lead to more empirical data regarding what needs to be improved and how changes should be made in order to provide a smoother referral experience for people requiring mental health support. Ideally, referral processes will also include comprehensive risk assessments and will work well for the client, the referral source and the provider receiving the referral.

FIGURE 46: STAKEHOLDERS INVOLVED IN REFERRAL PROCESSES



## PROGRAM ENTRY CRITERIA

Although half of CMO programs cater for people with “any mental illness”, for others program access criteria are set on the basis of diagnoses (eg, “serious” mental illness).

Someone with a diagnosis characteristic of serious mental illness may have significantly less need for service than another with a diagnosis characteristic of mild mental illness who is severely functionally disabled as a result of that illness. Ideally, access to core services will be based on functional needs rather than diagnostic criteria.

<sup>27</sup> Personal Communications with the author (2009)

### RECOMMENDATION 5

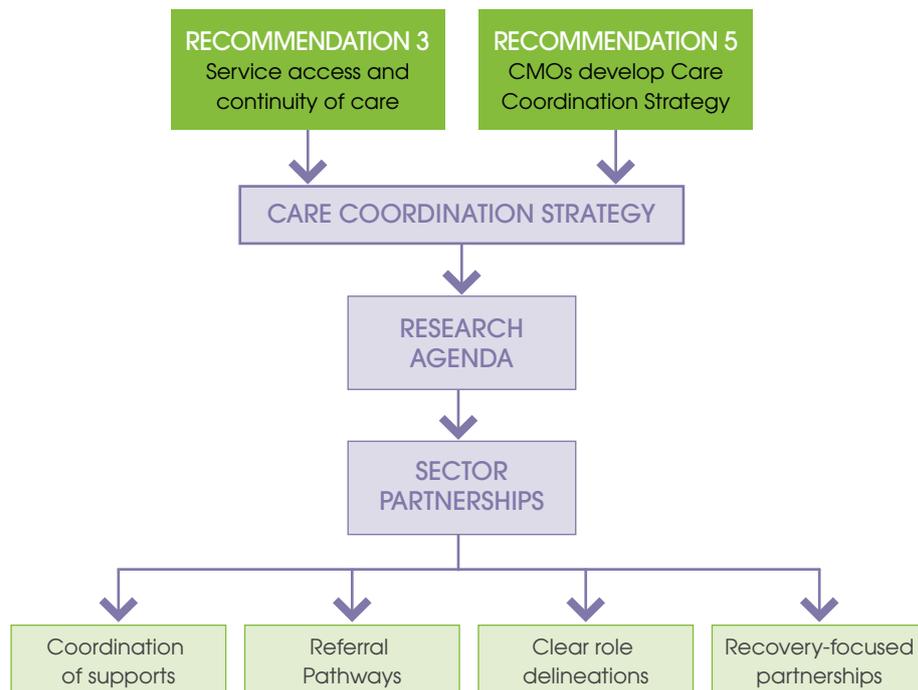
CMOs develop and adopt a *Care Coordination Strategy* that will promote pathways and linkages across the mental health service system.

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 3 & 5

The **Care Coordination Strategy** will involve three components:

- Commitment to a care coordination research agenda to conduct detailed research into local and contextual factors across regions of NSW will determine:
  - Population density and geographic variables for service demand and delivery. (e.g. differences between urban, rural and remote areas);
  - Best-practice models of care-coordination and partnership development;
  - Existing public, private and community-managed organisation linkages at local levels; and,
  - Existing formal and informal partnerships.
- Development by CMOs and government of:
  - Clear role-delineations between components of the service system; and,
  - More effective referral pathways.
- A specific set of indicators or recommendations to inform future planning and support for the NSW CMO sector.

### IMPLEMENTATION GUIDE FOR RECOMMENDATIONS 3 AND 5



## INFORMATION MANAGEMENT: Data Collection Systems

The low rate of computerised systems is probably making it difficult for CMOs to effectively administer resources, plan strategically and to report to funding bodies.

Government provided software is associated with more data collection relating to clients than off-the-shelf or customised software, possibly due to funding being contingent upon the associated government reporting requirements. However, government reporting requirements may not relate directly to the broader data collection needs of CMOs. Off-the-shelf software is often expensive and requires resources to tailor it to the needs of the CMO and to link it to other systems.

The consultation comments indicate that CMO information systems are a concern to funders.

Given the lack of standardisation, a well-researched, sector-wide approach to software should be developed to enable data collected to be relevant and meaningful to all stakeholders. MHCC is currently undertaking a CMO sector *Data Management Strategy* (DMS), part of which involves a scoping study of CMO IT infrastructure needs. Subsequent development of CMO IT infrastructure should strongly consider the findings of the DMS.

## MEASURING PROCESS, OUTCOMES AND IMPACT: Types of Client Data Collected

The low rate of data collection relating to client exit details and duration of support needs to be rectified in order to enable clients to see what works for them and to improve referral systems. The variation in collected data relating to clients may reflect what some survey respondents have described as a “fragmented system”.

Client-centred approaches – focusing on aspects of the journey with coordinated supports – could be the basis on which a consistent approach to data collection may develop.

## MEASURING PROCESS, OUTCOMES AND IMPACT: Outcome Measures

The *Sector Mapping Survey* results indicate low use of outcome measures and the highest reported outcome measures used by CMOs focus on illness and symptoms. While it is important to enable clients to monitor these factors it is essential that CMOs also focus on supporting clients to see changes in health, social outcomes and wellbeing. A recovery approach focuses on supporting consumer progress towards wellbeing. Outcome measures should focus on measuring health, social outcomes and wellbeing, not just illness and symptoms.

It is noted that the MHCC *Learning and Development Unit* integrates content about outcome measurement in all training and further work needs to be done to enable standardisation.

## MEASURING PROCESS, OUTCOMES AND IMPACT: Key Performance Indicators (KPIs)

Almost three quarters of responding organisations reported that they used KPIs. However, the NSW Health *NGO Grant Program* uses mostly descriptive or process KPIs for its funded community mental health programs. A weakness of this approach is that KPIs may reflect how busy a service is rather than being a measure of effect. NSW Health should state clear KPIs that are consistent, succinct, and measurable. Outcome-focused indicators should also be considered in order to ensure a more meaningful measure of performance.

## SYSTEMS IMPROVEMENT: Accreditation

The number of accredited CMOs has increased markedly. In the MHCC *Sector Mapping Project* (2000) the number of accredited NGOs was negligible whereas 23% of responding NGOs in the current mapping survey are accredited. 38% of CMOs stated they intended to seek accreditation in the next two years. Funding, human resources and lack of perceived need were stated as reasons for not seeking accreditation.

Subjective feedback from CMOs indicates that substantial improvement in organisational processes occur as a result of accreditation, however, the cost and time involved can make it difficult. Accreditation is to be encouraged in order to promote overall systems improvement. Research is also recommended on the association between accreditation and efficient, effective service provision.

## SYSTEMS IMPROVEMENT: OH&S, Risk Assessment and Management

OH&S, risk assessment and risk management have been mentioned in the consultation comments and subjective feedback provided through the qualitative questions. These are essential areas to ensure: clients are supported in a planned, responsible manner; and staff experience a safe working environment.

The provision of infrastructure grants by NSW Health to CMOs via MHCC has met with success. However, there is ongoing need to develop CMO infrastructure so that CMOs can bring services up to accreditation standard.

### RECOMMENDATION 6

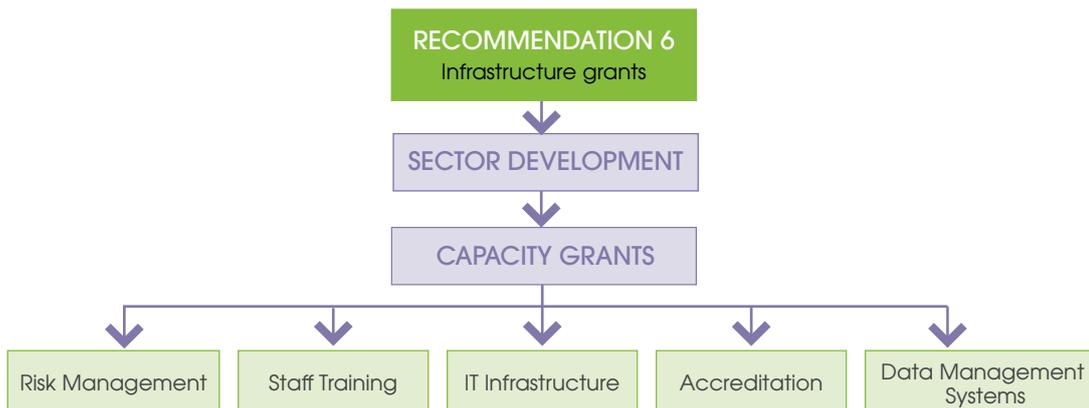
The CMO sector is supported to meet quality standards and build capacity to deliver effective services.

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 6

The CMO sector development function will administer capacity building grants to CMOs which target:

- IT infrastructure;
- Data management systems;
- Attainment of accreditation status;
- OH&S, risk assessment and risk management; and,
- Staff training

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 6



## HUMAN RESOURCES:

CMOs bring expertise and a broad range of perspectives through the use of volunteers who provide professional, peer and lay support to clients, Boards, and employees. Some voluntary positions in the CMO sector seem to have been replaced with paid positions, possibly due to complex tendering and accountability requirements<sup>28</sup>. The Productivity Commission (2010) found that CMOs in the community services sector experience great challenges in attracting and retaining employees and volunteers.

### HUMAN RESOURCES: CMO Volunteers

When channelled correctly, volunteering can be a highly valuable asset. However, there are rising costs of recruiting, managing and training volunteers<sup>29</sup>. Unfortunately, volunteers are often not viewed as strategic assets and communities have not yet developed ways to take full advantage of them. In fact, most CMOs are losing volunteers each year<sup>30</sup>. The Productivity Commission (2010, p249) found that most Board members of CMOs volunteer their time and expertise, and may lack the skills required to conduct their duties: *“greater training and support for Boards would help enhance the effectiveness of [CMOs]”*. The consultation comments indicate that knowledge of CMO governance is important for funders.

Stigma around mental illness can be a barrier for attracting volunteers. The finding that Type 1 organisations report more volunteer usage than Types 2 and 3 is unexpected. Higher levels of volunteers could indicate a better ability to manage employees, peer support or a host of other factors.

### HUMAN RESOURCES: CMO Full Time Equivalent (FTE) Mental Health Staff

Workforce is noted as a key challenge by mapping respondents. It is not only the quantity but the quality of staff which impact on responsive, relevant, client-centred program delivery. Over the past few decades many CMOs have lifted workforce standards, engaging more professionally qualified employees. The *“demand for staff with higher level qualifications is expected to continue growing as clients present with more complex needs and community expectations of standards of care rise”*<sup>31</sup>. The National Health Workforce Taskforce (NHWT) is undertaking a *NGO Mental Health Workforce Study* which aims to develop an understanding of the existing CMO mental health workforce, and to anticipate what the future needs of the workforce may be. The NHWT will design and test a methodology to support mental health workforce planning for the CMO mental health sector.

Australian research on CMO employees suggests that while salary and conditions are poorer in the community managed sector, the levels of qualifications and experience are high, some career progression does occur, and CMO sector managers are motivated by a combination of personal development and social contribution<sup>32</sup>. The NSW mental health CMO workforce was quantified by MHCC in a 2006 sector training needs analysis and estimated it to be about 3000 FTE (with recent growth this figure is now thought to be 5000 FTE). Managers had an average of 14 years industry experience and 96% had a tertiary qualification - 54% had a university level qualification. 70% of direct care staff also had tertiary qualifications, however, 68% of these qualifications were not considered mental health specific.

CMOs have been under strain from the recent economic crisis, a leadership drain as older executives retire, and high turnover among younger CMO staff<sup>33</sup>. There is substantial movement of employees from CMOs to the public sector, which may be due to uncertainty of position tenure created by government contracts, and relatively low wages<sup>34</sup>.

<sup>28</sup> Productivity Commission (2010)

<sup>29</sup> Productivity Commission (2010)

<sup>30</sup> Eisner et al (2009)

<sup>31</sup> Productivity Commission (2010, p249)

<sup>32</sup> Centre for Australian Community Organisations and Management (2009)

<sup>33</sup> Eisner et al (2009)

<sup>34</sup> Productivity Commission (2010, p249)

The Productivity Commission (2010) notes that the small size of many CMOs can result in fewer career paths for employees, and can contribute to higher staff turnover. Frequently, staff development expenses are not regarded by funding bodies, or the public, as a necessary part of service delivery, and many CMOs are unable to sufficiently invest in training their staff. Facilitating career paths which are both attractive and recognised by new entrants is likely to contribute to retention of high quality workers within the sector<sup>35</sup>.

Career paths have begun to be addressed by the MHCC *Learning and Development Unit* (LDU) – established in 2007 by MHCC in partnership with NSW Health in recognition of the need for sector workforce development. The LDU provides professional development opportunities and qualification pathways for workers engaged in the provision of community mental health services and delivers nationally recognised qualifications including:

- Certificate IV in Mental Health Work - which is the NSW CMO mental health sector industry-recognised minimum qualification for mental health support staff<sup>36</sup>;
- Certificate IV in Alcohol and Other Drugs (AOD) Work;
- Diploma of Community Services (Mental Health);
- Diploma of Community Services (AOD and Mental Health); and,
- Advanced Diploma of Community Sector Management (*“Leadership in Action”*).

The *Professional Development Scholarship Program* (PDSP) 2010 – 2012 is a three year initiative making available \$1.6M from NSW Health and administered by MHCC. Scholarships are for vocational, university, direct care, leadership and trainer/assessor professional development opportunities for existing workers, consumers and carers.

A widespread concern is that management in the CMO sector is *“often made up of service delivery employees looking for career advancement who may not necessarily have sufficient management skills”*<sup>37</sup>. Training in CMO business management should alleviate this concern. In addition, leadership skills have been recognised as a critical factor in system and service reorientation to provide community-based and recovery-oriented mental health services<sup>38</sup>.

Specific CMO mental health workforce development needs identified through the mapping data and *Literature Review* include:

- Business management skills;
- Recruitment & management of volunteers;
- Risk management and OH&S;
- Data management;
- Partnerships; and,
- Perspectives on team approaches to client support.

## HUMAN RESOURCES: Employees who have experienced mental illness

The involvement of employees who have direct experience of mental illness in the provision of mental health services has been recognised as an important element in the improvement of mental health supports<sup>39</sup>.

Although there are some consumer-run organisations in NSW, there is much work to be done to bring about general acceptance and support. This notion reflects a statement made by one of the *Sector Mapping Survey* respondents: *“We want acceptance of consumer operated services which are independent: that can, and do, have a positive impact on consumers’ lives and recovery journeys of choice”*.

**35** Carson, Maher & King (2007)

**36** Themhs (2009)

**37** Productivity Commission (2010, p272)

**38** Anthony & Huckshorn (2008).

**39** Hardiman (2007)

It is likely that the number of people who have direct experience of mental illness employed by consumer run organisations and other CMOs will increase. In order to ensure that the NSW mental health CMO sector is prepared to meet future demands, workforce development for employees who have direct experience of mental illness (consumers utilised in consumer run organisations and other CMOs) should be included in the sector capacity building agenda.

*"We want acceptance of consumer operated services which are independent; that can, and do, have a positive impact on consumers' lives and recovery journeys of choice"*

*Sector Mapping Survey Respondent*

## RECOMMENDATION 7

Workforce Development continues to be strengthened as a critical factor in sector development

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 7

*CMO Training & Workforce Development* will be enhanced to:

- Develop clear career pathways for CMO employees;
- Ascertain the workforce development needs of employees who have direct experience of mental illness, and provide relevant support
- Facilitate access to training and support for CMO Boards;
- Enable CMO employees to access training and support in:
  - mental health
  - business management skills
  - recruitment & management of volunteers
  - risk management and OH&S
  - data management
  - partnerships
  - contemporary perspectives on team approaches to client support

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 7



# POLICY AND PLANNING

## Results of the Sector Mapping Survey

### PROGRAM FUNDING

All programs reported their primary funding source. Overall, 26 different funding sources were identified for mental health CMOs in NSW (Appendix 10).

Respondents reported that around two-thirds of their program funding came from either the NSW government or the Federal government.

- 44% of responding programs are primarily funded by the NSW government (across five government departments).
- 22% of responding programs are primarily funded by the Federal government (across three government departments).

FIGURE 47: REPORTED SOURCES OF CMO PROGRAM FUNDING (BROAD) NOT INCLUDING PEAK BODIES

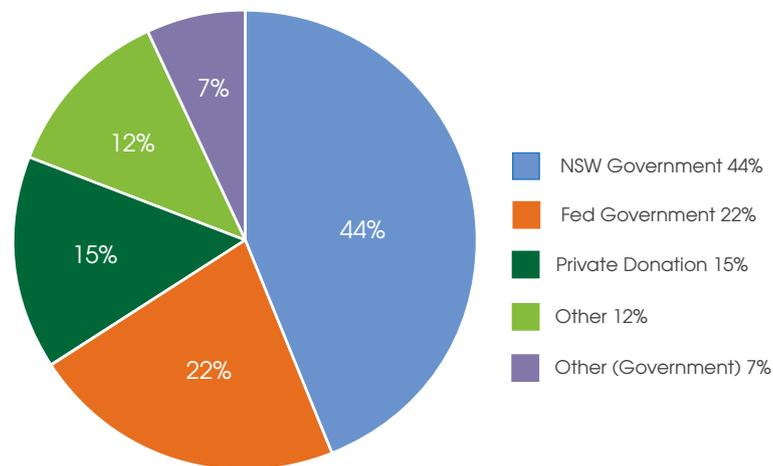
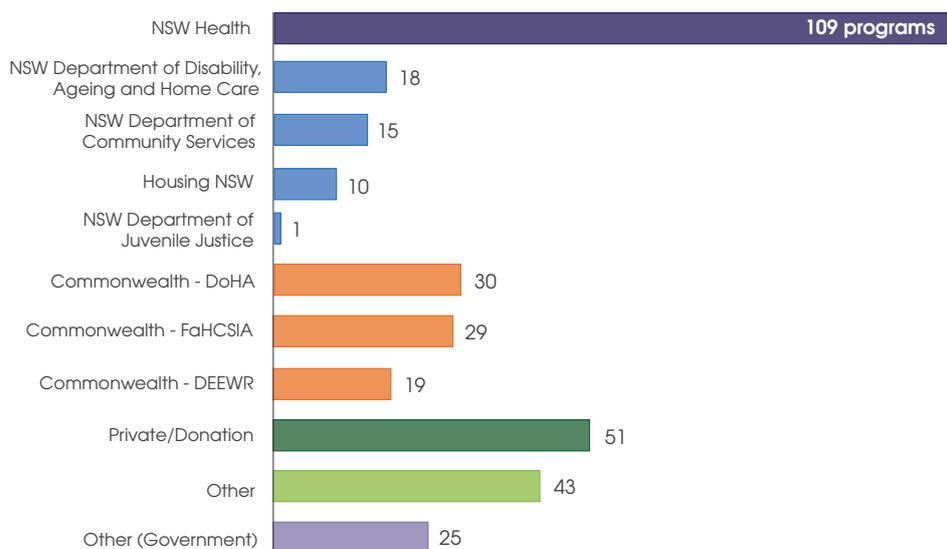
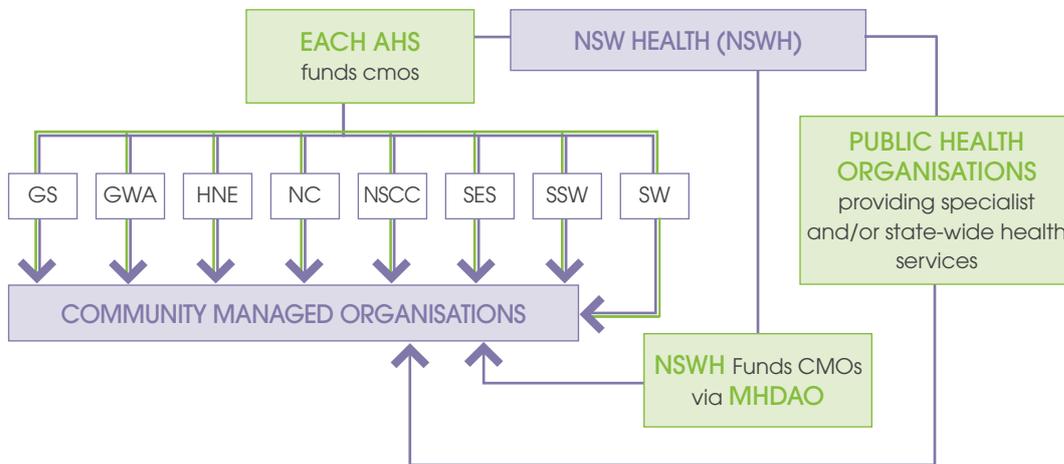


FIGURE 48: REPORTED SOURCES OF CMO PROGRAM FUNDING (SPECIFIC) NOT INCLUDING PEAK BODIES



Of the government funding sources, NSW Health funds the largest proportion of programs (31%) followed by the Commonwealth Departments of Health and Ageing (8.6%) and Families, Housing Community Services and Indigenous Affairs (8.3%).

FIGURE 49: FUNDING RELATIONSHIPS BETWEEN NSW HEALTH AND CMOS



### IDENTIFIED NSW HEALTH FUNDING STREAMS

Publicly available information was used to form a list of identifiable funding streams for programs declaring their primary funding source as NSW Health. Usable information was found for programs funded through NSW Health's *NGO Program* within one of four funding streams:

- NGO Grant;
- HASI;
- Family & Carers Support Program; and,
- Resource & Recovery Services.

Of these four identified funding streams the largest group of programs are funded through the NGO Grant Program (Table 9). More detailed information about NSW Health funded programs is provided in Appendix 7.

FIGURE 50: PROPORTION OF RESPONDING PROGRAMS FUNDED THROUGH NSW HEALTH'S NGO PROGRAM

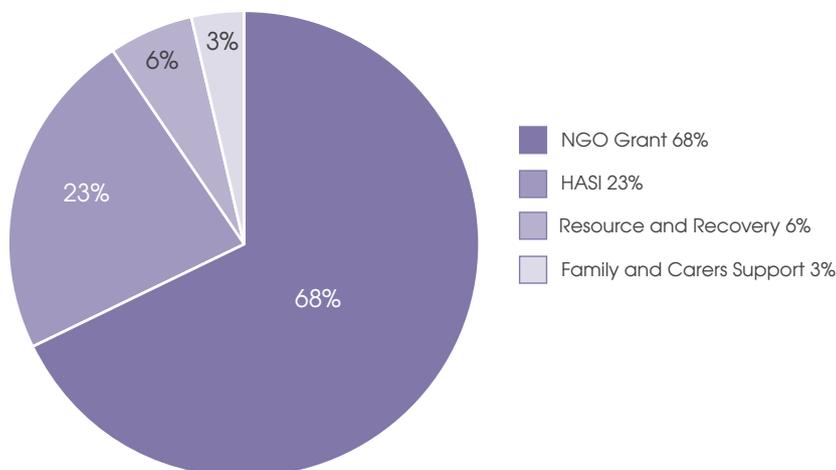


TABLE 9: CORE PROGRAMS FUNDED BY NSW HEALTH THROUGH THE NGO GRANT FUNDING STREAM

Program Type	No. of Programs
Employment & Education	17
Accommodation Support & Outreach	11
Self-help & Peer Support	7
Information, Advocacy & Promotion	6
Family Support & Carers	6
Helpline & Counselling services	6
Leisure & Recreation	2
<b>Total</b>	<b>55</b>

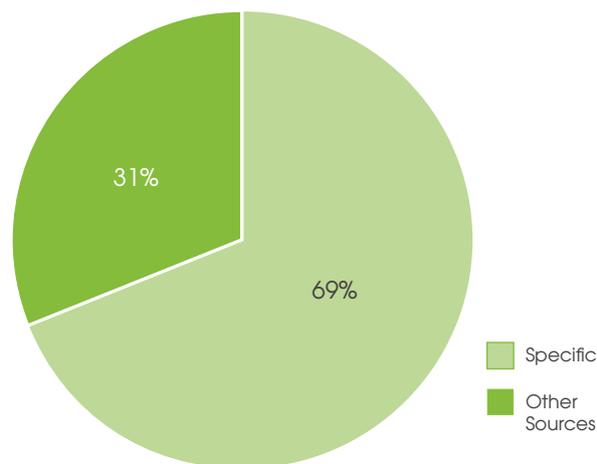
### SPECIFIC NSW HEALTH FUNDING STREAMS AND OTHER SOURCES

Streams of CMO funding in NSW Health are complicated and some sources of funding are more transparent than others.

Of the programs in which respondents declared NSW Health as the primary funding source, 67 out of 105<sup>40</sup> core programs were identified as receiving funding through a specific and identifiable stream. A further 16 programs were identified as receiving specific NSW Health funding even though their primary funding sources were declared to be from a source other than NSW Health. In total, 87 out of 105 core programs were identified as receiving funding through a specific funding stream (Figure 51).

Both of the above calculations attribute approximately two thirds of programs receiving funding from NSW Health to be specific and identifiable. Other sources of NSW Health funding may include various types of direct funding through Area Health Services as well as recurrent and ad-hoc grants.

FIGURE 51 : PERCENTAGE OF IDENTIFIED FUNDING STREAMS IN NSW HEALTH FUNDED PROGRAMS

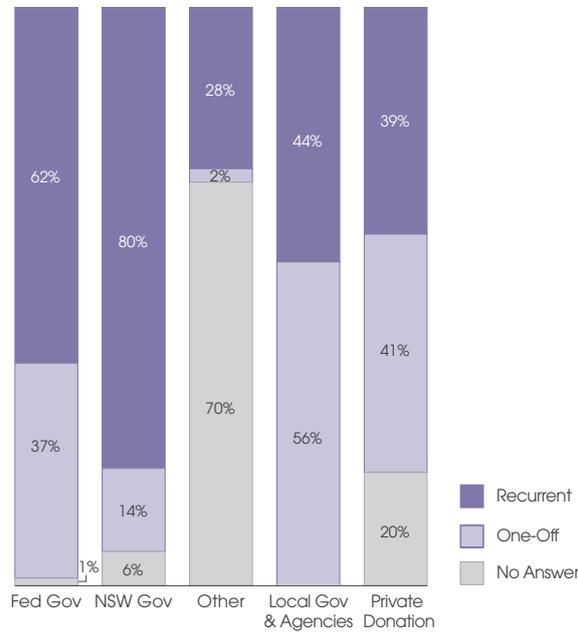


<sup>40</sup> Four programs indicating primary funding by NSW Health were classified as non-core.

## RECURRENT VS ONE-OFF FUNDING

Programs funded for a minimum of three years were considered to be recurrent. The NSW government provides the greatest proportion of recurrent program funding.

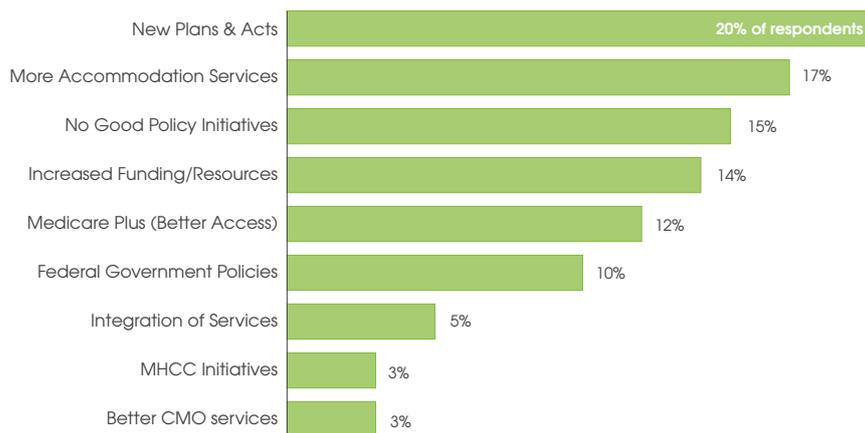
FIGURE 52: FUNDING TERMS (PERCENTAGE) FOR EACH FUNDING SOURCE



## POLICY RESPONSE FROM THE CMO PERSPECTIVE

Respondents were asked the open question “What has been the most important policy initiative in mental health in NSW over the past three years”?

FIGURE 53: RESPONSE THEMES TO OPEN QUESTION ON MOST IMPORTANT POLICY INITIATIVE OVER THE PAST THREE YEARS



Many CMOs pointed to the progress made with the implementation of new Plans and Acts that have been introduced by the NSW government. Many also responded positively towards the increase in accommodation funding and services over the past three years. However, the third highest response was either neutral or negative towards policy initiatives effecting mental health in NSW.

The full list of categorised responses is in Appendix 6.

## DISCUSSION & RECOMMENDATIONS: Policy and Planning

There has been a shift from traditional direct government to a contemporary, more networked government. Governments are focusing on funding & monitoring while delivering fewer services (which are, in turn, delivered by CMOs).

There are very few explicit statements clarifying the roles of CMOs and governments in mental health support, highlighting the need to develop clarity regarding the roles of NSW mental health CMOs and governments in funding and providing mental health support.

The *Literature Review* found that funders' expectations of low CMO running costs contribute to underreporting by CMOs of overheads and low infrastructure investment. Realistic expectations of CMO running costs need to be made by funders.

There are at least eight different government departments funding the community mental health programs of reporting CMOs. (In 2009, the NSW Government formed the Department of Human Services which includes Community Services, Ageing, Disability & Home Care, NSW Housing, and Juvenile Justice. This was not in place at the time of the *Sector Mapping Survey*). Each government department has its own administrative system and there may be several systems within NSW Health, adding burden and complexity for CMO administrators. Consistent methods of government funding for NSW mental health CMOs need to be developed.

Internationally and nationally, submission and reporting complexities are placing administrative burdens on CMOs. A more streamlined approach is required. The consultation comments indicate that the contracts management process between NSW Health and CMOs needs to be improved.

One of the challenges facing CMOs is government funding guidelines. The consultation comments refer to challenges within the contracts management process such as "a rigidity which precludes accountable variations to application of funds". Matching support to client need throughout phases of clients' journeys will enable a more flexible, stepped approach to support.

### RISK FACTORS AND FUNDING CMOs

The NSW Office of Fair Trading is increasing reporting requirements on Incorporated Associations on the basis of turnover. Conversely, there are moves to reduce the administrative burden on CMOs on the basis of the size of grants or size of the organisation.

CMO age, life cycle stage, size, asset base, and experience with government grants contribute to an understanding of CMO funding risk factors. However, there is little agreement about what constitutes CMO size. CMO funding risk factors need to be defined, along with a mechanism to indicate how risk factors will impact on CMOs receiving or applying for government funding.

### GOVERNMENT – CMO CONTRACTS

Sidoti et al (2009)<sup>41</sup> state that it is the contractual relationship that embodies particular areas of the government–CMO relationship including<sup>42</sup>:

- Agreement of clarity of purpose;
- Role of government (purchaser in its own right or as agent of the beneficiaries?);
- Recognising and managing the power imbalance that exists; and,
- Balancing tensions such as:
  - competition and co-operation;
  - control and accountability;
  - appropriately sharing risk factors.

<sup>41</sup> Sidoti, Banks, Darcy, O'Shea, Leonard, Atie, Di Nicola, Stevenson & Moor (2009)

<sup>42</sup> Sidoti et al (2009), page 1

More information regarding this framework for contractual partnerships is provided as Appendix 11.

## NSW HEALTH'S NGO PROGRAM

The NSW Government's November 2008 mini-budget included an initiative to reform grants to CMOs through efficiencies and limiting new arrangements. This has led to a review, the aim of which is to develop the most efficient, effective and responsive NSW Health *NGO Program* practicable while at the same time meeting savings targets<sup>43</sup>. It is not yet clear where savings will be made in the NSW Health *NGO Program*. However, steps should be taken to ensure that the reform process does not inadvertently contribute to pressures for CMOs to be more efficient in a way that leads to reduction in overhead spending which, over time, is considerably detrimental to effectiveness and resource allocation.

The majority of *Sector Mapping Survey* respondents declared insufficient funding to be the main challenge currently facing the sector. There are considerable gaps in information about NSW Health funding of CMOs, possibly due to there being several funding systems within NSW Health.

Different government funding sources for mental health programs have different reporting requirements and separate planning systems. MHCC recommends that NSW Health changes CMO contractual arrangements, reporting requirements and ways in which resources are allocated to CMOs with the aim being to benefit all stakeholders.

### RECOMMENDATION 8

Streamline procurement processes and introduce outcome focused funding and performance agreements.

### IMPLEMENTATION GUIDE FOR RECOMMENDATION 8

#### How

Sector Development will be enhanced by:

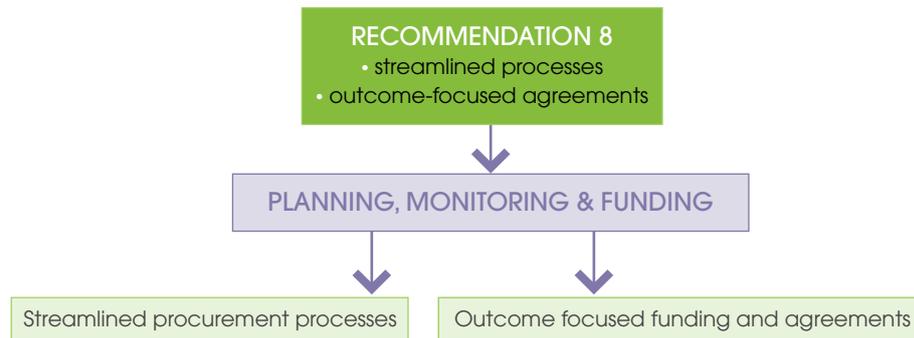
- Streamlining procurement processes and funding agreements; and,
- Providing CMOs with:
  - information on factors which may be associated with financial risk, such as size of the grant, CMO age, life cycle stage, size (gross income, number of staff, asset base), age of relationship with Government ("newness" to Government grants) and previous audit performance; and,
  - support to complete the tender process and identify risk factors for potential funders.

**NSW Health** may consider streamlining procurement processes and introducing outcome-focused funding & performance agreements so that there is, where possible:

- a single funding relationship between the CMO & NSW Health
- less burden for CMOs during the procurement process
- a longer program funding term
- factoring into funding agreements resources for recovery oriented outcome measures
- flexibility to match support to the client's functional need
- flexibility for accountable variations to the agreement
- provision for CMO reporting requirements to be based on relative risk
- a focus on meaningful qualitative and quantitative outcomes relating to health and wellbeing.

<sup>43</sup> NSW Health (2009), page 21

## IMPLEMENTATION GUIDE FOR RECOMMENDATION 8



## CHALLENGES FOR COLLABORATIVE DATA USE

The *Sector Mapping Survey* indicates that CMOs are least likely to use collected data strategically, to identify unmet need or manage change. A rich source of information could be developed and tapped into which could be used for sector planning

Privacy requirements may be preventing CMOs from using data collaboratively. However, sharing data to collaborate: allows individuals and organisations to resolve collective problems; enables communities to operate more efficiently; expands awareness of how organisations' fates are linked; establishes networks and other structures that facilitate the flow of information required to facilitate the accomplishment of goals; and, produces a positive impact on individuals' lives<sup>44</sup>.

## DATA MANAGEMENT STRATEGY

MHCC is currently undertaking a CMO sector *Data Management Strategy* (DMS) as follows:

**Phase 1:** Development of an Agreed Data Set for CMOs working in mental health in NSW (which necessitated development of a Comprehensive Data Set).

Review of available client management database systems for their appropriateness, efficiency and cost-effectiveness for CMOs working in NSW.

**Phase 2:** Consider the future IT needs of the sector:

- Scoping study of CMOs IT infrastructure needs;
- Development of a user manual;
- Trial a Comprehensive Data Set and User Manual; and,
- Establishment of capacity building systems (eg, finding "workplace champions" to sustain workplace skills).

An Agreed Data Set adopted by NSW mental health CMOs and government funding bodies, along with adequate CMO technology infrastructure, would enable collection of de-identified data generated from CMOs. The concept of an Agreed Data Set is related to finding consensus between minimum and comprehensive data collection approaches. The data could be used to inform sector, state and national policy, planning and evaluation; and build a clearer picture of the size and functionality of the CMO sector.

<sup>44</sup> Portwood, Shears, Eichelberger & Abrams (2009)

**RECOMMENDATION 9**

An Agreed Data Set be adopted by NSW mental health CMOs and government funding bodies.

De-identified data be generated from CMOs to:

- Build a clearer picture of the size and functionality of the CMO sector; and
- Enable CMO sector evaluation & planning.

**IMPLEMENTATION GUIDE FOR RECOMMENDATION 9**

Any collection of de-identified data will:

- involve voluntary participation by CMOs
- ideally, have outputs which are complementary with all state & federal government departments funding mental health CMOs
- have efficient methods, high functionality and a high level of transparency
- be utilised in conjunction with broader sector evaluations and the sector research & development strategy

## IMPLEMENTATION GUIDE FOR RECOMMENDATION 9



## RESEARCH AND DEVELOPMENT

### Discussion & Recommendations

The Cooperative Research Centre Program has supported collaborative research on social issues since 2008<sup>45</sup>. Despite being well suited to address some of the most critical issues in mental health services, practice-based research networks (collaborations of practice settings that decide to work together to generate research knowledge) are underused in mental health services research<sup>46</sup>.

In NSW, an *Alcohol & Other Drugs and Mental Health Research Network* is in the early stages of formation. It is essential that other evidence-based practices are researched, including: Illness Management and Recovery (including medication); Assertive Community Treatment; Family Education; Supported Employment; Supported Accommodation; Consumer-Operated Services; Supported Education; and, Promotion and Prevention. There is no dedicated research network for the broader community managed mental health sector in NSW.

The results of the *Sector Mapping Survey* suggest research related to the CMO mental health sector is desirable in:

- Recovery oriented practice;
- CMO recovery-oriented audit tool;
- Accreditation; and,
- Partnerships, role delineations and coordination of supports.

Developing CMO sector partnerships with prominent research bodies will provide the basis on which relevant research projects can be carried out. Easy access to research findings would enable CMOs to gain a balanced view on practices which effectively meet the needs of (and benefit) clients, staff, partners and funders.

The Productivity Commission (2010) notes that the natural inclination of CMOs to take innovative approaches to social problems is limited by: the increasingly risk averse attitudes of funders and Boards; resources; constraints on investments in knowledge; and, reluctance to collaborate with other CMOs. CMOs wanting to innovate are likely to require additional funding to pilot new projects. A mechanism to assist innovation funding from a range of sources is highly desirable.

#### RECOMMENDATION 10

*A broad Community Mental Health Research Network be developed.*

#### IMPLEMENTATION GUIDE FOR RECOMMENDATION 10

##### How

The *Alcohol & Other Drugs and Mental Health Research Network* will be expanded to include recovery oriented CMO practice.

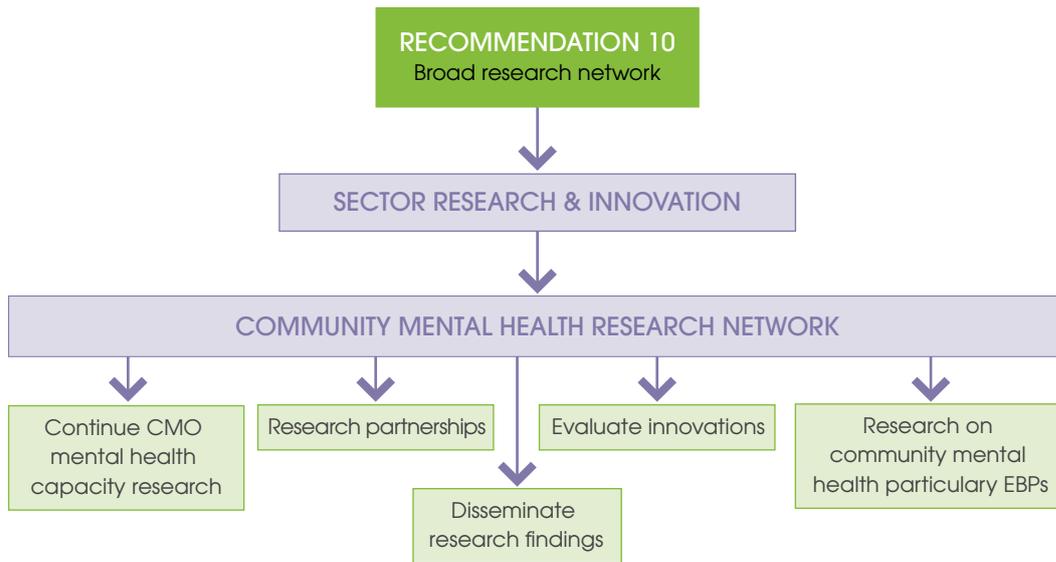
The research network will:

- Comprise partnerships with a range of reputable research bodies;
- Conduct research relevant to the community managed mental health sector;
- Disseminate research findings in areas such as mainstream journals, and/or a community managed mental health sector journal with an associated website;
- Seek funding for the development, implementation and evaluation of innovations including pilot programs.

<sup>45</sup> Productivity Commission (2010, p225)

<sup>46</sup> McMillen, Lenze, Hawley & Osborne (2009)

IMPLEMENTATION GUIDE FOR RECOMMENDATION 10



**RECOMMENDATION 11**

Evaluate the outcomes of the recommendations arising from the *Sector Mapping Project* and review capacity of the New South Wales mental health CMO sector in 2013.

**IMPLEMENTATION GUIDE FOR RECOMMENDATION 11**

**How**

MHCC will monitor and evaluate the implementation and outcomes of these recommendations and report back to its members.

The *Sector Mapping Project* will be reviewed and a new mapping survey will be conducted and report produced by 2015.

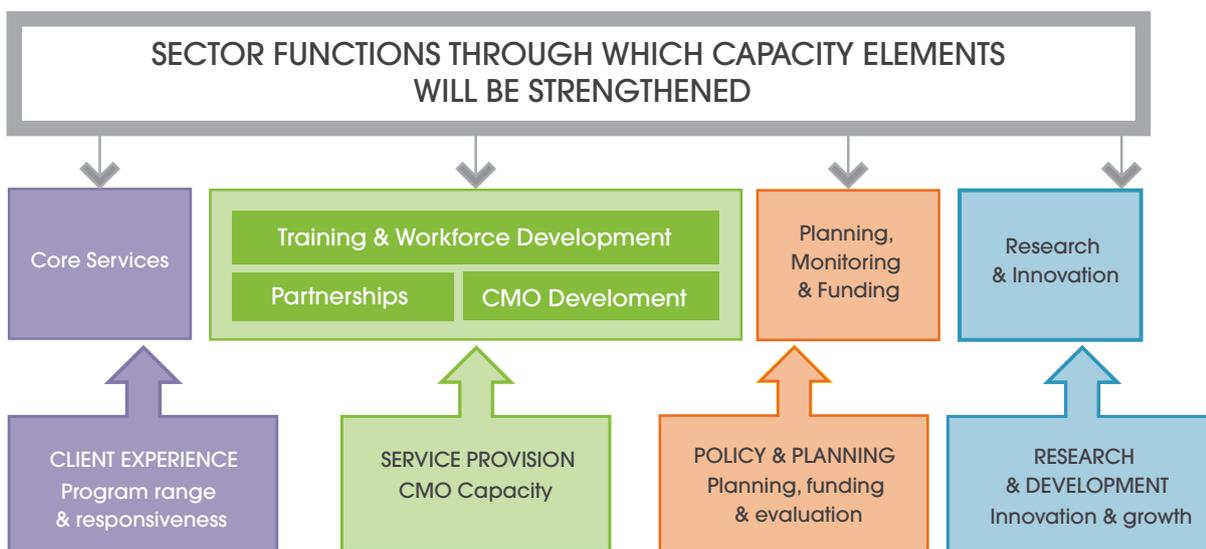
IMPLEMENTATION GUIDE FOR RECOMMENDATION 11



## SUMMARY OF RECOMMENDATIONS

The 11 recommendations arising from the *Sector Mapping Project* and introduced throughout the *Sector Mapping Survey Results* section are listed together overpage. MHCC has consulted widely in developing these recommendations to strengthen the capacity of NSW CMOs in responding to the needs of people affected by mental illness. MHCC member organisations and other stakeholders are encouraged to work with us over the next three years in progressing the recommendations to strategically develop sector capacity. Implementation of several recommendations has already been commenced and funding is being pursued to progress others.

The implementation guides provided throughout the *Sector Mapping Project Results* section identify sector functions through which *Sector Capacity Framework Elements* will be strengthened and these are summarised below.



Various government and other health and community service organisations and individuals may actively operate across and/or contribute to development activity occurring within all functions. However, the recommendations of this report are primarily relevant to CMOs delivering mental health services and NSW Health. The specific implications of each of the recommendations to NSW Health are summarised overpage and further discussed in our concluding remarks.

1	A clear framework will be produced by NSW Health which will structure its relationship with the mental health CMO sector.									
2	<p>Seven core community-managed mental health service areas (functions) to be accessible in each local area. The amount of support available is population-based with needs-based variation parameters.</p> <table border="1" data-bbox="215 504 1300 660"> <tr> <td data-bbox="215 504 414 582">Accommodation Support &amp; Outreach</td> <td data-bbox="414 504 726 582">Employment &amp; Education</td> <td data-bbox="726 504 997 582">Leisure &amp; Recreation</td> <td data-bbox="997 504 1300 582">Family Support &amp; Carer Programs</td> </tr> <tr> <td data-bbox="215 582 414 660"></td> <td data-bbox="414 582 726 660">Self-Help &amp; Peer Support</td> <td data-bbox="726 582 997 660">Helpline &amp; Counselling</td> <td data-bbox="997 582 1300 660">Information, Advocacy &amp; Promotion</td> </tr> </table>	Accommodation Support & Outreach	Employment & Education	Leisure & Recreation	Family Support & Carer Programs		Self-Help & Peer Support	Helpline & Counselling	Information, Advocacy & Promotion	CLIENT EXPERIENCE
Accommodation Support & Outreach	Employment & Education	Leisure & Recreation	Family Support & Carer Programs							
	Self-Help & Peer Support	Helpline & Counselling	Information, Advocacy & Promotion							
3	Mental health consumers have access to the range of service types and experience continuity of care between components of the mental health service system.									
4	<p>The CMO sector will develop a:</p> <table border="1" data-bbox="853 862 1380 952"> <tr> <td data-bbox="853 862 1125 952">CMO version of MH-CoPES</td> <td data-bbox="1125 862 1380 952">Recovery-oriented audit tool</td> </tr> </table>	CMO version of MH-CoPES	Recovery-oriented audit tool							
CMO version of MH-CoPES	Recovery-oriented audit tool									
5	<p>CMOs develop and adopt a <i>Care Coordination Strategy</i> that will promote:</p> <table border="1" data-bbox="869 1041 1380 1131"> <tr> <td data-bbox="869 1041 1125 1131">Recovery focused Partnerships</td> <td data-bbox="1125 1041 1380 1131">Effective referral pathways</td> </tr> </table>	Recovery focused Partnerships	Effective referral pathways	SERVICE PROVISION						
Recovery focused Partnerships	Effective referral pathways									
6	The CMO sector is supported to meet quality standards and build capacity to deliver effective services.									
7	Workforce Development continues to be strengthened as a critical factor in sector development.									
8	Streamline procurement processes and introduce outcome-focused funding and performance agreements.									
9	<p>An Agreed Data Set be adopted by NSW mental health CMOs and government funding bodies.</p> <table border="1" data-bbox="893 1624 1380 1713"> <tr> <td data-bbox="893 1624 1189 1713">Clearer picture of the size and functionality of the CMO sector</td> <td data-bbox="1189 1624 1380 1713">CMO sector evaluation &amp; planning</td> </tr> </table>	Clearer picture of the size and functionality of the CMO sector	CMO sector evaluation & planning	POLICY & PLANNING						
Clearer picture of the size and functionality of the CMO sector	CMO sector evaluation & planning									
10	A broad <i>Community Mental Health Research Network</i> be developed.									
11	Evaluate the outcomes of the recommendations arising from the <i>Sector Mapping Project</i> and review capacity of the New South Wales mental health CMO sector in 2013.	RESEARCH & DEVELOPMENT								

## SUMMARY OF RECOMMENDATIONS: NSW Health

NSW Health is positioned to assist implementation of the *Sector Mapping Project* recommendations through the following activities:

**RECOMMENDATION 1:**

Develop a NSW Health state-wide mental health CMO sector framework.

**RECOMMENDATION 2:**

Work with the mental health CMO sector to develop benchmarks for core services.

**RECOMMENDATION 3 & 5:**

Fund – and collaborate with CMOs to adopt - a *Care Coordination Strategy* that will promote pathways and linkages across the mental health sector.

**RECOMMENDATION 4:**

Fund implementation of the recovery-oriented audit mechanism and CMO equivalent of MH-CoPES.

**RECOMMENDATION 6:**

Support CMO quality improvement processes and fund *Infrastructure Grants* to strengthen service effectiveness.

**RECOMMENDATION 7:**

Fund ongoing CMO sector workforce development.

**RECOMMENDATION 8:**

Streamline procurement processes and introduce outcome focused funding and performance agreements.

**RECOMMENDATION 9:**

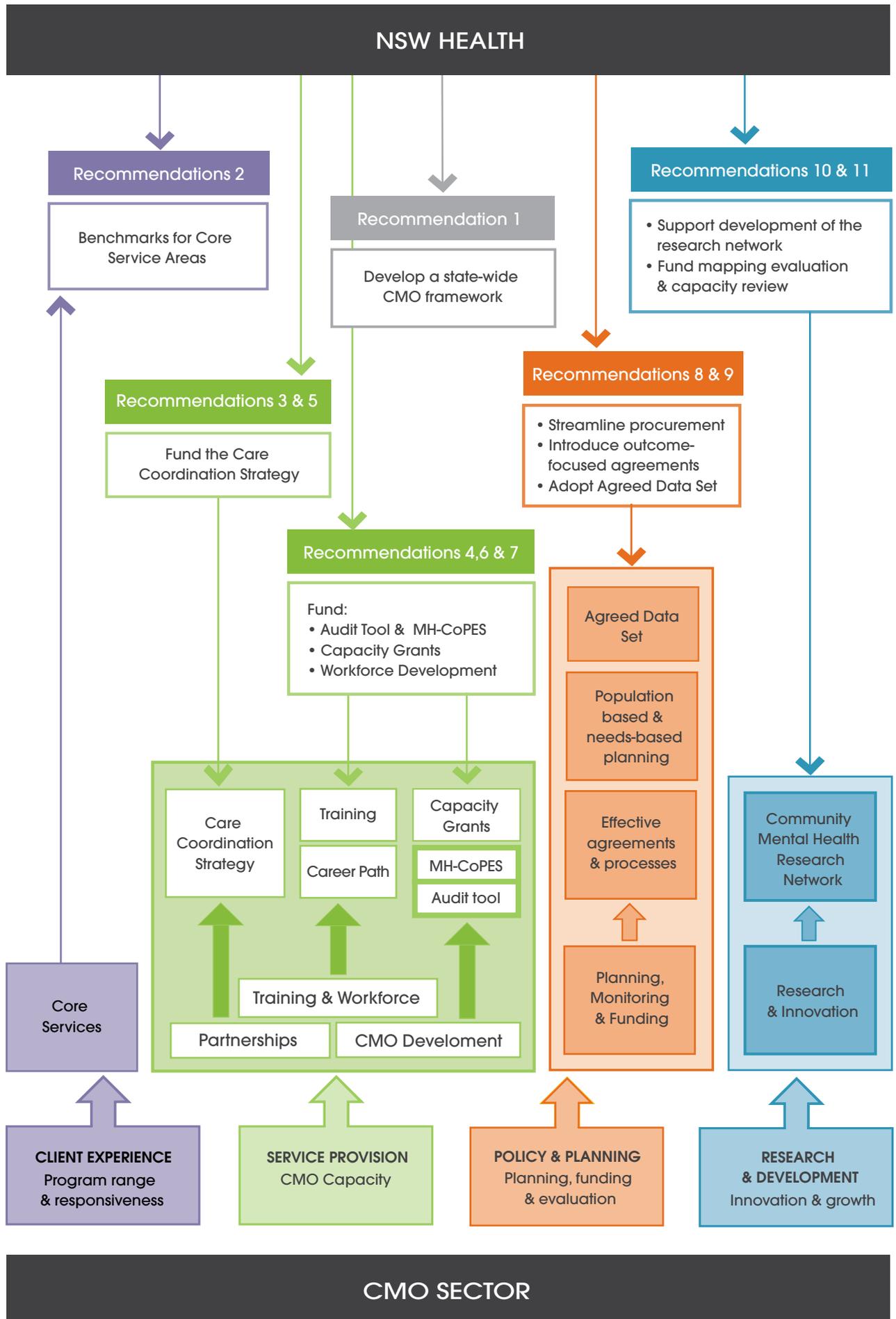
Adopt an *Agreed Data Set* for CMOs.

**RECOMMENDATION 10:**

Support the development of a broad *Community Mental Health Research Network* and continue to fund CMO *Research Grants*

**RECOMMENDATION 11:**

Fund an evaluation of the outcomes of the *Sector Mapping Project* and review capacity of the NSW mental health CMO sector in 2013.







# CONCLUSION

## CONCLUSION

The *Sector Mapping Project* has yielded rich information about the community managed mental health sector in NSW. The data collected demonstrate considerable growth and professionalisation of the sector since this task was last undertaken ten years ago in 1999/2000.

This objective sector information - along with the context provided by the *Sector Capacity Framework Elements* arising from the *Literature Review* - has resulted in specific recommendations to be strategically pursued for future sector capacity building.

The recommendations contained in the *Sector Mapping Project Report* are sound and provide a clear direction for progressive development of the community managed mental health sector including its relationship with NSW Health and other stakeholders, including GPs.

In making concluding remarks about a project as large, complex and ambitious as the *Sector Mapping Project* there is a risk of reducing the learning that has occurred to just a few key areas. However, it is important to highlight some key findings and issues that have been identified.

Key findings of the *Sector Mapping Project* include:

- Clear growth in community mental health service delivery by non-mental health specific organisations (ie, consistent with “mainstreaming” directions under the National Mental Health Strategy);
- Greater understanding of the seven core CMO mental health services which is fundamental to pursuing population-based planning approaches in mental health;
- The significant increase in accredited CMOs; and,
- Routine inclusion of quality review processes most notably with increased use of client outcome measurement data collections.

Key issues identified during the *Sector Mapping Project* include:

- Documentation of the increasing funding and administrative complexities being experienced by mental health CMOs;
- The critical need for data collection and research infrastructure development;
- The importance of a continuing focus on workforce for achieving sector development including the need for more targeted skill sets to be developed in the area of care coordination;
- The need to increase referrals to CMOs from GPs/primary healthcare providers and government mental health service providers; and,
- That as the sector grows and professionalises there is a risk of losing direction from its community values base and this must be maintained for recovery oriented service provision to be possible.

The *Sector Mapping Project* occurred in a context of significant change likely to be approaching the NSW mental health CMO sector in addition to continued growth. Some aspects of this were discussed in the *Literature Review* and most notably include:

- The NSW Health NGO Program Review; and,
- The National Health and Hospitals Reform Commission recommendations.

The publication of the *Sector Mapping Project Report* is timely and coincides with the release of the NSW Health NGO Program Review Recommendations Report. This report makes specific recommendations to achieve the following outcomes from the NGO Program Review:

- “Where possible, to reduce red tape and improve governance, transparency, efficiency and effectiveness of the NSW Health NGO Program”;

- “For NSW Health and the NGO sector to work together to ensure that health funded NGO services provide value for money services and are broadly complementary with NSW Health priorities”; and,
- “For NSW Health and the NGO sector to strengthen partnerships to improve the health planning and health service delivery across all NSW health services” .

In order to achieve these outcomes numerous recommendations are made including for the MHDAO Mental Health Program Council to undertake enhanced strategic planning in CMO sector development and to ensure increased complementarity in service delivery. The findings of the *Sector Mapping Project* will be of great benefit to NSW Health and the mental health CMO sector in pursuing these directions.

The future implications of impending healthcare reform in Australia for mental health CMOs is less clear. Strengthened relationships with both NSW Health and GPs/primary healthcare organisations remain critical to CMO sector development regardless of where the sector’s primary planning and funding relationships may lie in the future.

The findings of the *Sector Mapping Project* provide clear directions for MHCC as the leader in pursuing mental health CMO sector development in NSW. It is essential that funding is secured to implement the recommendations provided in this *Sector Mapping Project Report* in order to:

- Build the capacity and enhance the investment made by NSW Health in the CMO sector;
- Ensure a continued efficient, robust and integrated mental health sector; and,
- Increase the responsiveness of the community based mental health sector in supporting people affected by mental illness in their journey of recovery and wellbeing.

*It is **essential** that funding is secured to implement the recommendations provided in this report in order to:*

- *Build the capacity and enhance the investment made by NSW Health in the community managed mental health sector;*
- *Ensure a continued efficient, robust and integrated mental health sector; and,*
- *Increase the responsiveness of the community based mental health sector in supporting people affected by mental illness in their journey of recovery and wellbeing.*





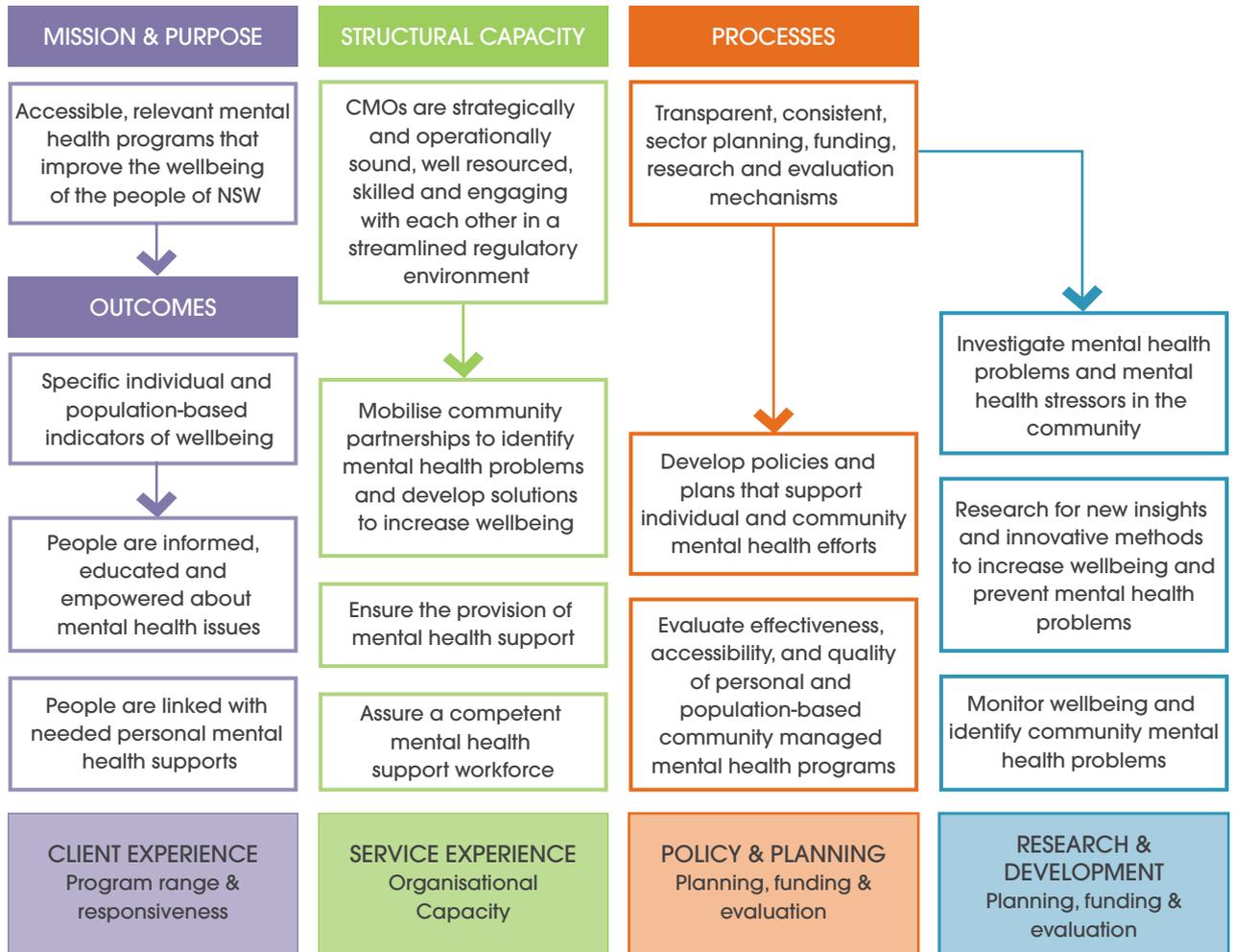
# APPENDICES

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# APPENDIX 1: Sector Capacity Framework Elements

ELEMENTS OF THE NSW COMMUNITY MANAGED MENTAL HEALTH SECTOR CAPACITY FRAMEWORK (ADAPTED & DEVELOPED FROM TURNOCK, 2007).



## APPENDIX 2: Details of Methodology – Sector Mapping Project

### PROJECT PLANNING AND GOVERNANCE

MHCC developed a detailed project plan and contracted several consultants to implement the project. Key stages and activities of the project are summarized below.

Stage	Description
Project planning and preparation	<ul style="list-style-type: none"> <li>• Clarifying scope of project</li> <li>• Establishing Project Reference Group</li> <li>• Resource identification</li> <li>• Risk management</li> </ul>
Research	<ul style="list-style-type: none"> <li>• Initial literature search</li> <li>• Consultation with key persons</li> <li>• Survey development</li> </ul>
Literature review	<ul style="list-style-type: none"> <li>• Substantial review of the literature</li> </ul>
Data collection	<ul style="list-style-type: none"> <li>• Survey distribution and collection</li> <li>• Public submissions</li> <li>• Data entry</li> </ul>
Consultation	<ul style="list-style-type: none"> <li>• Consultation on emerging themes</li> </ul>
Analysis and reporting	<ul style="list-style-type: none"> <li>• Data analysis</li> <li>• Consultation as required</li> <li>• Report writing</li> <li>• Printing and distributing report</li> </ul>
Evaluation	<ul style="list-style-type: none"> <li>• Measuring the impact of the report's findings and recommendations</li> </ul>

The project was managed by MHCC, and involved people with specific expertise to provide advice and undertake certain tasks as follows:

- MHCC Chief Executive Officer (CEO) and staff – project oversight;
- Project consultants – project implementation including data analysis;
- ARTD Consultants – data analyst consultants;
- Project Reference Group – NSW Health's MHDAO Mental Health Program Council (MHPC) and Chronic and Continuing Care Rehabilitation and Recovery Working Group (CCRRWG); and,
- MHCC's CEO provided regular updates to the MHCC Board of Directors, and quarterly reports on the progress of the project and financial accounts to NSW Health.

### THE SECTOR MAPPING SURVEY

#### Scope of the survey

MHCC defined a broad scope for the NSW community managed mental health sector. This included NFPs and for-profits funded to provide specific mental health programs, those adjusting other programs for mental health consumers and carers, and unfunded groups providing mental health related activities. MHCC sought the support of State and Commonwealth government departments to maximise the likelihood of including all NFPs funded to provide mental health programs in NSW. These departments included:

- NSW Health;
- NSW Department of Ageing, Disability and Home Care;

- NSW Department of Community Services;
- NSW Department of Corrective Services;
- Justice Health NSW;
- NSW Department of Juvenile Justice;
- Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs;
- Commonwealth Department of Health and Ageing; and,
- Commonwealth Department of Education, Employment and Workplace Relations.

From this consultation MHCC identified a list of 741 CMOs in NSW which were likely to provide mental health programs/activities.

### Survey development

MHCC sought the views of CMO representatives, the MHCC Board of Directors and NSW Health's CCCRRWG in developing initial drafts of the survey. This occurred to ensure that key areas of current relevance were included in the content. The information sought included: organisation and program details; funding sources; geographical reach; data collection and analysis; quality improvement activities; gaps in the sector; and, views about challenges and areas for improvement.

MHCC engaged ARTD Consultants - a private company with experience and expertise in data collection and in the health and community sector. Additional refinements were made to the *Sector Mapping Survey* including addition of a section regarding the status of partnerships. Items for the partnership sections were based on items from partnership assessment tools developed by the Victorian and UK Governments. The survey was refined in multiple iterations by ARTD and MHCC.

### Pilot testing and interviews

The draft online survey instrument was pilot tested and interviews were conducted with representatives from three organisations in the NSW community managed mental health sector to ensure survey items were relevant, made sense and collected the required information. Minor amendments were made to some survey items (mainly clarifications to instructions and spelling of acronyms in full). A copy of the final *Sector Mapping Survey* is provided as Appendix 3.

### Implementation of the survey

MHCC provided ARTD with email contact details for 741 CMOs based on all potential mental health providers known to MHCC. MHCC sent an initial email to all providers and updated email addresses to ARTD as needed throughout the survey implementation phase.

After approval from MHCC, ARTD distributed the online survey on 26 November 2008, a reminder was issued to all non-respondents on 4 & 10 December for a 12 December 2008 close. The survey was subsequently re-opened on 19 December and an email advising the new closing date of 11 January 2009 was issued to non-respondents. Due to a request from MHCC the survey deadline was re-extended and the survey finally closed on 14 January 2009.

Subsequent to ARTD's data collection and analysis (February 2009), around 200 non-responding CMOs with known links to the NSW community managed mental health sector were followed up on several occasions. Additional CMOs and program survey responses were manually added to the data sets. The final survey responses were entered in July 2009.

### Participation in the survey

Responses were initially received from 430 organisations out of the 741 to which the survey was distributed. After reviewing the data to remove non-mental health related organisations and filtering out peak bodies (including Regional GP Divisions of Practice)

valid responses from 247 organisations were analysed. Overall response rate to the survey was not factored into results analysis for the following reasons:

- Duplicates were difficult to detect prior to survey delivery as in some cases different emails for the same organisations were provided. In other cases particular organisations were known by multiple names.
- It is also known that the survey was not relevant to every organisation as 21 answered 'none of the above' to the question about the services they provide. Presumably many more organisations simply ignored the survey for similar reasons.

Calculating statistical significance of response rate was not needed for results analyses as the intention was to survey the entire population of service providers. It was not to determine if the sample of service providers selected was representative of the overall population (which is unknown).

### STRENGTHS OF THE DATA

**Sample Size:** As this is a sample of a broad sector that has not been well defined it is hard to know the population size that this sample represents. However, if the approximation of the 741 CMOs that were approached is taken as a rough guide then our survey results represent around one third to one half of the sector.

**Validity and Reliability:** Most quantitative responses displayed distributions which suggest that the items were well worded and that the respondents understood the questions. There was a very high participation rate in the qualitative responses indicating consistent engagement throughout the survey and allowing the coding of items into "themes".

### LIMITATIONS OF THE DATA

The *Sector Mapping Survey* has all the limitations inherent in self-report questionnaires and psychometrics. Further, there were a number of specific issues:

#### Unreliable or invalid items

Some items could not be reported due to very low response rates, apparent misunderstanding of questions, or other inconsistencies, making the findings unusable.

Items not reported:

- Specific funding amounts;
- Detailed partnership questions;
- Accreditation questions (specific types, intentions); and,
- Standards and quality systems.

#### Age of survey

New funding rounds and initiatives by the NSW and Commonwealth governments have occurred since the data collection period of the survey:

- A number of CMOs have lost funding and/or changed funding arrangements for employment programs through funding round decisions at the Commonwealth Department of Education, Employment and Workplace Relations.
- Ongoing and/or ad-hoc funding grant changes through the Area Health Services.

## SPECIFIC ITEMS

Page 33	<p><b>GEOGRAPHIC REGION</b></p> <p>The division of rural/urban Area Health Services is a rough approximation based on distinctions made by NSW Health in previous reports. While these descriptions are roughly accurate, there are urban regions in the “rural” Area Health Services and population densities vary significantly in parts of the “urban” Area Health Services.</p>
Page 36	<p><b>AGE</b></p> <p>MHCC was made aware after the survey collection period that many programs for young adults target ages up to and including 25 years of age. Some programs declared as targeting “Adults” may target the “Youth” age group (up to 25 years) as well or exclusively.</p>
Page 37	<p><b>COMPLEX NEEDS</b></p> <p>A significant number of respondents chose all or almost all of the complex needs items (Q10-18). Such homogeneity of responses across items may indicate that respondents misunderstood the intent of this set of questions.</p> <p>No major categories in the “other” item (Q19) were detected, and many were invalid (e.g. “n/a” or “none”), so the results were not included.</p>
Page 45	<p><b>RECEIVED REFERRALS</b></p> <p>Clients recorded as “Self-referral” may have come from other referral sources without specifying this fact. It is possible that true self-referral rates are substantially lower than that specified.</p>
Page 53	<p><b>TYPES OF CLIENT DATA COLLECTED</b></p> <p>MHCC was made aware after the survey collection period that most of the Client Data items are operational rather than client-focused items and are not high priority data items in a best-practice recovery-oriented organisation.</p>

## APPENDIX 3: Sector Mapping Survey

Thank you for participating in this important Sector Mapping Project. This project is being conducted by the Mental Health Coordinating Council with technical support by ARTD, and is supported by Commonwealth (FaHCSIA, DEEWR, DoHA) and NSW State Government departments (NSW Health, DADHC, DCS, DoCS and DJJ).

The sector mapping project comprises a survey in two sections.

The first will collect information about your organisation as a whole and will ask you to list the programs or services that your organisation provides. The second will collect some key information about each program or service that your organisation provides.

In some cases you may not be sure of the answer to a question. You can always save a draft of the survey and return to answer questions later. The survey will show you the status of your organisation's responses to different survey sections. If necessary, different people from your organisation can fill in different parts of a survey. However, once a survey section is submitted it will be considered complete. Questions marked with (\*) are mandatory.

We really value your time and input into this important project.

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### GLOSSARY

For the purposes of the survey, 'Consumer' refers to the person whose mental illness is the reason for the service being required.

'Client' refers to the person directly receiving services from your organisation, this may be a consumer, a carer of this person, or others.

---

### MENTAL HEALTH PROGRAMS

1. \* Which of the following does your organisation provide?

- Mental Health services/programs only
- Some Mental Health services/programs, as well as other programs for different consumer groups
- No specific Mental Health services/programs, but the organisation has made adjustments for mental health consumers
- None of the above

You are now being asked to list up to 10 mental health programs provided by your organisation. If you have different locations for the same program but they are under the same funding stream of a government or other agency, please consider this as one program. If you provide multiple HASI programs, please treat each (i.e. HASI 1-4) as separate programs, although funding contracts may be with different Area Health Services.

2. \* Please enter the names of each of the MENTAL HEALTH programs you provide. You may list up to 10 programs. At the end of the survey you will be asked to provide a few key details about each of these programs

1.
2.
3.
4.
5.

6.
7.
8.
9.
10.

---

### ORGANISATION DETAILS

Please provide details for your organisation below.

3. \* Please enter the name of your organisation  
*This is the organisation about which you will be answering the rest of the survey*
- 
4. If your organisation has a parent or umbrella organisation, please enter the name of that organisation  
*For example, if your organisation is a service centre for a bigger organisation please enter the name of that organisation*
- 
5. \* Which of the following best describes your organisation?
- Co-operative limited                       Local Government
- Incorporated association                       Registered Housing Organisation
- Company limited by guarantee                       Other (please specify)
- State Government
6. \* What is your organisation's office address?
- 
7. \* Office postcode:
- 
8. \* Office telephone number:  
*Please include the area code*
- 
9. \* Office fax number:
- 
10. Organisation website:
- 
11. Please enter your mailing address if different from your office address:
- 
12. \*Contact person name (for clarification about survey if needed):
- 
13. \*Contact person position title:
-

**GENERAL QUESTIONS ABOUT YOUR ORGANISATION**

14. From which of the following have you received referrals in the last three months? (tick all that apply)

- Self-referral/drop in
- Family referral
- Hospitals
- Government treatment facilities
- Government agencies
- Community centres/organisations
- Not Applicable
- Other (please specify)

15. How many full time equivalent staff (FTE) working in your organisation’s mental health programs does your organisation employ?

*Please enter your answer by typing a numeral, you may use a decimal point if required*

FTE staff

16. Please estimate how many hours of support for mental health programs are provided by volunteers in your organisation, including board and committee members?

*Please enter your answer by typing a numeral, you may use a decimal point if required*

average hours per week

**AGREEMENTS.**

These questions are asking about agreements your organisation may have with other NGOs for joint projects and activities. It is asking about both formal and informal agreements.

17. How many formal agreements (e.g. a Memorandum of Understanding (MOU) or service level agreement) does your organisation have with other NGOs for joint projects and activities?

(number)

18. How many NGOs are covered by these formal agreements? (Do not include your own organisation in this count)

(number)

19. How many NGOs with whom you work regularly do you have informal agreements for joint projects and activities?

(number)

20. What are the MAIN reasons your organisation has these formal and informal agreements?

- Advocacy
- Tendering arrangements
- Negotiating with AHS
- Referrals
- Sharing expertise/Mentoring/Training
- Community development
- Joint service delivery
- Joint funding arrangements
- Other please specify

## PARTNERSHIPS

For the following questions we are asking about partnerships whose main purpose is to benefit consumers directly i.e. partnerships that have consumer outcomes or service delivery as their primary purpose.

Partnerships may be described on a continuum from least to most intensive:

- **Networking** (the exchange of information for mutual benefit)
- **Coordinating** (Networking, AND altering activities for a common purpose)
- **Cooperating** (Networking & Coordinating AND sharing resources and clients in common, and investing significant time and resources)
- **Collaborating** (all the above plus, and enhancing the capacity of another organisation to create a more seamless service system)

21. Considering the most intensive service-delivery partnership involving your organisation, which partnership type best describes that partnership?

- Networking
- Coordinating
- Cooperating
- Collaborating

Now consider a *typical* formal partnership involving your organisation. To what extent do you agree that

	Disagree	Tend to disagree	Tend to agree	Agree	NA
22. There is a clear goal for the partnership	<input type="radio"/>				
23. This goal is realistic	<input type="radio"/>				
24. Each partner's areas of responsibility are clear and understood	<input type="radio"/>				
25. The action is adding value (rather than duplicating services) for clients	<input type="radio"/>				
26. The partnership can demonstrate or document the outcomes of its collective work	<input type="radio"/>				
27. There are clear arrangements to ensure the partnership is reviewed to ensure it continues to meet its objectives	<input type="radio"/>				

### REFERRALS

Please indicate the extent to which you agree or disagree with the following. In the last three months the client referral system has been effective between our organisation and:

	Disagree	Tend to disagree	Tend to agree	Agree	Don't know
28. NSW Health	<input type="radio"/>				
29. Other NGOs	<input type="radio"/>				
30. Government departments	<input type="radio"/>				
31. General Practitioners	<input type="radio"/>				

Does your organisation accept referrals direct from

	Yes	No
32. Mental Health Consumers	<input type="radio"/>	<input type="radio"/>
33. Carers of mental health consumers	<input type="radio"/>	<input type="radio"/>

### DATA COLLECTION

The following questions are asking you about how your organisation collects and uses data about consumers and services to inform planning, monitoring and evaluation activities.

*Please note the definitions of 'consumer' and 'client' in the instructions at the top of the survey.*

Does your organisation collect

	Yes	No
34. Client personal information (eg address, gender, date of birth/ age groups, cultural background)	<input type="radio"/>	<input type="radio"/>
35. Client circumstances (eg living arrangements, income source, eg.government pension/benefits)	<input type="radio"/>	<input type="radio"/>
36. Consumer functional status (eg level of disability)	<input type="radio"/>	<input type="radio"/>
37. Referral sources	<input type="radio"/>	<input type="radio"/>
38. Client exit details (eg. transition plans, reason for exiting services)	<input type="radio"/>	<input type="radio"/>
39. Client progress monitoring	<input type="radio"/>	<input type="radio"/>
40. Type of assistance provided	<input type="radio"/>	<input type="radio"/>
41. Length of time assistance is provided	<input type="radio"/>	<input type="radio"/>
42. Mental Health diagnosis	<input type="radio"/>	<input type="radio"/>

43. Does your organisation collect any other data about consumers and/or services to inform program planning and monitoring activities?

*Please exclude any client outcome measures: these are the subject of Questions 46 & 47.*

Yes                       No

Please specify

44. This question is about the kind of data collection system/s you use for mental health program/s performance reporting across your organisation?

Do you use a

- Manual System, eg. paper-based
- Computerised
- Both manual and computerised
- Neither

45. If it is computerised is it

- Off-the-shelf software.
- Government provided softwares
- Internal developed system

46. If you use a computerised sytem please enter the name of the software

47. Does your organisation use any of the following for outcomes monitoring ?

- HoNOS
- HoNOSCA
- HoNOS65+
- LSP-16
- K10+
- CANSAS
- SF24
- DASS
- RUG-ADL
- CGAS
- MHI
- BASIS-32
- SDQ
- SF12
- GAF
- Other (Please specify)

48. In what other ways, if any, does your organisation measure outcomes for your clients?

### DATA UTILISATION

Thinking about all the monitoring data you may collect, to what degree is this data being utilised for each of the following?

	Not at all utilised	Partially	Somewhat	Fully utilised
49. To manage change in the organisation/program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50. As evidence for use in funding applications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51. For program planning or development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
52. For business or strategic planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53. To monitor KPIs/report to funders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
54. For monitoring consumer outcomes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
55. To identify unmet need in the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

56. What mental health services do your clients require that they are unable to obtain from either your organisation or any others in the area(s) that you service?

### EXTERNAL ACCREDITATION

This section asks about your organisation's status with respect to formal accreditation to specific standards.

The following section will ask about less stringent 'quality improvement' or 'service development' reviews that may be undertaken prior to attempting accreditation.

### ACCREDITATION REVIEWS

Has the organisation or any of its mental health services/programs, had an accreditation review in the last 3 years to any of the following:

	Yes	No
57. Quality Improvement Council	<input type="radio"/>	<input type="radio"/>
58. ISO	<input type="radio"/>	<input type="radio"/>
59. The Australian Council on Health Care Standards (ACHS)	<input type="radio"/>	<input type="radio"/>
60. SAI Global (Business Excellence Framework)	<input type="radio"/>	<input type="radio"/>

### ACCREDITATION

Is the organisation, or any of its mental health services/programs, externally accredited as complying with any of the following:

	Yes	No
61. Quality Improvement Council	<input type="radio"/>	<input type="radio"/>
62. ISO	<input type="radio"/>	<input type="radio"/>
63. The Australian Council on Health Care Standards (ACHS)	<input type="radio"/>	<input type="radio"/>
64. SAI Global (Business Excellence Framework)	<input type="radio"/>	<input type="radio"/>

65. Is your organisation intending to seek accreditation to any of the above external quality standards in the next two years? (tick one)

- Yes
- No

66. If your organisation is externally accredited or currently seeking accreditation what were the major reasons for seeking accreditation?

67. If your organisation is NOT externally accredited or seeking accreditation, what would it take for your organisation to pursue accreditation?

68. Do you have any arrangements/contracts with external organisations for them to conduct reviews of your organisation for the purposes of accreditation or for more general service development?

*These reviews may include a self-assessment component*

- No
- Yes

If so, please enter the name of the review agency(s)

## QUALITY IMPROVEMENT SYSTEMS

The following questions are asking about any 'quality reviews' or 'service development reviews' of your organisation conducted by or in consultation with an external organisation. These reviews are generally undertaken by organisations as a first step towards accreditation.

69. Are you intending to have a general 'service development' review in the next two years conducted by an external organisation? (tick one)

- Yes  
 No

If No, why not?

70. Is the organisation, or any of its mental health services/programs required to comply with quality systems developed by government?

*For example, FaHCSIA or DADHC*

- Yes  
 No

If so, please describe

71. Does your organisation have internally developed quality standards that new programs are required to comply with?

- Yes  
 No

If 'Yes' please describe

## YOUR VIEWS

Please provide a brief response to the following questions. MHCC may contact the organisation to seek further clarification if needed.

72. What do you think is the key challenge currently facing the NGO mental health sector in NSW? Please explain.

73. Excluding additional funding, what change to the mental health service system would best enable your organisation to move forward with the provision of mental health services?

74. What has been the most important policy initiative in mental health in NSW over the past three years? Why?

## PROGRAM CONTENT OF THE SECTOR MAPPING SURVEY

Thank you for filling in the details about your organisation.

We would now like to ask you a few questions about each of the programs that you deliver.

Please remember that we are asking you about all locations of the program that you may be providing.

Please answer the following questions for INSERT PROGRAM NAME

1. What is the main type of service provided by this program?

- Accommodation and/or accomodation support
- Education/training
- Information/advocacy/policy
- Employment/pre-vocational
- Counselling
- Support/self help group
- Research
- Carer services
- Recreational
- Community development/mental health promotion
- Emergency or crisis care
- Psycho-social rehabilitation
- Other please specify

---

### FUNDING

2. What is the main funding source for this program for the financial year 2008-09?

- Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)
- Commonwealth Department of Health and Ageing (DOHA)
- Commonwealth Department of Education Employment and Work Place relations (DEEWR)
- NSW Department of Disability Ageing and Home Care (DADHC)
- NSW Department of Community Services (DoCS)
- NSW Health (NSW Government)
- NSW Department of Corrective Services (DCS)
- NSW Department of Juvenile Justice (DJJ)
- Housing NSW (NSW Government)
- Private donation
- Sponsorship
- Other, please specify

3. What is the term of this funding?
- One-off
- Recurrent
4. What is the full amount of funding for this program (planned and expected) from all sources for this financial year (i.e. 2008/09)
- \$
5. Are there Key Performance Indicators (KPIs) or 'Key Deliverables' for the program?
- Yes  No

---

### TARGET GROUP OF THIS PROGRAM

6. Does the program have 'defined entry criteria' for assessing new clients?
- Yes  No
7. If you answered yes to the above question, does this criteria include a specific mental health diagnosis?
- Yes  No
8. What is the target age group for the program?
- Child (0 to 11 years)
- Youth (12 to 17 years)
- Adult (18 to 64 years)
- Aged (65 years +)
- All Ages
9. What is the target client type for the program?
- Carers
- Consumers with any mental illness
- Consumers with a serious mental illness or a significant disability as a result of a mental illness
- Consumers with a specific mental health diagnosis (e.g. schizophrenia)
- Others, eg NGOs, Government or community groups
- Please describe*
- 
10. What is the target gender group for this program?
- Male
- Female
- Both male and female

### Special needs target groups

Does the program specifically target

	Yes	No
11. People from culturally and linguistically diverse (CALD) backgrounds?	<input type="radio"/>	<input type="radio"/>
12. People with drug and alcohol problems?		
13. People who are Aboriginal and/or Torres Strait Islanders?		

14. People with a disability (e.g. physical, intellectual, or acquired brain injury)?
15. People who are homeless?
16. People experiencing or escaping domestic violence?
17. People with gambling problems?
18. People with other serious physical health issues e.g. HIV?
19. If the program specifically targets any other groups please specify that target group.

### HOSPITALISATIONS

20. If relevant, please estimate the percentage of consumers receiving this program who have been hospitalised for their mental health condition in the last 12 months prior to receiving your program?

 %

### LOCAL COUNCIL COVERAGE

21. Please select the local government areas for which this program is able to provide services?

*You may select, "statewide", one or more entire NSW Health Region(s), or individual LGAs across any region.*

- |  |  |
|--|--|
| <input type="radio"/> Statewide                                | <input type="radio"/> Northern Sydney & Central Coast Area Health Service  |
| <input type="radio"/> Greater Southern Area Health Service     | <input type="radio"/> South Eastern Sydney & Illawarra Area Health Service |
| <input type="radio"/> Greater Western Area Health Service      | <input type="radio"/> Sydney South West Area Health Service                |
| <input type="radio"/> Hunter & New England Area Health Service | <input type="radio"/> Sydney West Area Health Service                      |
| <input type="radio"/> North Coast Area Health Service          |  |

*Greater Southern Area Health Service*

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="radio"/> Albury            | <input type="radio"/> Greater Hume Shire | <input type="radio"/> Temora        |
| <input type="radio"/> Bega Valley       | <input type="radio"/> Griffith           | <input type="radio"/> Tumbarumba    |
| <input type="radio"/> Berrigan          | <input type="radio"/> Gundagai           | <input type="radio"/> Tumut Shire   |
| <input type="radio"/> Bland             | <input type="radio"/> Harden             | <input type="radio"/> Upper Lachlan |
| <input type="radio"/> Bombala           | <input type="radio"/> Hay                | <input type="radio"/> Urana         |
| <input type="radio"/> Boorowa           | <input type="radio"/> Jerilderie         | <input type="radio"/> Wagga Wagga   |
| <input type="radio"/> Carrathool        | <input type="radio"/> Junee              | <input type="radio"/> Wakool        |
| <input type="radio"/> Conargo           | <input type="radio"/> Leeton             | <input type="radio"/> Yass Valley   |
| <input type="radio"/> Coolamon          | <input type="radio"/> Lockhart           | <input type="radio"/> Young         |
| <input type="radio"/> Cooma-Monaro      | <input type="radio"/> Murray             |                                     |
| <input type="radio"/> Cootamundra       | <input type="radio"/> Murrumbidgee       |                                     |
| <input type="radio"/> Corowa Shire      | <input type="radio"/> Narrandera         |                                     |
| <input type="radio"/> Deniliquin        | <input type="radio"/> Palerang           |                                     |
| <input type="radio"/> Eurobodalla       | <input type="radio"/> Queanbeyan         |                                     |
| <input type="radio"/> Goulburn Mulwaree | <input type="radio"/> Snowy River        |                                     |

*Greater Western Area Health Service*

- |   |  |  |
|---|--|--|
| <input type="radio"/> Balranald         | <input type="radio"/> Cowra                | <input type="radio"/> Unincorporated NSW |
| <input type="radio"/> Bathurst Regional | <input type="radio"/> Dubbo                | <input type="radio"/> Walgett            |
| <input type="radio"/> Blayney           | <input type="radio"/> Forbes               | <input type="radio"/> Warren             |
| <input type="radio"/> Bogan             | <input type="radio"/> Gilgandra            | <input type="radio"/> Warrumbungle Shire |
| <input type="radio"/> Bourke            | <input type="radio"/> Lachlan              | <input type="radio"/> Weddin             |
| <input type="radio"/> Brewarrina        | <input type="radio"/> Mid-Western Regional | <input type="radio"/> Wellington         |
| <input type="radio"/> Broken Hill       | <input type="radio"/> Narromine            | <input type="radio"/> Wentworth          |
| <input type="radio"/> Cabonne           | <input type="radio"/> Oberon               |  |
| <input type="radio"/> Central Darling   | <input type="radio"/> Orange               |  |
| <input type="radio"/> Cobar             | <input type="radio"/> Parkes               |  |
| <input type="radio"/> Coonamble         |  |  |

*Hunter & New England Area Health Service*

- |   |  |  |
|---|--|--|
| <input type="radio"/> Armidale Dumaresq | <input type="radio"/> Gwydir           | <input type="radio"/> Port Stephens      |
| <input type="radio"/> Cessnock          | <input type="radio"/> Inverell         | <input type="radio"/> Singleton          |
| <input type="radio"/> Dungog            | <input type="radio"/> Lake Macquarie   | <input type="radio"/> Tamworth           |
| <input type="radio"/> Glen Innes Severn | <input type="radio"/> Liverpool Plains | <input type="radio"/> Tenterfield        |
| <input type="radio"/> Gloucester        | <input type="radio"/> Maitland         | <input type="radio"/> Upper Hunter Shire |
| <input type="radio"/> Great Lakes       | <input type="radio"/> Moree Plains     | <input type="radio"/> Uralla             |
| <input type="radio"/> Greater Taree     | <input type="radio"/> Muswellbrook     | <input type="radio"/> Walcha             |
| <input type="radio"/> Gunnedah          | <input type="radio"/> Narrabri         |  |
| <input type="radio"/> Guyra             | <input type="radio"/> Newcastle        |  |

*North Coast Area Health Service*

- |                                       |                                     |                                       |
|---------------------------------------|-------------------------------------|---------------------------------------|
| <input type="radio"/> Ballina         | <input type="radio"/> Coffs Harbour | <input type="radio"/> Lismore         |
| <input type="radio"/> Bellingen       | <input type="radio"/> Hastings      | <input type="radio"/> Nambucca        |
| <input type="radio"/> Byron           | <input type="radio"/> Kempsey       | <input type="radio"/> Richmond Valley |
| <input type="radio"/> Clarence Valley | <input type="radio"/> Kyogle        | <input type="radio"/> Tweed           |

*Northern Sydney & Central Coast Area Health Service*

- |                                     |                                    |                                  |
|-------------------------------------|------------------------------------|----------------------------------|
| <input type="radio"/> Gosford       | <input type="radio"/> Manly        | <input type="radio"/> Warringah  |
| <input type="radio"/> Hornsby       | <input type="radio"/> Mosman       | <input type="radio"/> Willoughby |
| <input type="radio"/> Hunter's Hill | <input type="radio"/> North Sydney | <input type="radio"/> Wyong      |
| <input type="radio"/> Ku-ring-gai   | <input type="radio"/> Pittwater    |                                  |
| <input type="radio"/> Lane Cove     | <input type="radio"/> Ryde         |                                  |

*South Eastern Sydney & Illawarra Area Health Service*

- |                                  |                                    |  |
|----------------------------------|------------------------------------|--|
| <input type="radio"/> Botany Bay | <input type="radio"/> Randwick     | <input type="radio"/> Sutherland Shire |
| <input type="radio"/> Hurstville | <input type="radio"/> Rockdale     | <input type="radio"/> Waverley         |
| <input type="radio"/> Kiama      | <input type="radio"/> Shellharbour | <input type="radio"/> Wollongong       |
| <input type="radio"/> Kogarah    | <input type="radio"/> Shoalhaven   | <input type="radio"/> Woollahra        |

*Sydney South West Area Health Service*

- |                                    |                                  |                                     |
|------------------------------------|----------------------------------|-------------------------------------|
| <input type="radio"/> Ashfield     | <input type="radio"/> Canada Bay | <input type="radio"/> Marrickville  |
| <input type="radio"/> Bankstown    | <input type="radio"/> Canterbury | <input type="radio"/> Strathfield   |
| <input type="radio"/> Burwood      | <input type="radio"/> Fairfield  | <input type="radio"/> Sydney        |
| <input type="radio"/> Camden       | <input type="radio"/> Leichhardt | <input type="radio"/> Wingecarribee |
| <input type="radio"/> Campbelltown | <input type="radio"/> Liverpool  | <input type="radio"/> Wollondilly   |

*Sydney West Area Health Service*

- |                                      |                                      |                                  |
|--------------------------------------|--------------------------------------|----------------------------------|
| <input type="radio"/> Auburn         | <input type="radio"/> Blue Mountains | <input type="radio"/> Lithgow    |
| <input type="radio"/> Baulkham Hills | <input type="radio"/> Hawkesbury     | <input type="radio"/> Parramatta |
| <input type="radio"/> Blacktown      | <input type="radio"/> Holroyd        | <input type="radio"/> Penrith    |

22. OPTIONAL

Please describe an innovative aspect of this program that you would be willing to discuss with MHCC if requested

23. You have indicated the 'service type' for this program in question 1. What if any, other activities are undertaken by this program?

*For example, activities undertaken by the program outside the scope of the program's funding agreements that add value and enhance quality and outcomes.*

## APPENDIX 4: Responding Organisations

The following organisations have consented to being named in this report as *Sector Mapping Survey* respondents:

Advocates for Survivors of Child Abuse (ASCA)	Glenecho Neighbourhood House
After Care Association	Global Counselling Solutions (GCS) Pty Ltd
AICAFMHA	Good Grief
AIDS Council of NSW (ACON)	Granville Multicultural Community Centre
Alcohol & Drug Foundation of NSW	Griffith Early Intervention Service
Anglicare NSW	Griffith Neighbourhood House
Association of Relatives and Friends of the Mentally Ill (ARAFMI) NSW	GROW in NSW
Australian Mental Health Suicide Consumer Alliance (Club Speranza)	Homes Out West
Australian Red Cross Society	Homicide Victims' Support Group
B Miles Women's Housing Scheme	Hunter Joblink
Bankstown Mental Health Family & Friends Support Group	Illawarra Housing Trust
Baptist Community Services NSW & ACT	Independent Community Living Association
Barnados Australia	Inner West Neighbour Aid
Bathurst Mental Health Carers Support Group	Interchange Respite Care (NSW) Inc.
Bellingen Neighbourhood Centre	Inverell Community Housing Inc.
Billabong Clubhouse Inc.	Inverell Disability Services
Biripi Aboriginal Medical Service	Jarrah House
Blackheath Area Neighbourhood Centre	Justice Action
Blue Mountains Food Services	Kaiyu Enterprises Inc.
Bobby Goldsmith Foundation	Kedesh House
Brain and Mind Research Institute	Kirribilli Neighbourhood Centre
Break Thru Employment Solutions	Lake Macquarie Neighbourhood Information Centre
Campbelltown Family Support Service	Lightning Ridge Neighbourhood Centre
Carers NSW	Lower Hunter Dementia Advisory Service
Centacare	Lyndon Community
City Women's Hostel	Macarthur Disability Services
Community Options Illawarra Inc.	Mandala Community Counselling Service
Community Programs Inc.	Manly Drug Education and Counselling Centre
Compeer	Matthew Talbot Homeless Facilities
Consumer Activity Network (Mental Health Inc.)	Mayumarri Trust
Crossroads Community Care	Mercy Services McAuley Outreach Service
Deniliquin Mental Health Awareness Group Inc. (DeniMHAG)	Metro Community Housing Co-op
Echo Neighbourhood Centre	Midwest Community Care Inc.
Family Drug Support	Mission Australia
	Mt Pleasant Neighbourhood Centre
	Nambucca Valley Neighbourhood Centre
	Narrabri Community Tenancy Scheme Inc.

## Appendix 4: Responding Organisations

National Association for Loss & Grief (NSW)  
NEAMI  
New Horizons Enterprises  
Newcastle Family Support Services Inc.  
Nimbin Neighbourhood & Information Centre  
Northern Beaches Interchange Inc.  
Northern Beaches Mental Health Support Group  
Nowra Neighbourhood Centre  
NSW Consumer Advisory Group - Mental Health Inc. (NSW CAG)  
NSW Rape Crisis Centre  
On Track Community Programs  
One Step at a Time Counselling  
Peer Support Foundation Limited  
Peninsula Community Centre  
People with Disabilities (NSW) Inc.  
Pole Depot Neighbourhood Centre  
Port Macquarie Neighbourhood Centre  
Port Stephens Family Support Service  
Psychiatric Rehabilitation Australia (PRA)  
Progressive Employment Personnel  
Public Interest Advocacy Centre (PIAC)  
Recreation, Sports and Aquatic Club for People with Disabilities  
Relationships Australia  
Richmond Community Services Inc.  
Richmond Fellowship of NSW  
Rockdale Community Services Inc.  
Ryde Hunters Hill Community Housing Co-op Limited  
San Remo Neighbourhood Centre  
Sapphire Coast Tenancy Scheme Inc.  
Schizophrenia Fellowship of NSW  
Shopfront Youth Legal Centre  
SIDS and Kids  
South Sydney Community Transport  
South Sydney Youth Services  
Southern Community Welfare  
Southern Youth and Family Services Association Inc.  
Special Training & Employment Placement Services (STEPS)  
St Laurence House  
Sugarvalley Neighbourhood Centre  
Suicide Prevention Australia  
Support After Suicide  
The Benevolent Society  
The Salvation Army  
Ulladulla & Districts Community Resource Centre  
Uniting Care Mental Health  
Uralla Neighbourhood Centre  
Valleys to Plateau Community Support Services  
Weigelli Centre Aboriginal Corporation  
Wesley Mission  
Western District Supported Employment  
Western Suburbs Housing Co-op Limited  
Western Sydney Drug & Alcohol Resource Centre Inc.  
WHOS (We help Ourselves)  
Windgap Enterprises  
Wollongong Crisis Centre  
Wollongong West Street Centre  
Women's Housing Company Limited  
WorkAbility Personnel  
Yerin Aboriginal Health Services Inc.  
Youth Connections  
Youth Off The Streets

## APPENDIX 5: Consultation Feedback from NSW Health

In August 2009, the NSW Health Mental Health Program Council (MHPC) and the Chronic and Continuing Care Rehabilitation and Recovery Working Group (CCCRRWG) were each provided with an overview of progress and the initial analysed data relating to the *Sector Mapping Project*. Following the presentations, members were invited to consult by answering the following open question:

*“What needs to be in place for you to engage with and support CMO delivery of mental health programs?”*

Client Experience	Policy & Planning	Service Provision
Access to services	Needs-based planning and funding	Inter-agency relationships
People with complex needs	Contracts management process	CMO resources
Person-centred planning	CMO program evaluation	Workforce
Coordination of support		CMO management & processes
CMO program delivery		Information about CMOs

Consultation comments are grouped above according to emerging themes related to mental health CMO sector capacity building Literature Review as indicated. The consultation comments did not directly relate to Research and Development, however, strengthening the three elements captured will provide a foundation on which innovation and growth will be facilitated. The details of written comments are provided below.

### CLIENT EXPERIENCE (PROGRAM RANGE AND RESPONSIVENESS)

#### Access to services

- “NGO referral system”.
- “Clear and transparent eligibility criteria for clients”.

#### People with complex needs

- “The importance of, and more information on, NGOs in relation to mental health needs of groups such as: children and adolescents; people with Intellectual Disability, Autism, CALD, COPMI”.
- “NGO complex needs clients getting access to NSW Health services”.

#### Coordination of support

- “Individual client centred care planning & coordination”.
- “Rules of engagement, clear protocols on shared care and management plans”.
- “Role delineation”.
- “Coordinate care with non-contracted NGOs”.

#### Inter-agency relationships:

- “Networking complex needs CMOs with NSW Health”
- “Interagency Forums”
- “A feeling of trust between NSW Health and the NGO staff about shared values”.
- “A framework on how NSW Health MH links with NGO sector, including dealing with difference”.

#### Person-centred planning

- *"Individual client centred care planning & coordination"*.
- *"A clear view of the involvement with consumers/patients/carers"*.

### SERVICE PROVISION (ORGANISATIONAL CAPACITY)

#### CMO Resources

- *"Resources dedicated for purposes including human, financial, infrastructure"*.

#### Workforce

- *"Resolution of issues around criminal checks"*.
- *"Capacity of staff"*.

#### CMO Management & Processes

- *"Knowledge of governance and supervision of NGO programs"*.
- *"Information systems"*.

### POLICY & PLANNING (PLANNING, FUNDING AND EVALUATION)

#### Needs-based planning and funding

- *"Map the allocation of resources according to need"*.
- *"Evidence for equity of funding for the various categories/programs"*.

#### Contracts management process:

- *"Contracts management process AHS – finance"*.
- *"Legal contracts, etc"*.

#### CMO Program Delivery & Evaluation

- *"Evidence based practice, identified outcomes, data"*.

#### Information about CMOs

- *"More about which NGOs exist, their services, target group and partners"*.

## APPENDIX 6: Extended Responses to Open Questions

### (Q56)

Responses to the question “What mental health services do your clients require that they are unable to obtain?” are divided by the CMO’s stated FTE equivalent number of mental health staff as an indicator of organisation size.

Number of FTE Mental Health Staff	Service Need	# of Respondents
No FTE	Clinical Services	19
	Accommodation/Respite	5
	Long-term treatment/support	4
	Child & Adolescent Services	4
	Emergency Services	4
	Public Health	1
	** Services are Adequate	1
	More Volunteering	1
	Services Catering for Disability	1
	Old Age Services	1
	Carer support	1
	Suicide Prevention	1
	All Services Needed	1
	CALD Services	1
	Mental Health First Aid	1
<b>No FTE Total</b>		<b>46</b>
<2 FTE	Clinical Services	6
	Long-term treatment/support	4
	Accommodation/Respite	4
	Transport to/from Services	3
	Life Skills	2
	Co-existing Conditions	2
	Auslan information	1
	New/Innovative Services	1
	** Services are Adequate	1
	Counselling Services	1
	Indigenous Services	1
	All Services Needed	1
	<b>&lt;2 FTE Total</b>	

Number of FTE Mental Health Staff	Service Need	# of Respondents
2-4.5 FTE	Clinical Services	5
	Accommodation/Respite	4
	Long-term treatment/support	3
	Co-ordination of Services	2
	** Services are Adequate	2
	Peer support	2
	Services Catering for Neurological Conditions	1
	Child & Adolescent Services	1
	Adult Survivors of Child Abuse	1
	Emergency Services	1
	Indigenous Services	1
	Co-existing Conditions	1
<b>2-4.5 FTE Total</b>		<b>24</b>
5-9 FTE	Clinical Services	5
	Child & Adolescent Services	3
	Emergency Services	2
	Transport to/from Services	1
	** Services are Adequate	1
	Long-term treatment/support	1
	Daily Assistance	1
	Peer support	1
	Accommodation/Respite	1
	All Services Needed	1
	Life Skills	1
<b>5-9 FTE Total</b>		<b>18</b>
10+ FTE	Accommodation/Respite	4
	All Services Needed	3
	Clinical Services	3
	Emergency Services	2
	** Services are Adequate	2
	Long-term treatment/support	2
	Advocacy Services	2
	Services Catering for Disability	2
	Co-existing Conditions	2

Number of FTE Mental Health Staff	Service Need	# of Respondents
	Early Intervention	1
	Old Age Services	1
	Case Management	1
10+ FTE Total		25
Grand Total		140

**(Q72)**

*“What do you think is the key challenge currently facing the NGO mental health sector in NSW?”*

	# of Respondents
Lack of Funding/Resources/Increasing Demand	71
Workforce/Training	22
Better AHS Communication & Access (incl. referrals)	17
Govt Relationship (dependence, short-term, communication)	17
Accommodation	8
Long-term treatment/support	6
Co-ordination	6
Co-existing Conditions	5
Non-emergency Clinical Services	5
Partnerships	5
Rural/Indigenous issues	4
Public Health	4
Distraction from mission	3
Evidence-based practice	3
Service Quality	2
CALD	1
Program design	1
Community Outreach	1
Political will	1
Accreditation Affordability	1
Homelessness	1
Funding Crisis	1
Grand Total	185

## (Q73)

*"How can mental health services be improved apart from 'more funding'?"*

	# of Respondents
Workforce Development	30
Better Co-ordination (CMO-CMO & CMO-NSW Health)	18
MOUs/Specific Role Delineation	16
NSW Health structure (complexity, red tape)	12
Public Health Campaigns	7
Rural Services	6
Better Communication by NSW Health	5
Early Intervention/Prevention Programs	5
More Accommodation/Respite	5
Service Integration	5
More Recovery Focus	4
More/Stronger Partnerships	4
Centralised Funding and Service Agreements	4
Indigenous Services	3
Outreach Services	3
Most Services Are Poor	3
Better Marketing	2
Respectful AHS workers	2
Change Management services	2
Divergence from mission	1
Most Services are Adequate	1
Lower Collaboration	1
Disability Awareness	1
Uncapping services in high demand	1
Pre-crisis Support	1
Better feedback mechanisms	1
Consumer participation	1
Youth Services	1
Emergency/Drop-in services	1
Better Data Systems	1
More Accreditation	1
Child Abuse Services	1
General Support Services	1
NSW Health Consistency	1
Disability Awareness	1
Community Integration	1
Accessibility	1
Longer term funding	1
<b>Grand Total</b>	<b>155</b>

## (Q74)

*“What is the most important policy initiative in NSW over past 3 years?”*

	# of Respondents
New Plans & Acts	17
More Accommodation Services	15
No Good Policy Initiatives	13
Increased Funding or Resources	12
Medicare Plus (Better Access)	10
Federal Govt Policies	9
Integration of Services	4
Better CMO services	3
MHCC Initiatives	3
Better Recovery Focus	2
Better Media Behaviour	2
Better Employment Services	1
Better Case Management	1
NSW Health structural changes	1
Youth Services	1
Better Role Delineation	1
Better Data Systems	1
Better Career in CMOs	1
More Consultation	1
More Open Disclosure	1
Better Attention to Disability	1
Consumer Consultation	1
Mental Health Nurse Incentive Program	1
Greater Diversity in Services	1
More Training	1
Focus on Homelessness	1
<b>Grand Total</b>	<b>105</b>

## APPENDIX 7: NSW Health Funded Programs

The *Sector Mapping Survey* identified 33 organisations delivering 87 programs (excluding peak bodies) with funding received from NSW Health through a specific and identifiable stream. The four identified program funding streams are:

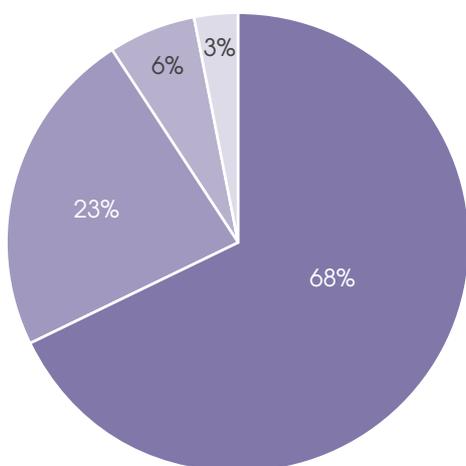
- NGO Grant Program;
- Housing and Accommodation Support Initiative (HASI);
- Family & Carers Support Program; and,
- Resource & Recovery Services Program.

Further data on organisations & programs within the four identified funding streams are provided below:

### PROGRAMS: IDENTIFIED NSW HEALTH FUNDING STREAMS

Funding Stream	No. of Programs
NGO Grant	59
HASI	20
Family and Carers Support	3
Resource and Recovery	5

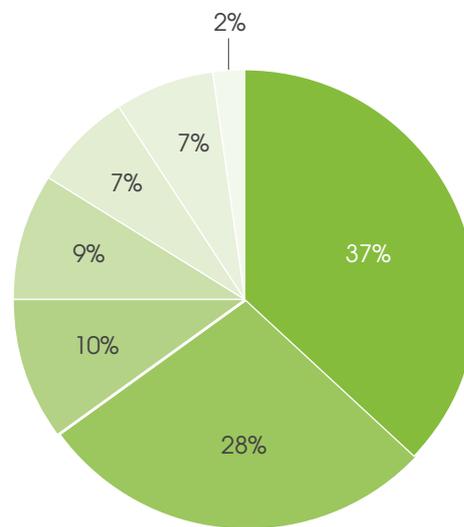
Identified program numbers are an indicative sample only. Some responding organisations were known to provide specific NSW Health programs but did not provide details that were able to be separated into funding streams. According to NSW Health documentation there are a total of 8 "Family and Carers Support" programs (one for each AHS) provided by four organisations and 10 "Resource and Recovery" programs provided by five organisations.



- NGO Grant 68%
- HASI 23%
- Resource and Recovery 6%
- Family & Carers Support 3%

### PROGRAMS: CORE SERVICES

	No. of Programs
Accommodation Support & Outreach	31
Employment & Education	23
Self-help & Peer Support	8
Helpline & Counselling Services	7
Information, Advocacy & Promotion	6
Family Support & Carers	6
Leisure & Recreation	2
<b>Total<sup>47</sup></b>	<b>83</b>



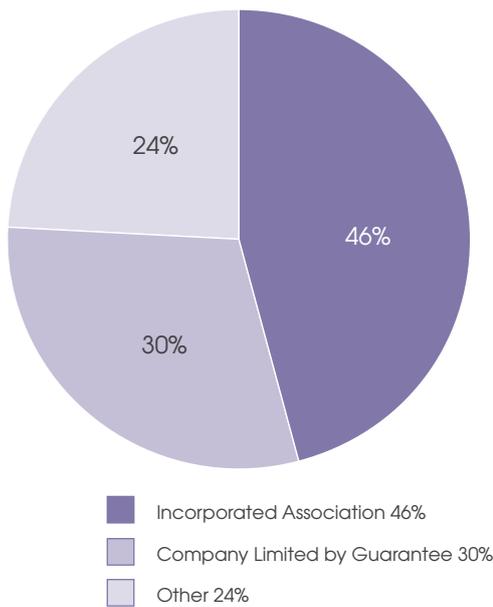
- Accommodation Support & Outreach 37%
- Employment & Education 28%
- Family Support & Carers 10%
- Self-help & Peer Support 9%
- Information, Advocacy & Promotion 7%
- Helpline & Counselling Services 7%
- Leisure & Recreation 2%

Only four programs with an identified NSW Health funding stream did not fit within the core service areas. These were a mix of indigenous and time-limited residential treatment programs and two had a focus on working with people with co-existing mental health and substance use problems.

<sup>47</sup> Four programs indicating primary funding by NSW Health were classified as non-Core.

## CORPORATE STRUCTURE

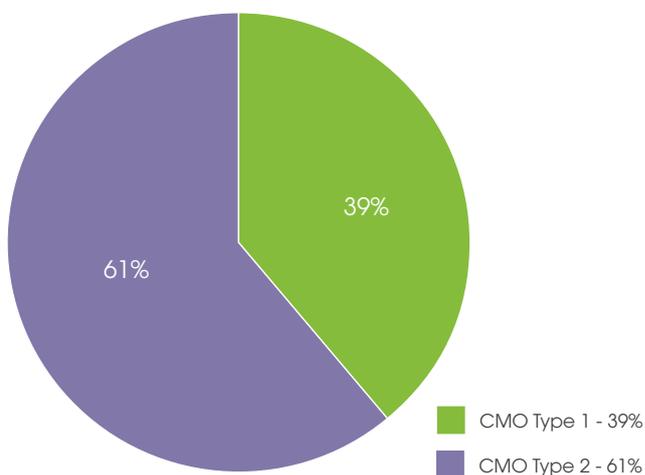
Corporate Structure	No. of Organisations	Percentage
Incorporated Association	15	45%
Company Limited by Guarantee	10	30%
Other	8	24%
<b>Total</b>	<b>33</b>	<b>100%</b>



## ORGANISATION TYPE

	No. of Organisations	Percentage
CMO Type 1	13	39%
CMO Type 2	20	61%
<b>Total</b>	<b>33</b>	<b>100%</b>

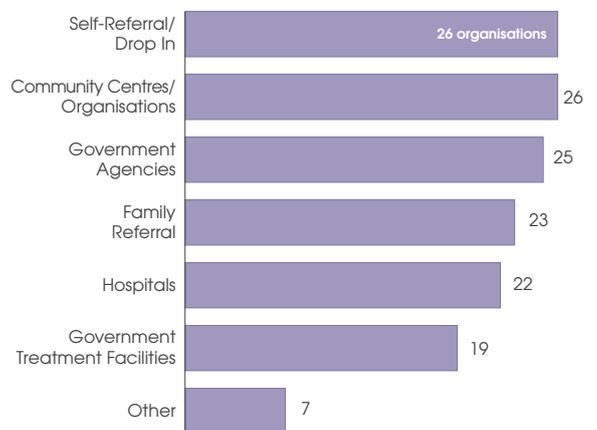
Note: No Type 3 CMOs were identified within the four NSW Health funding streams.



## REFERRAL SOURCES

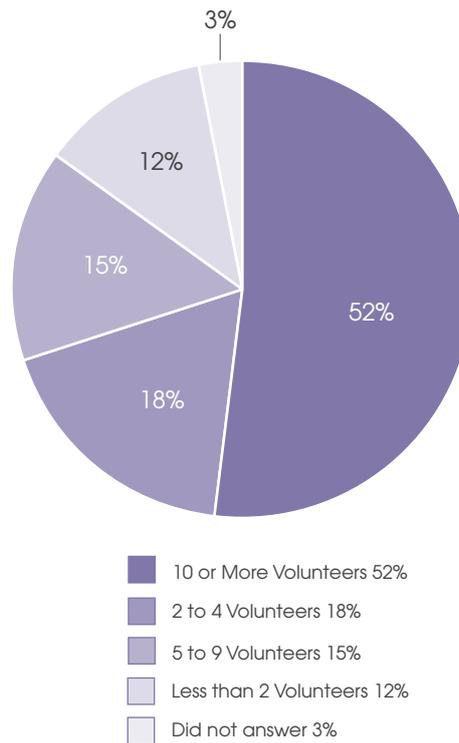
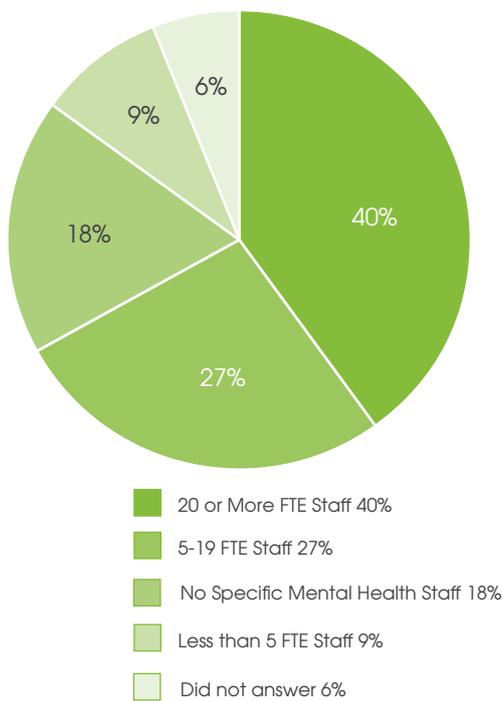
Number of CMOs (out of 33 total) declaring each referral source within the previous three months at the time of answering the survey:

Referral Type	No. of Organisations
Self-Referral/Drop In	26
Community Centres/Orgs	26
Govt Agencies	25
Family Referral	23
Hospitals	22
Govt Treatment Facilities	19
Other	7



## MENTAL HEALTH STAFF (Full Time Equivalent)

	No. of Organisations
No specific MH staff	4
Less than 5 FTE staff	6
5 to 19 FTE staff	5
20 or more FTE staff	17
Did not answer	1
<b>Total</b>	<b>33</b>



## OUTCOME MONITORING TOOLS

	Average No. of Outcome Measures
CMO Type 1	2.7
CMO Type 2	2.5

## VOLUNTEERS

	No. of Organisations
Less Than 2 Volunteers	4
2 to 4 Volunteers	6
5 to 9 Volunteers	5
10 or More Volunteers	17
(Did not answer)	1
<b>Total</b>	<b>33</b>

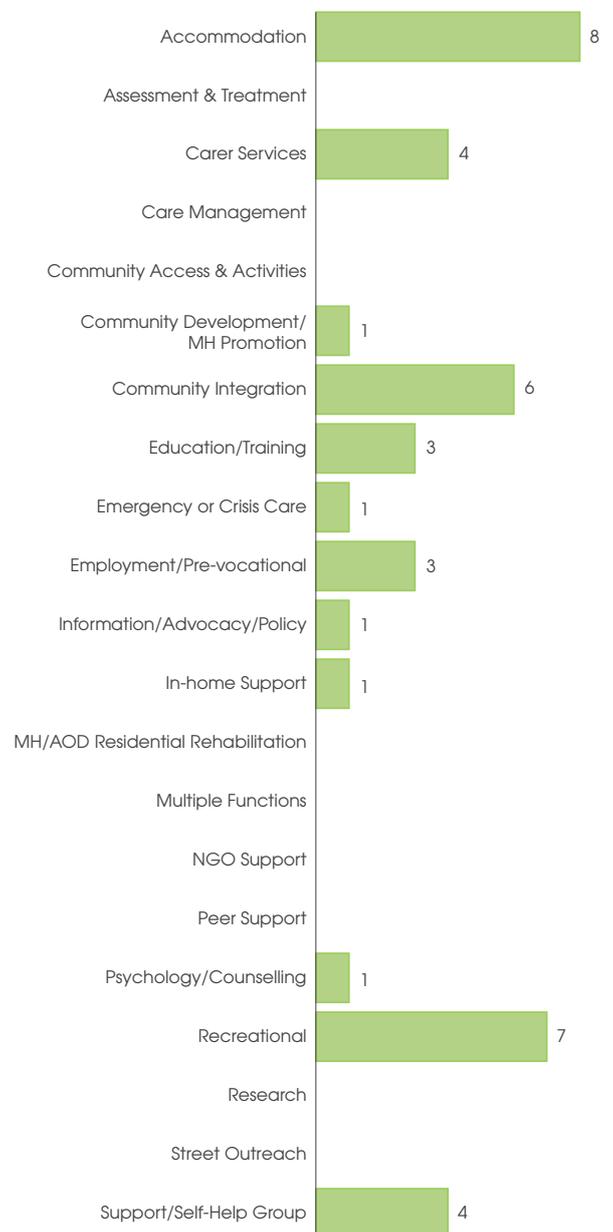
## APPENDIX 8: Data Sheets for Each New South Wales Area Health Service

### GREATER SOUTHERN AHS

#### RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Albury	12
Bega Valley	6
Berrigan	1
Bland	1
Bombala	
Boorowa	1
Carrathool	1
Conargo	2
Coolamon	1
Cooma-Monaro	1
Cootamundra	3
Corowa Shire	6
Deniliquin	2
Eurobodalla	3
Goulburn Mulwaree	4
Greater Hume Shire	6
Griffith	3
Gundagai	1
Harden	2
Hay	2
Jerilderie	2
Junee	5
Leeton	4
Lockhart	2
Murray	
Murrumbidgee	
Narrandera	1
Palerang	
Queenbeyan	13
Snowy river	
Temora	2
Tumbarumba	1
Tumut Shire	2
Upper Lachlan	
Urana	1
Wagga Wagga	7
Wakool	1
Yass Valley	4
Young	2

#### PROGRAM TYPES

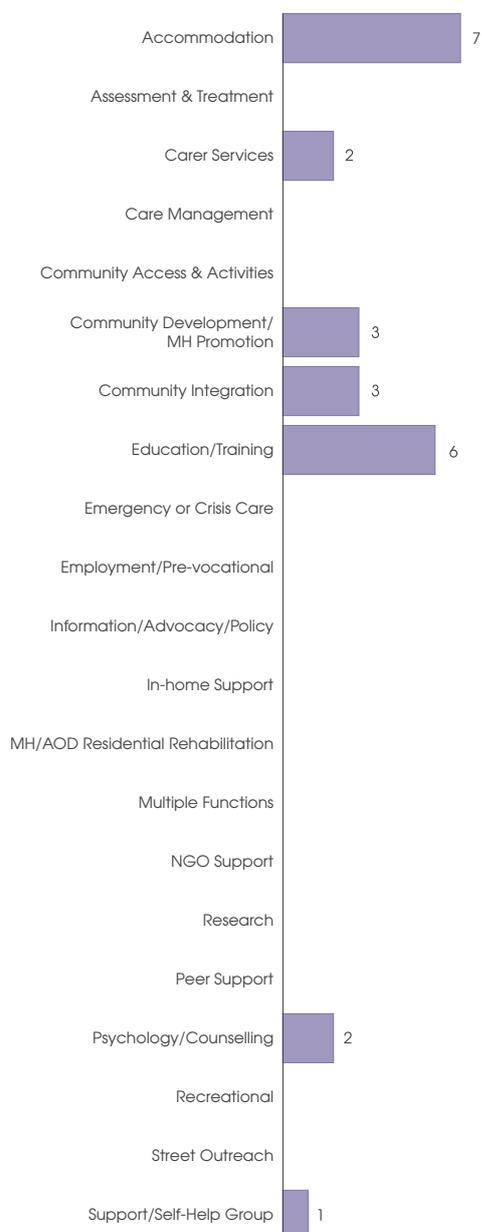


## GREATER WESTERN AHS

### RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Balranald	4
Bathurst Regional	4
Blayney	1
Bogan	
Bourke	2
Brewarrina	
Broken Hill	3
Cabonne	1
Central Darling	2
Cobar	
Coonamble	
Cowra	3
Dubbo	7
Forbes	1
Gilgandra	
Lachlan	
Mid-Western Regional	1
Narromine	
Oberon	
Orange	5
Parkes	2
Unincorporated NSW	1
Walgett	1
Warren	
Warrumbungle Shire	1
Weddin	
Wellington	1
Wentworth	3

### PROGRAM TYPES

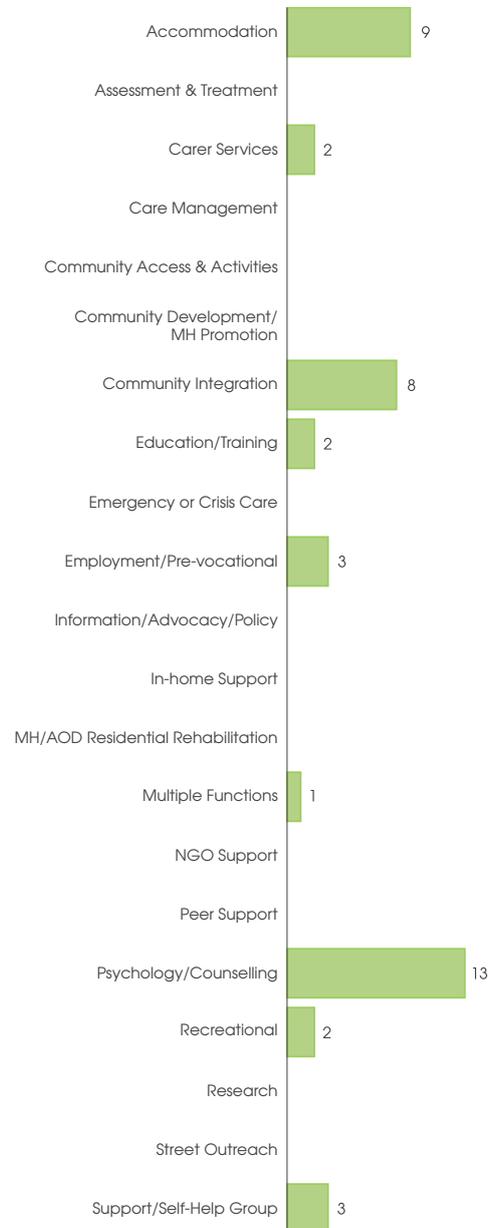


## HUNTER &amp; NEW ENGLAND AHS

## RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Armidale Dumaresq	3
Cessnock	4
Dungog	2
Glen Innes Severn	
Gloucester	2
Great Lakes	1
Greater Taree	5
Gunnedah	
Guyra	1
Gwydir	
Inverell	
Lake Macquarie	15
Liverpool Plains	
Maitland	7
Moree Plains	7
Muswellbrook	2
Narrabri	
Newcastle	23
Port Stephens	4
Singleton	3
Tamworth	3
Tenterfield	
Upper Hunter Shire	3
Uralla	1
Walcha	1

## PROGRAM TYPES

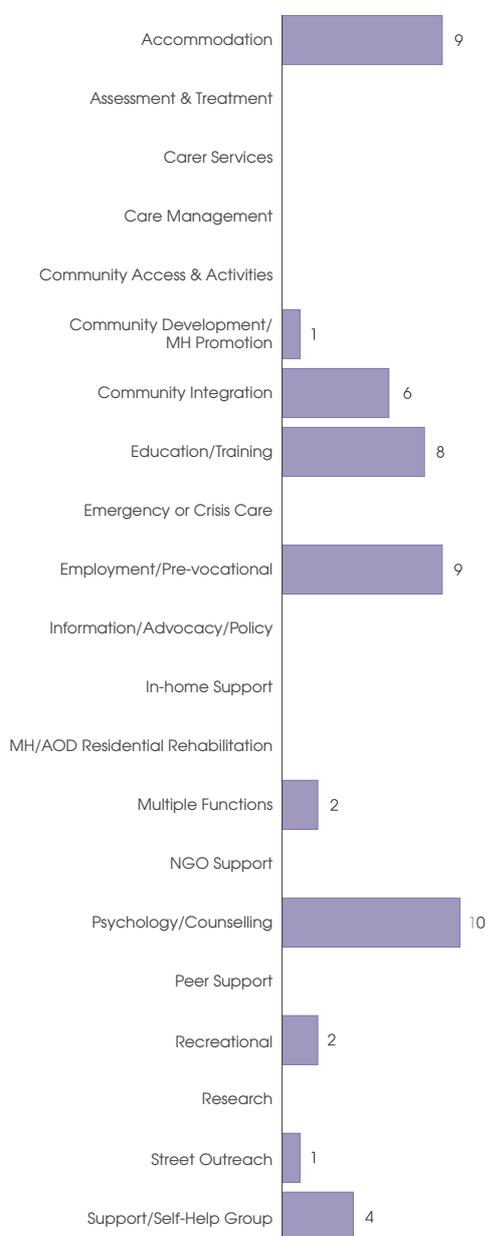


## NORTH COAST AHS

### RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Ballina	12
Bellingen	14
Byron	12
Clarence Valley	12
Coffs Harbour	14
Hastings	6
Kempsey	11
Kyogle	10
Lismore	18
Nambucca	16
Richmond Valley	6
Tweed	13

### PROGRAM TYPES

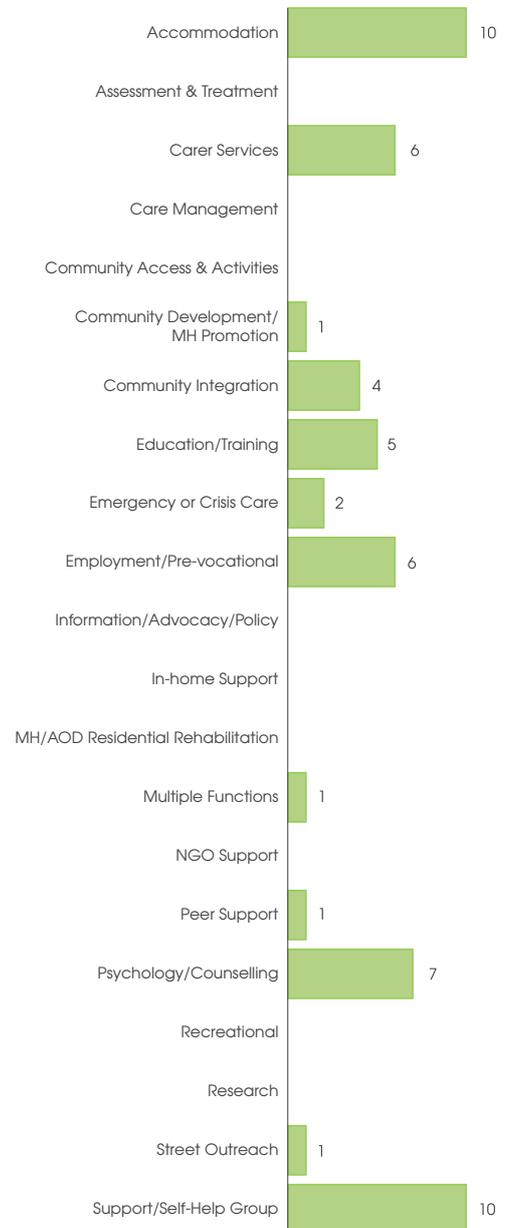


## NORTHERN SYDNEY &amp; CENTRAL COAST AHS

## RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Gosford	10
Hornsby	12
Hunters Hill	10
Ku-ring-gai	12
Lane Cove	14
Manly	13
Mosman	10
North Sydney	13
Pittwater	9
Ryde	18
Warringah	11
Willoughby	10
Wyong	15

## PROGRAM TYPES

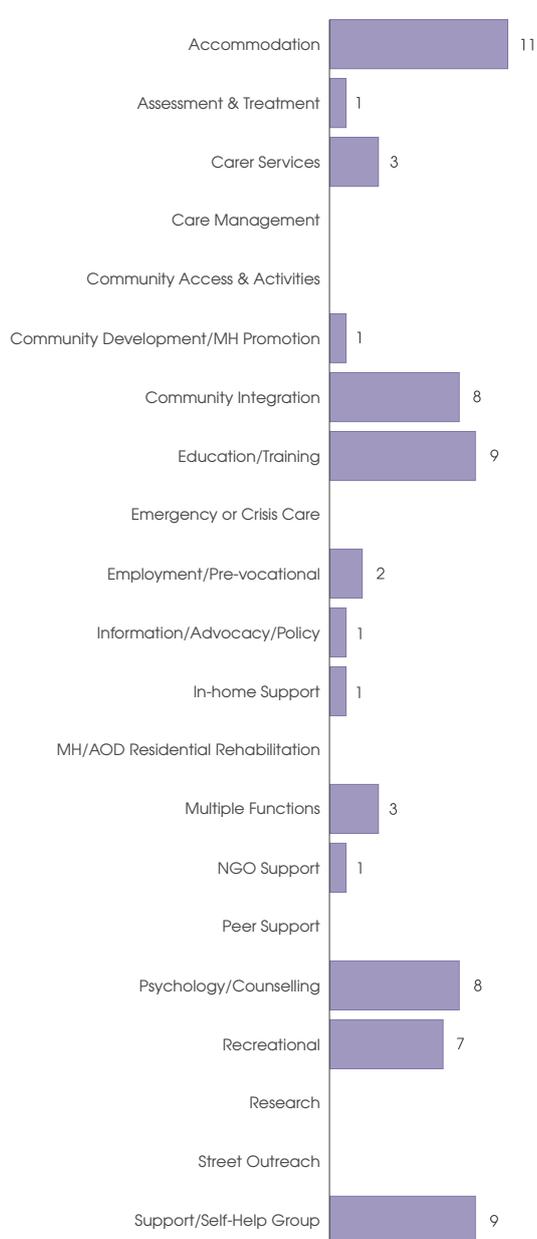


## SOUTH EASTERN SYDNEY & ILLAWARRA AHS

### RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Botany Bay	9
Hurstville	4
Kiama	
Kogarah	4
Randwick	18
Rockdale	4
Shellharbour	6
Shoalhaven	13
Sutherland Shire	7
Waverly	16
Wollongong	8
Wollahra	12

### PROGRAM TYPES

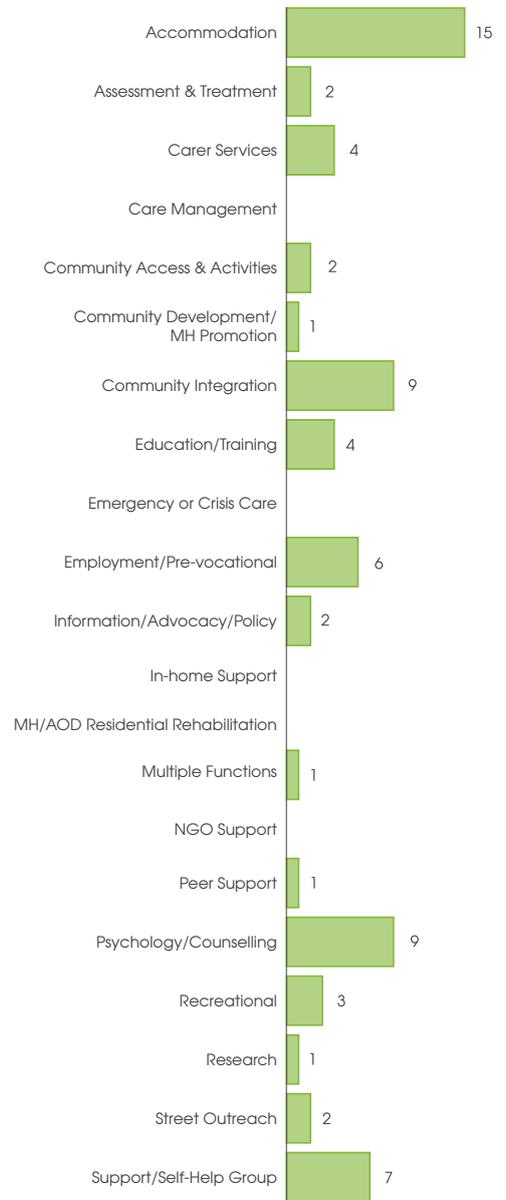


## SYDNEY SOUTH WEST AHS

### RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Ashfield	15
Bankstown	14
Burwood	12
Camden	10
Campbelltown	17
Canada Bay	10
Canterbury	13
Fairfield	11
Leichhardt	11
Liverpool	11
Marrickville	13
Strathfield	11
Sydney	16
Wingecarribee	11
Wollondilly	10

### PROGRAM TYPES

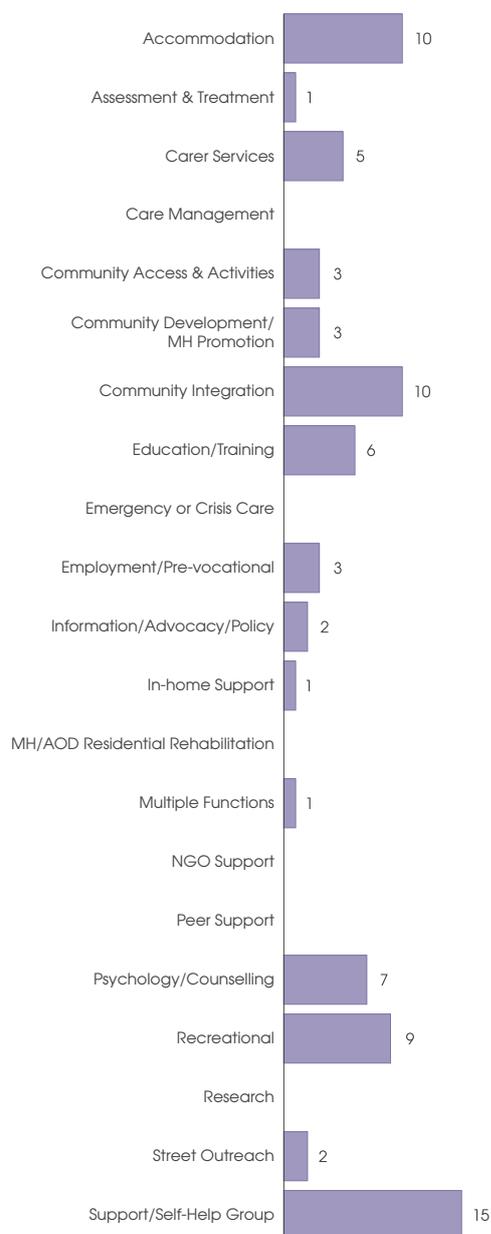


## SYDNEY WEST AHS

### RESPONDING PROGRAM LOCATIONS

Local Government Area	No. of Programs
Auburn	10
Baulkham Hills	5
Blacktown	21
Blue Mountains	14
Hawkesbury	13
Holyroyd	7
Lithgow	4
Parramatta	14
Penrith	16

### PROGRAM TYPES



## APPENDIX 9: Quality Review Processes

Quality review processes identified by community managed mental health services responding to the *Sector Mapping Survey*:

### ACCREDITATION

1. AI Global (Business Excellence Framework)
2. Australian Council on Health Care Standards (ACHS)
3. Australian General Practices Accreditation Limited (AGPAL)
4. BSI Benchmark
5. Global Mark
6. International Centre for Clubhouse Development
7. International Standards Certification
8. ISO (Standards Australia)
9. National Childcare Accreditation
10. NCS International (NCSI)
11. Quality Improvement Council (QIC)

### GOVERNMENT REQUIREMENTS

12. Department of Health and Ageing (DOHA - Commonwealth)
13. Department of Ageing, Disability and Aged Care (DADHC - NSW)
14. Office of the Children's Guardian
15. Department of Education and Training (DET - NSW)
16. Department of Community Services (DoCS - NSW)
17. Department of Education, Employment and Workplace Relations (DEEWR - Commonwealth)
18. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA - Commonwealth)
19. Housing NSW - Office Community Housing Performance Based Registration System
20. Office for Aboriginal and Torres Strait Islander Health (OATSI - Commonwealth)

### OTHER

21. Dual Diagnosis Capability in Addictions Treatment (DDCAT)
22. IMF and Quarterly Reporting
23. Integroe Partners
24. Quality Safe Systems
25. Self-assessment

## APPENDIX 10: Funding Sources of NSW Mental Health CMOs

26 funding sources were identified by the *Sector Mapping Project*.

11 primary funding sources (ie, covers most respondents):

1. Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)
2. Commonwealth Department of Health and Ageing (DOHA)
3. Commonwealth Department of Education Employment and Workplace Relations (DEEWR)
4. NSW Department of Disability Ageing and Home Care (DADHC)
5. NSW Department of Community Services (DoCS)
6. NSW Health (NSW Government)
7. NSW Department of Corrective Services (DCS)
8. NSW Department of Juvenile Justice (DJJ)
9. Housing NSW (NSW Government)
10. Private/Donation
11. Other government - e.g. other departments, LGAs.

15 "Other" sources were identified:

12. Service Fees
13. Program Sales
14. Private Health Funds
15. CHESS
16. ENVITE
17. St Vincent de Paul Society
18. ACT Health
19. RSL Grant
20. ECHO
21. NSW Cancer Council
22. Legal Aid NSW
23. NSW Public Purpose Fund
24. SAAP
25. National Youth Mental Health Foundation
26. Central Coast Division of GPs

## APPENDIX 11: Common Principles for Government-CMO Contracts

### COMMON PRINCIPLES FOR GOVERNMENT-CMO CONTRACTS

(SIDOTI ET AL 2009, P2)

#### A. Foundations

- All parties should enter into the contract in *Good Faith*.
- There is a presumption of *Good Will*.

#### B. The relationship between the contracting parties

- The relationship between the contracting parties is one of *Trust*
- The contracting parties will accord each other *Proper Respect*.
- The relationship between the contracting parties is *Supportive and Collaborative*.

#### C. Nature of the contract

- The contract should be *Clear and Readily Understood*.
- The requirements in the contract should be guided by *Proportionality*.
- The terms of the contract should be *Responsible and Reasonable*.
- The contract should establish *Meaningful Outcomes*.

#### D. Operation of the contract

- The contract should allow for *Decisions* to be made at the *Appropriate Level*.
- The contract should operate *Consistent* with the presumption of *Good Will and Trust*.
- The contract should be based on *Full and Fair Costing*.
- The contract should allow that *Risk* exists, cannot be eliminated and will be *Shared*.
- The contract should be administered in a *Timely Manner*.

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# LITERATURE REVIEW

## BUILDING CAPACITY IN THE NSW MENTAL HEALTH CMO SECTOR: A Review of the Literature

### PUBLICATION DETAILS

Mental Health Coordinating Council (2010). *Building Capacity in the NSW Mental Health CMO Sector: A Review of the Literature*. NSW Australia.

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### ABOUT THE MENTAL HEALTH COORDINATING COUNCIL OF NSW

MHCC is the state peak body for community managed organisations (CMOs) representing the views and interests of over 200 CMOs throughout NSW. Member organisations specialise in the provision of services and support for people with a disability as a consequence of mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community.

Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development. The organisation consults widely in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector, and is a registered training organisation, delivering mental health certified training and professional development to the workforce.

### FUNDED BY NSW HEALTH

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## INTRODUCTION

NSW Health is committed to developing effective, efficient, responsive specialist mental health community managed organisations (CMOs) in order to improve service delivery to people who experience mental illness<sup>48</sup>. Since 2007, NSW Health has allocated four million dollars to improve infrastructure within the mental health CMO sector in NSW through the Infrastructure Grants Program (IGP). 66 infrastructure projects have been funded through the IGP, in addition to the development of projects such as the *NSW Mental Health CMO Sector Mapping Project 2008-2010* of which this Literature Review is a part.

NSW Health has developed a vision of the potential future structure of the community managed mental health system after implementation of the *NSW Community Mental Health Strategy 2007–2012*<sup>49</sup>. This structure draws on public mental health and CMOs and comprises: service partnerships; core programs; and, age-specific programs. The role of NSW Health in this structure is to *“work together in a recovery-focused approach to provide a seamless integrated specialist community mental health service coordinated with other partnership services to provide best practice care for people of all ages [experiencing mental illness], their families and carers”*<sup>50</sup>.

The Mental Health Coordinating Council (MHCC) supports a person-centred, recovery-oriented, coordinated approach to support and seeks to explore current trends, other informed structural visions and knowledge of what works to anticipate progressive steps in the evolution of the community managed mental health sector. MHCC is interested in developing practical ways for the government, non-profit and for-profit sectors to work cooperatively in order to provide accessible, effective supports for people experiencing mental illness.

The purpose of this Literature Review is to provide a context for the NSW Mental Health CMO Sector Mapping Project and to inform recommendations to develop the capacity of the NSW community managed mental health sector.

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<sup>48</sup> NSW Health (2008) p50

<sup>49</sup> NSW Health (2008)

<sup>50</sup> NSW Health (2008) p77

## COMMUNITY MANAGED ORGANISATIONS (CMOs)

“Non-government organisation” (NGO) is a term often used in Australia to refer to community managed (not-for-profit) organisations. However, it is also used to refer to any organisation - not-for-profit or for-profit - which is not part of government. Defining the NGO sector has been considered difficult due to the diversity in the size, nature and scope of NGOs<sup>51</sup>.

Australian bodies such as the Social Inclusion Unit and Productivity Commission use the term “not-for-profit” (NFP)<sup>52</sup>. The term “non-profit” has international recognition and seems to have popular usage as a catch-all term and “community organisation” is a highly preferred specific description of non-profit organisations<sup>53</sup>. The MHCC prefers positive terminology so CMO is used interchangeably with NFP in this review.

The majority of leading theories exploring the role of the not-for-profit sector adopt a three-sector approach: government; for-profit; and, not-for-profit<sup>54</sup>.

The way in which profits are distributed provides a clear distinction between not-for-profit and for-profit entities. Not-for-profit Boards have some ownership rights (for example, the right to direct the use of resources) but they - and individual members - may not profit from the use of the organisation’s resources<sup>55</sup>.

In contrast, those in control of the organisational assets of for-profit entities have full ownership rights, including the right to profit from the use of the entity’s resources<sup>56</sup>. Other features of a not-for-profit organisation include: a formal governance structure; independence from government; autonomy in decision-making; and, voluntary participation by members<sup>57</sup>.

Community managed organisations arise from community need<sup>58</sup>, are flexible, responsive, build social capital, raise and give community resources, design new services and encourage empowerment and participation<sup>59</sup>.

### CMO PARADIGMS

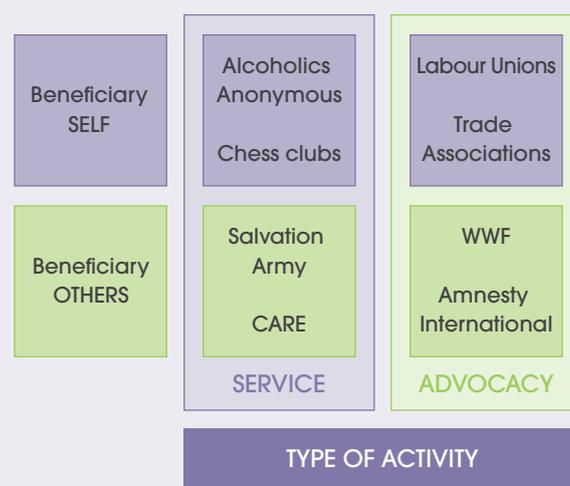
Moore, Hadzi-Miceva, and Bullain (2008) state that there is generally a broad distinction between two CMO types<sup>60</sup>:

- General purpose associations, foundations, non-profit companies; and,

- Those established for specific purpose which are regulated with separate legislation (trade unions, political parties, etc.) and are usually outside of the public benefit system.

Yaziji and Doh (2009) extend the typologies to four<sup>61</sup> based on a matrix over two dimensions: whom the CMO is designed to benefit; and, what the CMO does - as shown in Figure 1.

FIGURE 1: CMO TYPOLOGY MATRIX (YAZIJI AND DOH, 2009)



CMOs providing mental health programs generally fall into the category in which the beneficiary is “other” and the type of activity is “service”. Earles (2006) proposes four CMO provider paradigms which compete for primacy in any organisation or parts of organisations at any one time and over time: excellence, sustainability, viability, and identity. The paradigms are based on quadrants formed from the intersection of two dimensions as shown in Figure 2:

- *The policy field* and associated funding (growth of these is **accumulation**; stagnation or reduction is **attrition**).
- *Restructuring and institutionalisation of organisational infrastructure* (absence of these is **atrophy**; presence of these is **aggregation**).

The major organisational concern in the:

- **Excellence paradigm (accumulation and aggregation):** pursuit of ‘excellence’ in NFP governance, management and service provision.
- **Sustainability paradigm (atrophy and accumulation):** sustainability of the organisation, achieved through service growth.
- **Viability paradigm (attrition and aggregation):** viability of services through organisational change.
- **Identity paradigm (attrition and atrophy):** survival of the service for particular clients/members.

<sup>51</sup> Tilt, C. A. (2006)

<sup>52</sup> Productivity Commission (2009a) p7

<sup>53</sup> Donoghue, Prizeman, O’Regan and Noël (2006), p32

<sup>54</sup> Powell, WW, & Steinberg, R. (2006) p2

<sup>55</sup> Australian Tax Office (2009)

<sup>56</sup> Powell & Steinberg (2006) p2

<sup>57</sup> Productivity Commission (2009a)

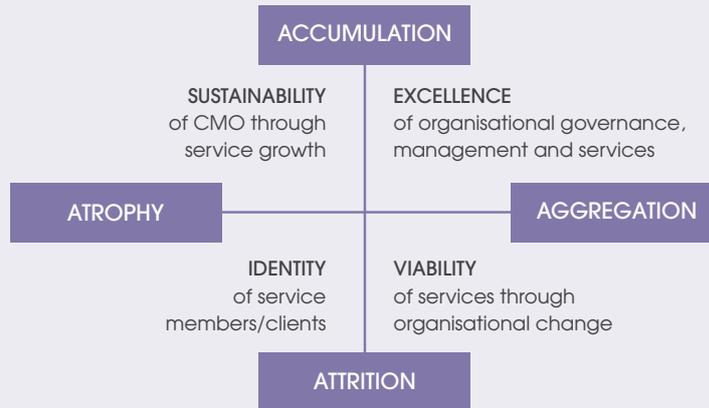
<sup>58</sup> NCOSS (2009a)

<sup>59</sup> Monteduro, Hinna & Ferrari (2009)

<sup>60</sup> Moore, Hadzi-Miceva, and Bullain (2008), p14

<sup>61</sup> Yaziji and Doh (2009)

FIGURE 2: FOUR CMO "PARADIGMS" (EARL, 2006)



CMOs are not uniform, static organisations.  
*Dialogue with CMOs is likely to be smoother if there is an understanding of the paradigm(s) from which they are operating.*

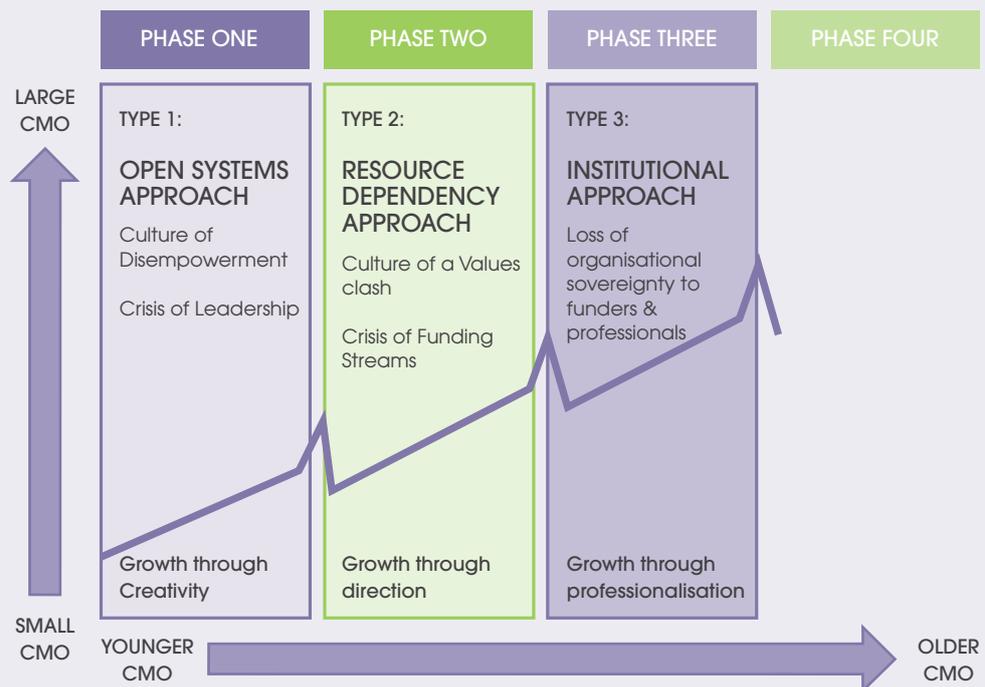
Earl notes that "in a simplistic sense, dialogue on the identity and sustainability paradigms would be about 'reform' (and the role of the state in supporting reform) while it would be about 'recognition' for the viability and excellence paradigms".<sup>62</sup>

### LIFE CYCLE STAGES OF CMOs

Donnelly-Cox & O'Regan (1999) propose a theoretical model which takes into consideration factors such as age, size, means of growth and culture in describing three CMO types as shown in Figure 3:

- **Type I:** Small or start-up organisation;
- **Type II:** Larger resource dependent organisation; and,
- **Type III:** Heavily government funded, agency-type organisation.

FIGURE 3: TYPES OF CMOS (FROM DONNELLY-COX & O'REGAN, 1999)



<sup>62</sup> Earl (2006), p12

Type I CMOs may grow into Type II or Type III CMOs. If so, the above model may be viewed as a broad description of CMO life cycle stages. The CMO life cycle is described in more detail by Stevens (2007) as having seven stages: the idea; start-up; growth; maturity; decline; turnaround; and, terminal. Each CMO has different needs and challenges at each life cycle stage and the main challenges for each stage are noted in Box 1.

#### BOX 1: SEVEN STAGES OF THE CMO LIFE CYCLE (STEVENS, 2007)

Stage 1: Idea	Main Challenges	
Perceived community need sparks a founding idea or vision of what could be	Identifying an unmet need Developing mission and vision	Mobilising support of others Converting the idea into action
Stage 2: Start-up	Main Challenges	
The beginning stage of operations - energy and passion are at their highest, but systems often lag behind	Knowing when to say “no” Living within budget Hiring versatile staff	Leveraging sweat equity into support Sharing vision & responsibility with staff, board, constituencies
Stage 3: Growth	Main Challenges	
Program opportunity and service demand exceed current systems and structural capacities	Too much to do, too little time Developing board ownership Program/strategic focus keeps creativity, vision Identifying distinctive competence	Opportunity and demand exceed current systems & capacities
Stage 4: Maturity	Main Challenges	
CMO has a reputation for providing steady, relevant and vital services to the community; operates with a solid foundation and an overall sense of security	Remaining client-centred, rather than policy-bound Keeping staff mission-focused Building financial reserves	Maintaining programmatic “edge”, cycling programs in and out based on continued relevance Becoming “position” rather than “person” dependent
Stage 5: Decline	Main Challenges	
CMO makes status quo decisions based on internal factors rather than external client needs, resulting in diminished client status and insufficient income to cover operating expenses	Reconnecting with community need, discarding programs that add no value Remembering policies, procedures, systems and structure are no substitute for creativity and risk-taking	Raising income so reserves not drawn down Examining the budget for top-heavy admin expenses Keeping the board engaged
Stage 6: Turnaround	Main Challenges	
CMO is at a critical juncture because of lost market share and income; takes decisive action to reverse prior actions to increase relevance and viability	Finding a turnaround champion and letting them lead Establishing a turnaround culture/mindset Consistent open dialogue with constituents, funders and community	Cutting expenditure Restoring eroded community credibility via consistency, honesty & results
Stage 7: Terminal	Main Challenges	
CMO has lost its will, reason or energy to exist	Accepting responsibility for renewal/termination Resisting the urge to blame others for terminal situation	Communicating termination plans to clients and making appropriate referrals Closing up shop in an honourable manner

## THE COMMUNITY MANAGED SECTOR

Types of organisational structure in the Australian community managed sector include<sup>63</sup>:

- Unincorporated entities, which have no distinct legal status from their members;
- Incorporated Associations (under State/Territory legislation);
- Companies Limited by Guarantee (incorporated under Commonwealth legislation); and,
- Other legal structures for CMOs such as: trusts; cooperatives; Aboriginal corporations; religious organisations; and, organisations formed by Royal Charter or by a special Act of Parliament.

There are approximately 600,000 CMOs in Australia<sup>64</sup> and it is estimated that 440,000 of these are unincorporated associations. There are 9,700 Companies Limited by Guarantee (Productivity Commission figures of 11,700 with 2,000 finance and insurance mutuals removed); 136,000 Incorporated Associations; and, 9,000 organisations incorporated by other methods.

CMOs can be categorised by sector, industry, or market environment as well as organisational structure<sup>65</sup>. This review considers CMOs broadly, then focuses on the role of CMOs in the community managed mental health sector.

### INTERNATIONAL PERSPECTIVES ON CMOs

CMOs have different roles in different countries and receive different levels of revenue from government.

A Johns Hopkins University international CMO study grouped countries into “country clusters” for comparative purposes<sup>66</sup>. Countries with cultural similarities in relative CMO size, volunteer participation, revenue & structure – and sometimes geopolitical proximity – were allocated to a particular cluster. Although countries within clusters are not identical, they bring to light certain similarities in CMO sector elements.

The Welfare Partnership Cluster is characterised by a large CMO sector engaged mostly in the delivery of publicly funded human services with a large share of government support (on average, at **least half of total CMO revenue** is from government). Countries in this cluster include Austria, Belgium, Canada, France, Germany, Ireland, Israel, Italy, Netherlands, Portugal, and Spain<sup>67</sup>.

Australia, New Zealand, United Kingdom, and the United States of America are included in a different common

cluster, in which the level of government support is considerably less than that of welfare partnerships (on average, **around a third of total CMO revenue**) leading to a larger percentage of revenue (than welfare partnerships) being from fee income and private philanthropy.

#### New Zealand

In New Zealand, the Ministry of Social Development administers the **Office for the Community and Voluntary Sector** which addresses overarching issues affecting the community and voluntary sector and raises the profile of the sector within government<sup>68</sup>. Thornton (2009) found that the most challenging issues facing the CMO sector in New Zealand are: financing the activities of the organisation; the role of the board; and, other governance issues<sup>69</sup>.

#### United Kingdom

In recognition of the increasingly important role the CMO sector plays in both society and the economy, the Office of the Third Sector (OTS) is part of the Cabinet Office. The OTS leads work across government to support the environment for the CMO sector and aims to enable the sector to campaign for change, deliver public services, promote social enterprise and strengthen communities across Britain<sup>70</sup>.

In its July 2009 report, the OTC reported its key activities: enabling voice and campaigning; strengthening communities; transforming public services; encouraging social enterprise; and, supporting the environment for a thriving CMO sector<sup>71</sup>.

The United Kingdom uses many structures to support CMOs such as: the Third Sector Advisory Body; Minister for the Third Sector; Futurebuilders Fund (grants and loans to build capacity in CMOs); an adviser on CMO sector innovation; a CMO sector skills strategy; and, Capacitybuilders (a non-departmental public body set up by the Home Office to improve support for CMOs, create a more effective CMO sector and work with other funders to build the capacity of the CMO Sector<sup>72,73</sup>). An example of support to CMOs at a local level is provided by London’s “Communities and Third Sector Team” which manages an expanding agenda of policies and programs aimed at developing the capacity and infrastructure of the CMO sector across London. The Government Office for London aims to ensure that London’s communities are supported by strong and sustainable CMOs<sup>74</sup>.

<sup>63</sup> Productivity Commission (2009b), p 1.8

<sup>64</sup> Productivity Commission (2009b), p 4.6

<sup>65</sup> Cartwright C, Sankaran S, Kelly J (2008)

<sup>66</sup> Sanders, J, O’Brien, M, Tennant, M, Wojciech Sokolowski, S, & Salamon, LM. (2008)

<sup>67</sup> Sanders et al (2008)

<sup>68</sup> Office for the Community and Voluntary Sector (2009)

<sup>69</sup> Thornton, G (2009)

<sup>70</sup> Cabinet Office (2009a)

<sup>71</sup> Cabinet Office (2009b)

<sup>72</sup> Capacity Builders (2009)

<sup>73</sup> Cabinet Office (2009b)

<sup>74</sup> Government Office for London (2009)

## United States of America

In the USA, CMOs are set up under State legislation and are said to be “*tools for community building, fostering a civil society and strengthening our social fabric, as well as essential to improving [the community’s] quality of life*”<sup>75</sup>. The Office of Faith-Based and Neighbourhood Partnerships (formerly the Faith-Based and Community Initiative - FBCI) is housed at the White House. Its aim is to be a resource for non-profits looking for ways to make a bigger impact in their communities, learn their obligations under the law, cut through red tape, and make the most of what the Federal government has to offer<sup>76</sup>.

## Canada

In Canada, CMOs may be formed at Federal or Provincial/Territory level. Supports for CMOs seem to be provided mainly at the provincial level, such as the British Columbia Centre for Non-Profit Development which operates on a grant received by three provincial ministries: Public Safety and Solicitor General; Children and Family Development; and, Community Services<sup>77</sup>.

## Europe

In Europe, different countries have a different focus. For example, CMOs in Hungary and Austria focus their efforts primarily in the areas of culture and sport<sup>78</sup> whereas CMOs in France primarily deliver social services<sup>79</sup>. Each country seems to have its own approach to government – CMO relationships. The Euclid Network is the European Network of CMO sector leaders and aims to make the CMO sector stronger and more innovative by providing support, contacts and development opportunities<sup>80</sup>.

## International CMO Capacity Themes

In Canada and Europe, themes relating to CMO capacity include:

- Enhancement of governance;
- Less complex procurement processes;
- Better partnerships; and,
- Consistent regulatory requirements (Appendix 1).

## AUSTRALIAN (NATIONAL) PERSPECTIVES ON CMOs

The Australian Social Inclusion Unit (SIU) was established in December 2007 in the Department of the Prime Minister and Cabinet (PM&C). Reporting to the Prime Minister and the Deputy Prime Minister it performs a strategic policy advisory and coordination function across government on social inclusion, including areas of place based disadvantage and CMO sector reform<sup>81</sup>. The SIU comprises four work groups: the Board secretariat; policy, strategy and coordination section; applied research, location and data analysis; and, community managed sector reform.

With the aims of “*working together and strengthening local communities*” the CMO sector reform group works across government departments to provide:

- Advice on philanthropy, corporate engagement, social innovation and volunteering; and,
- Advice and coordination to the government on CMO sector reform, including: tax and regulatory reform; reducing red tape; and, the development of a national compact with the CMO Sector.

## National Compact

Australian CMOs receive less government revenue than those in Canada and Europe.

Internationally, governments are devoting considerable resources to ensure CMOs continue in their essential role.

*Conceptually, the notion that governments provide support for building NSW CMO capacity aligns with international practice.*

In 2009, a national compact was proposed between the CMO sector and the Australian government<sup>82</sup>. The compact Discussion Paper begins with rules of engagement and principles which:

- Should be obvious every time the government and the CMO sector interact; and,
- Are the foundation for action and change.

Principles include: Respect; Inclusiveness; Diversity; Effectiveness; Efficiency; and, Sustainability.

The compact will include commitments to action which will make a measurable difference to: improve working relationships; achieve better results for people and communities; and, strengthen the viability of the CMO sector.

The proposed implementation and governance of the national compact is that a National Compact Council,

<sup>75</sup> Massachusetts Council of Human Service Providers, (2007)

<sup>76</sup> Office of the Press Secretary (2009)

<sup>77</sup> Centre for Non-Profit Development (2009)

<sup>78</sup> Giving in Europe (2009a)

<sup>79</sup> Giving in Europe (2009b)

<sup>80</sup> Euclid Network (2009)

<sup>81</sup> Australian Government (2009)

<sup>82</sup> Commonwealth of Australia (2009)

comprising CMO sector champions, could be an appropriate mechanism to represent the interests of the CMO sector in related matters and could have responsibility for developing a five year action plan and for recommending processes to resolve differences<sup>83</sup>.

### Productivity Commission

The Productivity Commission recently surveyed Australian government agencies engaged with NFPs in service delivery. Capacity issues were identified for the majority of programs included<sup>84</sup>:

- Demand outstripping sector capacity;
- The ability of the NFPs to evolve to meet client needs and to meet departmental requirements;
- An inability to co-fund;
- The capacity of Boards; and
- Workforce issues such as attracting volunteers and recruiting staff to remote locations.

The Productivity Commission proposed a regulatory and support framework for the NFP sector that could emerge if its suggested reforms are implemented and states that much of the framework already exists having been gradually developed by governments and the sector. Elements of the proposed framework include (among others)<sup>85</sup>:

- National Registrar for Community & Charitable Purpose Organisations & State/Territory regulators;
- Office for NFP Sector Engagement (in the Office of the Prime Minister & Cabinet);
- State/Territory agencies; and,
  - Government/sector compacts and protocols;
  - Workforce capabilities;
  - Community engagement and development strategies and initiatives such as:
    - Local infrastructure support hubs (resource centres involving local government to support small CMOs operating at the community level); and,
    - Social Intermediaries for CMO development in financial skills, business skills, governance & other training services.

## AUSTRALIAN STATE & TERRITORY SUPPORT FOR CMOs

### The NSW Government

The NSW Government sees CMO capacity building as a whole-of-government issue as evidenced by the following:

1. The **Working Together for NSW Agreement** (2006)<sup>86</sup> between the NSW Government and human service CMOs is based on the following principles: evidence-based approaches; outcomes; accountability; respect; communication; independence; and, inclusiveness.
2. The NSW Government states that the **NGO Support Stock-take** (2009)<sup>87</sup> reflects its responsibilities under the Working Together for NSW Agreement. The NGO Support Stock-take notes the NSW Government's commitment to: build and maintain relationships with CMOs; improve CMO service quality and community outcomes; streamline CMO funding and regulatory process; and, support the development of CMO organisational and workforce capacity
3. The **NSW State Plan 2009**<sup>88</sup> places emphasis on the requirement for the NSW Government to collaborate across all levels of government, business and non-government organisations.

**The Australian government has a national CMO sector reform group, and has proposed a national compact between itself and the CMO sector.**

The Productivity Commission has proposed a regulatory and support framework for the Australian CMO sector.

*Changes at a national level will impact on NSW mental health CMOs.*

### Examples of NSW Health's Support For and Engagement With the Community Managed Mental Health Sector

NSW Health has provided strong support for the CMO community managed mental health sector through funding initiatives such as:

- The **NGO Development Strategy 2004-2007** – focusing on Workforce Development, Quality and Outcomes and Partnerships initiatives).

<sup>83</sup> Productivity Commission (2009b) p13.4

<sup>84</sup> Productivity Commission (2009b) p13.9

<sup>85</sup> Productivity Commission (2009b) p XLIV

<sup>86</sup> NSW Department of Community Services and the Forum of Non-Government Agencies, (2006)

<sup>87</sup> NSW Department of Premier and Cabinet (2009)

<sup>88</sup> NSW Government (2009)

- Establishing the MHCC as a registered training organisation (RTO): **Learning and Development Unit 2007-2011** – workforce development and learning for community mental health, substance use and leadership/management development.
- **Infrastructure Grants Program 2007-2009** – two funding rounds for mental health CMOs to; develop facilities and operations; enhance corporate governance structures; strengthen management practices; and, modernise business operations and expertise<sup>89</sup>. This included the **Data Management Strategy** and the **Sector Mapping Project**.
- **Mental Health Drug and Alcohol Research Grants** - to strengthen the research and development base in partnership with NADA.
- **No Wrong Door: Mental Health Drug & Alcohol Change Management Project** – to strengthen organisational and workforce service delivery responses in partnership with NADA.
- **Mental Health Professional Development Scholarships Program 2009-2012** – including a stream to support development of the clinical workforce.
- The **NCOSS Management Support Unit**<sup>90</sup> which aims to develop the management capacity of NSW Health funded NGOs through developing resources, providing details on available training/courses and providing clients with information and referral on issues relevant to management and governance.
- The **NSW Mental Health Program Council**<sup>92</sup> which considers, provides advice to, and makes recommendations on a range of finance, activity and management issues and includes representation from the MHCC (the peak body representing mental health CMOs). The Council is complemented by other mechanisms for engagement with CMOs under major mental health strategies coordinated through the Mental Health Drug and Alcohol Office (MHDAO), including: Housing and Accommodation Support Initiative (HASI); The Family and Carer Program; The Resource and Recovery Program; and, the Aboriginal Mental Health and Wellbeing Reference Group.
- The **NSW NGO Health Program Review**<sup>93</sup> **discussion process** which follows the NSW Government's November 2008 mini-budget decision to reform grants to CMOs. The aim of the NSW NGO Health Program Review discussion process is to involve CMOs in planning "to develop the most efficient, effective and responsive NSW Health NGO Program practicable while at the same time meeting savings targets" <sup>94</sup>.

The NSW government sees CMO capacity building as a whole-of-government issue, with NSW Health demonstrating its commitment to engage with the CMO sector through a range of initiatives.

*Building on the investment made by NSW Health in the mental health CMO sector will enhance an efficient, robust and integrated mental health sector.*

NSW Health has demonstrated its commitment to engage with the CMO community managed mental health sector through initiatives such as:

- The **NSW Health NGO Advisory Committee**<sup>91</sup> which is a senior level forum encouraging collaboration between NSW Health and the non-government sector on the development and implementation of NSW Health policy, NSW Health's NGO Grant Program and the relationship with NSW Health funded NGOs. The Committee provides peak CMOs with opportunities to provide advice to NSW Health.

## Tasmania

Tasmania's *Office for the Community Sector* (OCS) was established in 2008 within the Department of Health and Human Services to develop and manage CMO sector service provision<sup>95</sup>. The OCS is responsible for<sup>96</sup>: providing strategic leadership in the development of the CMO sector; working across government and with CMO organisations to increase the effectiveness of Tasmania's CMO sector; developing policy, systems and processes to support the delivery of more effective CMO sector services; and, providing high level advice to government regarding CMO sector reform and the enhancement of services needed in the community.

## Victoria

Victoria's *Office for the Community Sector* (2008), established within the Department of Planning and Community Development<sup>97</sup> aims to strengthen government's support for community groups. The government's Action Plan for strengthening CMOs aims to simplify and streamline the government's interactions with CMOs and enable CMOs to invest in their own capabilities and long-term sustainability. The 25 actions in this Action Plan have the following themes<sup>98</sup>: reducing red tape; building CMO capacity; supporting innovation and growth; enhancing CMOs in local community life; engaging the CMO sector; and, coordinating efforts across government.

<sup>92</sup> NSW Department of Premier and Cabinet (2009)

<sup>93</sup> NSW Health Strategic Development Division Primary Health & Community Partnerships Branch(2009)

<sup>94</sup> NSW Health Strategic Development Division Primary Health & Community Partnerships Branch(2009)

<sup>95</sup> Strickland, M. & Goodes, K. (2008)

<sup>96</sup> Department of Health and Human Services (2009b)

<sup>97</sup> Department of Planning and Community Development (2009)

<sup>98</sup> Department of Planning and Community Development (2009)

<sup>89</sup> NSW Department of Premier and Cabinet (2009)

<sup>90</sup> NSW Department of Premier and Cabinet (2009)

<sup>91</sup> NSW Department of Premier and Cabinet (2009)

### Queensland

*The Queensland Compact: Towards a Fairer Queensland*<sup>99</sup> sets out expectations and commitments for the Queensland Government and the CMO community services sector to work together in a respectful, productive and forward-looking relationship that benefits the community. The Compact Governance Committee (which comprises five representatives from the CMO community services sector, five from government and an independent Chair) developed, and now oversees, the Compact Governance Committee Action Plan<sup>100</sup>.

The Queensland Government's *Department of Communities* has the *Strengthening Non-Government Organisations Initiative (2005)*<sup>101</sup> which consists of key initiatives undertaken collaboratively by the Queensland Government and the CMO and disability sectors. Overall, these initiatives are designed to<sup>102</sup>: clarify the government's expectations of funded CMOs; improve the government's systems for administering funding and other resources for community and disability services; ensure CMOs have organisational tools and resources to help them operate effectively; and, encourage sharing and collaboration between CMOs and stakeholders in the community and disability sectors.

McKinnon (2009)<sup>103</sup> notes that the Queensland Alliance (Queensland's peak organisation for the mental health community managed sector) recruited four sector development workers to support and build the capacity of mental health CMOs in rural and regional locations across the State.

### South Australia

South Australia's *Social Inclusion Board* (providing independent advice and leadership on social targets) and Commissioner for Social Inclusion (independent monitoring of implementation) are designed to achieve social targets quickly. These mechanisms stand outside government bureaucracy yet they deliver important reforms in social policy due to working relationships with all levels of community, business, non-government organisations, government departments, agencies and staff<sup>104</sup>. South Australia's Department of Families and Communities is enabling access to government contracts (such as fuel, motor vehicles, stationery and electricity) for eligible CMOs - such access contributes to CMO efficiency, and thereby sustainability<sup>105</sup>.

### Western Australia

In Western Australia, non-government organisations are clearly specified as being for-profit and not-for-profit. *The*

*Industry Plan for the Non-Government Human Services Sector*<sup>106</sup> developed by the Department of the Premier and Cabinet, focuses on the following areas:

- Government and non-government relations;
- The financial capacity and sustainability of non-government human services; and,
- The capacity of non-government organisations in relation to service delivery, policy, governance and human resource management.

A Mental Health Commission has been established. It will focus on mental health strategic policy, planning and procurement of services. The aim of such a commission is the increase accountability, coordination, and centralisation of stakeholder input.

Other initiatives in Western Australia include forums run by The Department of Child Protection to explore good practice, ways to increase service efficiency and ways to improve client outcomes. The Department of Housing funds CMOs for business improvement strategies, capacity building in indigenous CMO housing management and community housing.

### The Australian Capital Territory (ACT)

The Australian Capital Territory Government's *Social Policy and Implementation Branch* (part of the Chief Minister's Office) is responsible for providing strategic policy on current and emerging social policy issues and initiatives, providing whole of government advice on promoting improved social outcomes and undertaking research<sup>107</sup>. The Social Policy and Implementation Branch is the secretariat for the *ACT Community Inclusion Board* which states that governments have an enabling role in community inclusion. The role of government is to<sup>108</sup>:

- Set strategic policy frameworks to support community inclusion;
- Lead the whole of government approaches;
- Work in partnership with non-government partners; and,
- Support systems and structures that support community inclusion through planning and monitoring and streamlining processes and options for flexibility.

The *ACT Social Compact*<sup>109</sup> between the ACT government and the community managed sector expresses particular CMO capacity building elements through its statement that CMOs are most effective when the following are in place: strong leadership;

<sup>99</sup> Compact Governance Committee (2008)

<sup>100</sup> Queensland Government, Department of Communities (2009a)

<sup>101</sup> Productivity Commission (2009a) p13.9

<sup>102</sup> Queensland Government, Department of Communities (2009b)

<sup>103</sup> McKinnon, N (2009)

<sup>104</sup> South Australian Government (2009a)

<sup>105</sup> Productivity Commission (2009a) p13.9

<sup>106</sup> Industry Plan for the Non-Government Human Services Sector Working Party (2004)

<sup>107</sup> Chief Minister's Office, Australian Capital Territory Government (2009)

<sup>108</sup> Australian Capital Territory Government's Community Inclusion Board (2009)

<sup>109</sup> Australian Capital Territory Government (2004)

skilled and motivated people; good management; staff development; and, tapping into the collective community experience, knowledge, perspectives and strengths.

### The Northern Territory

In its *Framework for Health and Community Services*<sup>110</sup> the NT Government commits to collaborative, effective, practical, honest and open relationships which recognise different roles and histories of the partners, and a genuine desire to accept and learn from mistakes<sup>111</sup>.

### The Productivity Commission's Perspective on State/Territory Support for CMOs

The Productivity Commission<sup>112</sup> notes that while State and Territory governments provide considerable funding support to CMOs to develop their own capabilities that this support is provided on a piecemeal basis and there is no strategy for building up the supply of services to the sector. Further, the following is recommended<sup>113</sup>:

*"State and Territory governments should review their full range of support for sector development to reduce duplication, improve the effectiveness of such measures and strengthen strategic focus, including on:*

- *developing the sustainable use of intermediaries providing support services to the sector, including in information technology;*
- *improving knowledge of, and the capacity to meet, the governance requirements for not-for-profit organisations' Boards and management;*
- *building skills in evaluation and risk management, with a priority for those not-for-profit organisations engaged in delivery of government funded services".*

Each State/Territory government provides funds to strengthen CMOs, but support is provided on a piecemeal basis.

*A more strategic approach to CMO support is required.*

<sup>110</sup> Department of Health and Community Services (2004)

<sup>111</sup> Department of Health and Community Services (2004)

<sup>112</sup> Productivity Commission (2010)

<sup>113</sup> Productivity Commission (2010), recommendation 9.2, p237

# CAPACITY BUILDING

## WHAT IS CAPACITY BUILDING?

Capacity building, as it relates to CMOs, refers to activities that develop core organisational skills, processes and resources so that CMOs can effectively fulfil their missions<sup>114,115,116</sup> and serve their stakeholders more effectively. Core skills and processes include governance, leadership, management, professional expertise, finance and business skills, programs and evaluation<sup>117</sup>. Core resources include physical and financial assets and human resources<sup>118</sup>.

One of the most recent definitions of “capacity” provided by the United Kingdom is “a measure of an organisation’s capability and potential to apply appropriate skills and resources to accomplish its goals and satisfy its stakeholders’ expectations”<sup>119</sup>. According to the NSW Department of the Premier and Cabinet capacity building can be directed at developing:

- **Organisational capacity** – the ability to manage, govern and evaluate activities; and,
- **Capacity of the workforce** – needed to deliver the business of the organisation – the supply of appropriately skilled workers, their ongoing training, development and support to deliver against organisational responsibilities and strategies<sup>120</sup>

Social Ventures Australia (SVA) describes Strategic Capacity<sup>121</sup> and Operational Capacity<sup>122</sup>. The strategic capacity diagnostic<sup>123</sup> considers five dimensions: Mission; Understanding of Context; Assessment of Program and Capabilities; Goals and Strategic Alignment; and, Strategy Development. The operational capacity diagnostic<sup>124</sup> considers eight dimensions of operational performance: Programs and Activities; Leadership; Team; Board; Networks and Marketing; Funding and Business Model; Performance Management; and Systems and Infrastructure.

The Productivity Commission states that the capacity of CMOs to most efficiently and effectively provide services and improve the wellbeing of society is influenced by many linked factors, particularly<sup>125</sup>:

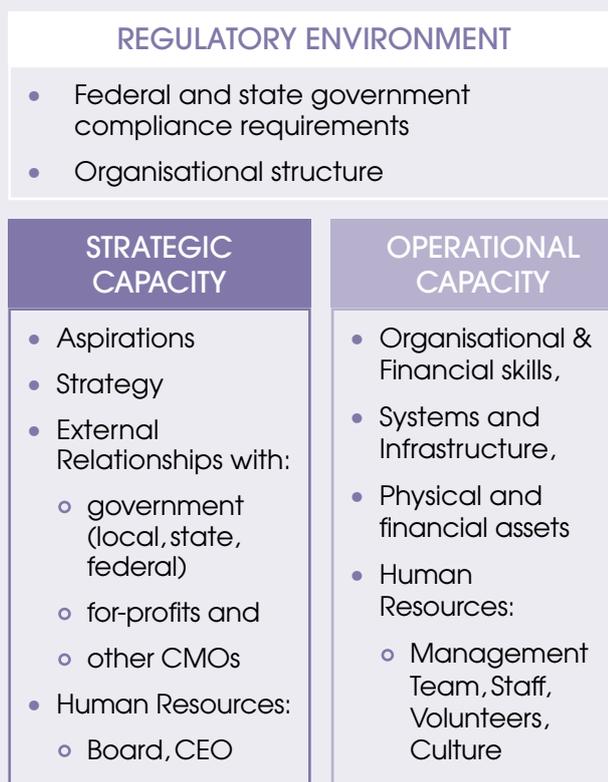
- Quantity and quality of the human and financial resources;
- Capacity to organise and use those resources to best effect; and

- The regulatory environment within which they operate.

Recognition of the regulatory environment is particularly important in this review - not only in relation to legal status of CMOs but also in relation to the requirements of NSW Health in its role as funder of many mental health CMOs. McKinsey’s (2001) approach to Non-Profit Capacity Assessment<sup>126</sup> considers seven capability elements in detail: Aspirations; Strategy; Organisational Skills; Human Resources; Systems and Infrastructure; Organisational Structure; and, Culture.

Drawing from the perspectives of NSW Health, Productivity Commission, NSW Department of the Premier and Cabinet, Social Ventures Australia, the UK National Audit Office and McKinsey this review considers that capacity building – for individual CMOs - includes regulatory, strategic and operational elements, as shown in Figure 4.

FIGURE 4 : CMO ORGANISATIONAL CAPACITY: REGULATORY, STRATEGIC AND OPERATIONAL ELEMENTS



114 McPhee, P. & Bare, J. (2001)

115 McPhee & Bare (2001)

116 NSW Department of Premier and Cabinet (2009)

117 Campobasso, L, & Davis, D. (2001)

118 Comptroller and Auditor General (2009)

119 Comptroller and Auditor General (2009)

120 NSW Department of Premier and Cabinet (2009)

121 Social Ventures Australia (2009a)

122 Social Ventures Australia (2009a)

123 Social Ventures Australia (2009b)

124 Social Ventures Australia (2009c)

125 Productivity Commission (2009a)

126 McKinsey & Company (2001)

## HOW DO WE BUILD CAPACITY?

CMOs can utilise independent assessors or engage in capacity assessments such as those provided by McKinsey<sup>127</sup> and Social Ventures Australia<sup>128</sup> to ascertain areas of particular need and develop strategies to meet those needs.

On a broader level, sector surveys may be used such as those used by the *NSW Mental Health CMO Sector Mapping Project* and the Productivity Commission. The Productivity Commission recently researched the Australian NFP sector. It is envisaged that implementation of recommendations arising from this research would strengthen the sector at a broad level. These recommendations include:

1. Smarter regulation of the not-for-profit sector;
2. Building knowledge systems;
3. Improving arrangements for effective sector development;
4. Stimulating social innovation;
5. Improving the effectiveness of direct government funding;
6. Removing impediments to better value government funded services; and,
7. Implementation of the proposed package of reforms.

Key CMO capacity building approaches in the UK and USA have been distilled by the Open University Foundation<sup>129</sup>: capacity grants; development partners; and, structured programs. The three key approaches and features of each support option are shown in Table 1.

TABLE 1. KEY FEATURES OF APPROACHES TO SUPPORTING CAPACITY BUILDING<sup>130</sup>

Support Option	Key features of support option
1. CAPACITY GRANT	<ul style="list-style-type: none"> <li>• CMOs define the project and apply for a grant</li> <li>• Funder reviews the project; decides if worthwhile</li> <li>• CMO selects consultant from the marketplace</li> <li>• Projects are generally short-term</li> </ul>
2. DEVELOPMENT PARTNER	<ul style="list-style-type: none"> <li>• Funder funds development partner (e.g. consulting firm) to provide capacity building service</li> <li>• CMOs referred to development partner by grant maker</li> <li>• Consultants :               <ol style="list-style-type: none"> <li>c) are involved in problem diagnosis</li> <li>d) can develop long-term relationship with grantees</li> <li>e) can provide ongoing coaching</li> <li>f) have incentives to focus on long-term improvement</li> </ol> </li> </ul>
3. STRUCTURED PROGRAMS	<ul style="list-style-type: none"> <li>• CMOs:               <ol style="list-style-type: none"> <li>a) are required to engage in specific 'educational' steps e.g. organisational assessment, setting performance goals, comprehensive planning</li> <li>b) receive long-term support e.g. consultancy, mentoring, coaching, incentives</li> <li>c) are helped to set long-term goals for change</li> <li>d) performance improvement monitored; continued support depends on progress towards goals</li> </ol> </li> </ul>

<sup>127</sup> McKinsey & Company (2001)

<sup>128</sup> Social Ventures Australia (2009a, 2009b, 2009c)

<sup>129</sup> Open University Business School (2008)

<sup>130</sup> Open University Business School (2008)

In the USA, *Grant Makers for Effective Organisations* suggest the following methods to support CMO effectiveness:<sup>131</sup> general operating support; fully loaded program support; grants for specific capacity-building activities<sup>132</sup> (*business planning, research/strategy, evaluation, financial systems improvements, board development, technology upgrades, collaboration/strategic restructuring, organisational assessment, leadership development*); direct assistance through staff or volunteers; grants to development organisations/ researchers/educators; capital financing (loans, grants).

The Canadian Mental Health Association has developed a range of tools and resources for CMO capacity building including<sup>133</sup>: Workshop: Role of the Board & CEO; Webinars & Resource Materials: Strategic Planning; CD & Handbook: Human Resources Policies & Procedures; On-Line Training for *Absenteeism, Accommodation, Role of the Board & CEO Relationship, Director's Legal Responsibilities and Liabilities, Conflict of Interest, Privacy Issues in Healthcare, Fiduciary Responsibility, Models of Governance, Board Succession Planning*.

CMOs have regulatory, strategic and operational capacity needs.

*Capacity grants, intermediaries and structured programs are used to strengthen organisational capacity.*

*Organisational capacity is one element of Sector Capacity.*

The Productivity Commission recommends that governments should consider supporting the development of intermediary services (equivalent to “development partners” described in Table 3) as part of their strategy for sector development.

Capacity building transcends individual CMOs to include groups of CMOs and the entire system in which groups operate and interact<sup>134</sup>. In this case, CMOs providing specialised mental health support can be supported to build capacity at a regional level<sup>135</sup> such as each NSW Health Area Health Service (AHS) or smaller areas such as those which align with the NSW Divisions of General Practice or local government boundaries. Although CMO capacity has been mentioned frequently in the literature the elements essential for strengthening the capacity of specific sectors are rarely mentioned. When capacity building support is designed and managed operation by operation it is difficult to capture cross-sector issues and to learn lessons across operations.

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**131** Enright, K.P. (2004)

**132** Enright, K.P. (2004)

**133** Canadian Mental Health Association (2009)

**134** Van Geene, J. (2003)

**135** Comptroller and Auditor General (2009)

## GOVERNMENT - CMO RELATIONSHIPS

### GOVERNMENT AS FUNDER AND CMO AS PROVIDER

As more programs are provided by CMOs, government funders such as NSW Health are driven to gain maximum benefit from the public dollar. More emphasis on efficiency has brought a process of rethinking and revision within which dialogue is riddled with complexity and simple solutions are not easy to see<sup>136</sup>.

Four broad challenges for government in ensuring social services are provided through contractual arrangements with CMOs are noted by Van Slyke (2006)<sup>137</sup> and include: range of CMO providers; government administrative capacity; ambiguous program requirements; and, impact on CMO governance practices. These need to be kept in mind when considering CMO "capacity building".

Kumar (2004)<sup>138</sup> describes the shift in the purpose of public administration from the original policy program to instruments through which public purposes are pursued. As government agencies focus more on funding and monitoring and deliver less services - which are in turn delivered by the community sector - a major fear by these government agencies is that control over service development and delivery is being abandoned. From the perspective of CMOs this division of roles leads to<sup>139</sup>:

- Expansion in the scope of services; and,
- Continuous seeking and securing of government funding opportunities.

Salamon (2002) in Kumar (2004)<sup>140</sup> provide a paradigm comparison showing the shift from traditional direct government to a contemporary more networked government which includes five key concepts (as shown in Table 2).

**TABLE 2: CLASSICAL AND NEW GOVERNANCE PARADIGMS**

Classical Public Administration	New Governance
Program/Agency	Tools
Hierarchy	Network
Public vs. Private	Public + Private
Command & Control	Negotiation & Persuasion
Management Skills	Enablement Skills

In the context of the classical public administration paradigm – which utilises traditional approaches to control the quality of service delivery and hold CMOs

accountable - people may understand accountability only as a way to establish whom to blame if something goes wrong. On this basis, traditional accountability practices may reflect and support an adversarial rather than a cooperative relationship, diverting attention from the public services that are the reason for the partnership<sup>141</sup>.

According to Young (2000), the community managed sector can be seen as supplementary, complementary, or adversarial to government<sup>142</sup>:

#### SUPPLEMENTARY VIEW:

- CMOs fulfil the demand for services left unsatisfied by government.
- CMO financing has an inverse relationship with government expenditure.
- As government takes more responsibility for provision, less needs to be raised through CMOs.

#### COMPLEMENTARY VIEW:

- CMOs are partners to government, helping to carry out the delivery of services largely financed by government.
- CMO and government expenditures have a direct relationship with one another.
- As government expenditures increase they help finance increasing levels of activity by CMOs.

#### ADVERSARIAL VIEW:

- CMOs prod government to make changes in public policy and to maintain accountability to the public.
- Government attempts to influence community organisations by regulating CMO services and responding to CMO advocacy initiatives.
- There is no specific relationship between the levels of CMO and governmental funding.

Henderson, Whitaker, and Altman-Sauer (2003) note that adversarial approaches to accountability inevitably lead to blame and punishment. An alternative is "mutual accountability" which encourages shared responsibility, shared learning and is likely to create more open communication. It includes processes which anticipate change and build strong relationships so that managing change becomes less stressful. Parties working towards mutual accountability will address four questions:

1. **Responsibility:** *Who is expected to carry out which actions for whom?;*
2. **Responsiveness:** *Who is expected or has the authority to invoke or alter mutual expectations, especially if circumstances do not work out as planned?;*

136 Kuhlmann, M.E. (2005)

137 Van Slyke, D.M. (2006)

138 Kumar, L (2004)

139 Trukeschitz, B. & Schneider, U. (2003) p1

140 Kumar (2004)

141 Henderson, M, Whitaker, GP & Altman-Sauer, L (2003)

142 Young, D (2000)

3. **Reporting:** *Who should provide what information to whom about how responsibilities are carried out?; and,*
4. **Reviewing:** *Who is expected to use what information to make decisions about the future of the relationship?*

In that context, community managed sector – government projects are effective when the following are present<sup>143</sup>:

- The focus is on one issue;
- Goals are clearly defined;
- Representatives of all the stakeholders are involved in the problem-solving process; and,
- Time and resources are available to support planning.

The Productivity Commission states that “*studies have shown that contracting practices are often poor and undermine efficient and effective service delivery*”<sup>144</sup>.

They propose that a common set of core principles should be developed to underpin all government contracts in human services which will result in better and fairer contracts. A set of common principles for government–CMO contracts is proposed and summarised by Sidoti et al (2009) in Box 2.

## BOX 2. COMMON PRINCIPLES FOR GOVERNMENT-CMO CONTRACTS (SIDOTI ET AL 2009, P2)

### FOUNDATIONS

- All parties should enter into the contract in *Good Faith*
- There is a presumption of *Good Will*

### THE RELATIONSHIP BETWEEN THE CONTRACTING PARTIES

- The relationship between the contracting parties is one of *Trust*
- The contracting parties will accord each other *Proper Respect*
- The relationship between the contracting parties is *Supportive and Collaborative*

### NATURE OF THE CONTRACT

- The contract should be *Clear and Readily Understood*
- The requirements in the contract should be guided by *Proportionality*
- The terms of the contract should be *Responsible and Reasonable*
- The contract should establish *Meaningful Outcomes*

### OPERATION OF THE CONTRACT

- The contract should allow for Decisions to be made at the *Appropriate Level*
- The contract should operate Consistent with the presumption of *Good Will and Trust*
- The contract should be based on *Full and Fair Costing*
- The contract should allow that Risk exists, cannot be eliminated and will be *Shared*
- The contract should be administered in a *Timely Manner*.

There has been a shift from traditional direct government to a contemporary, more networked government. Governments are focusing more on funding & monitoring, and deliver fewer services (which are in turn delivered by CMOs). The contractual relationship embodies particular areas of the government–CMO relationship. When contracting practices are poor they undermine efficient and effective service delivery.

*A common set of core principles should be developed to underpin all government contracts in human services.*

Sidoti et al (2009)<sup>145</sup> state that in Australia, there have been dramatic changes to the relationship between CMOs and governments which have been driven by factors such as: the change of federal government; mounting evidence on the limitations and inadequacies of the forms of public administration that dominated reforms over the past 20 years; the return of government intervention during the global financial crisis; and, some high-profile, for-profit providers of government-funded human services collapsing. Further, it is the contractual relationship that embodies particular areas of the government–CMO relationship including<sup>146</sup>:

*“... the need for clarity of purpose and agreement on that purpose; confusion over just where the beneficiaries ‘fit’ in the human services systems (for example, is government the purchaser in its own right or as agent of the beneficiaries?); recognising and managing the power imbalance that exists; balancing important tensions such as those between competition and co-operation, or between control and accountability; and appropriately sharing risk”.*

143 Altman-Sauer, L, Henderson, M & Whitaker, GP. (2001)

144 Productivity Commission (2010, pLXI)

145 Sidoti, Banks, Darcy, O’Shea, Leonard, Atie, Di Nicola, Stevenson & Moor (2009)

146 Sidoti et al (2009), page 1

### Government-CMO Role Delineations

Clear role delineations between governments and CMOs are likely to assist in an understanding of expectations of each other thus facilitating smoother interactions.

Role differentiations between CMOs and government are mentioned by the South Australian, Tasmanian and Victorian governments. South Australia's Common Ground is a partnership between three stakeholders aiming to improve health and wellbeing: the Department of Health; the Department for Families and Communities; and the community managed sector<sup>147</sup>. Common Ground acknowledges responsibilities for each partner as shown in Table 3.

TABLE 3: COMMON GROUND – RESPONSIBILITIES OF EACH PARTNER<sup>148</sup>

Partner	Responsibility
<b>GOVERNMENT</b> <ul style="list-style-type: none"> <li>• Dept of Health and/or</li> <li>• Dept for Families &amp; Communities</li> </ul>	<ul style="list-style-type: none"> <li>• The administration and operations of public health services, hospitals, housing, community services, disability services and services for the ageing.</li> <li>• Advise their Ministers, and through them the Government, on policy and planning,</li> <li>• The allocation and expenditure of government funds.</li> </ul>
<b>CMOs</b> <ul style="list-style-type: none"> <li>• That deliver services to many different consumer groups</li> <li>• Peak bodies</li> </ul>	<ul style="list-style-type: none"> <li>• Developing policies and programs that benefit South Australians.</li> <li>• Contributing varying degrees of funds, voluntary effort, infrastructure, expertise and networks.</li> <li>• Drawing on the voluntary contribution of community members and experts.</li> <li>• Advancing the interests of the community.</li> <li>• Developing networks of policy expertise that bring together unions, consumers, academics and community groups.</li> </ul>

Another example of clarity between governments and CMOs is provided in Table 4<sup>149</sup>, in which the roles planned for the Scottish Government, Local Government, the Scotland National Health Service and the Non-Profit sector are shown.

TABLE 4. KEY ROLES OF GOVERNMENT AND CMOs IN MENTAL HEALTH IMPROVEMENT

<b>SCOTTISH GOVERNMENT</b> Sets direction, policy, broad policy outcomes.	<ul style="list-style-type: none"> <li>• Give national leadership to the mental health improvement agenda and foster a culture which encourages mental health improvement.</li> <li>• Set, in partnership with others, the strategic framework for action and national priorities.</li> <li>• Support delivery organisations to develop and implement interventions and approaches.</li> <li>• Take forward wider policies that will contribute towards mental health improvement goals.</li> </ul>
<b>LOCAL GOVERNMENT</b> Development & delivery of local services in collaboration with Community Planning Partnerships.	<ul style="list-style-type: none"> <li>• Give local leadership to the mental health improvement agenda.</li> <li>• Develop, with Community Planning Partners and Community Health Partnerships, local plans for delivery.</li> <li>• Develop and implement local interventions and approaches.</li> <li>• Embed mental health improvement approaches into other services, building on the learning from implementing the Mental Health (Scotland) Act 2003.</li> </ul>

147 South Australian Government (2009b)

148 South Australian Government (2009b)

149 Donnelly, R.R. (2009)

<p><b>NHS SCOTLAND</b></p> <p>Has a lead role in health improvement.</p>	<ul style="list-style-type: none"> <li>• To provide national support and leadership for the delivery of mental health improvement.</li> <li>• Through local NHS Boards to support and deliver local plans for delivering mental health improvement in conjunction with Community Planning Partnerships and Community Health Partnerships.</li> <li>• To embed mental health improvement into all NHS activity, but in particular in respect of those who are at risk of developing mental health problems as a result of substance misuse or other lifestyle issue, and those experiencing mental illness.</li> </ul>
<p><b>COMMUNITY SECTOR</b></p> <p>Significantly contributes to the national &amp; local mental health improvement agenda.</p>	<ul style="list-style-type: none"> <li>• Deliver services which directly or indirectly promote mental health improvement.</li> <li>• Innovate in the development of new service approaches and interventions.</li> <li>• Act as a catalyst in promoting active citizenship and social capital to develop community capacity.</li> <li>• Advocate change &amp; improvement for service users &amp; the general population.</li> </ul>

In Tasmania, mental health services delivered by the Tasmanian Government are listed on the Department of Health & Human Services website<sup>150</sup> as are services delivered by CMOs (Residential Rehabilitation Services, Community Based Recovery and Rehabilitation Programs, Peer Support Groups, Advocacy, Peak Bodies, Support for Children, Carers and Family).

There are very few explicit statements clarifying the roles of CMOs and governments in mental health support.

*Develop clarity regarding the roles of NSW mental health CMOs and governments in funding and providing mental health support.*

The Victorian Department of Health distinguishes between “Clinical” and “Psychiatric Disability Rehabilitation and Support Services” (PDRSS)<sup>151</sup>. Clinical mental health services are managed by public hospitals and provide assessment, diagnosis, treatment and clinical case management to people with a serious mental illness. PDRSS (also referred to as “non-clinical specialist mental health services”) are provided by CMOs. According to the Victorian Department of Health specialist mental health services provided by CMOs include:<sup>152</sup> Psychosocial Rehabilitation (Day Programs and Home Based Outreach); Residential Rehabilitation; Planned Respite; Mutual Support and Self Help.

## NSW HEALTH AS FUNDER/PROVIDER AND CMOs AS PROVIDERS: The Challenge of Collaborative Care

According to NSW Health:

- CMOs “often provide services to people with high needs ... challenging behaviours ... hard to reach ... resource intensive and challenging to engage”<sup>153</sup>;
- Core community managed mental health services include: social and leisure programs; self-help and peer support programs; accommodation support initiatives; disability and employment support; promotion and prevention; and, family & carer mental health programs<sup>154</sup>.

150 Department of Health and Human Services (2009a)

151 Victorian Government (2005)

152 Victorian Government (2005)

153 NSW Health Strategic Development Division Primary Health & Community Partnerships Branch(2009) p 21

154 NSW: A New Direction for Mental Health (2006)

A source of tension between government as provider and CMO as provider is an unrecognised difference in teamwork expectations when cross-sector collaboration is required to plan and coordinate person-centred supports.

It is current practice to engage many health professionals working toward a solution in multidisciplinary teams, particularly in the support of people whose needs are complex.

According to NSW Health, *“a multidisciplinary team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care”*<sup>155</sup> and includes *“General practitioners; Practice nurses; Community health nurses; Allied health professionals (may be a mix of state funded community health and private professionals) such as physiotherapists, occupational therapists, dieticians, psychologists, social workers, podiatrists; Aboriginal Health Workers; and Health educators - such as diabetes educators”*.

The terms “multidisciplinary”, “interdisciplinary” and “transdisciplinary” are often used interchangeably causing confusion for those participating in collaborative integrated approaches to client support yet each of these descriptive categories represents different attributes and functions expected from a working team<sup>156</sup>.

Definitions of unidisciplinary, multidisciplinary, interdisciplinary and transdisciplinary as they relate to team models in health care are described by Kuhlmann (2005)<sup>157</sup> and Dyer (2003)<sup>158</sup>:

#### UNIDISCIPLINARY

- Dominated by professional independence and rigid professional boundaries which often preclude collaboration.
- Based on the notion that a single provider could diagnose and treat a medical problem.

#### MULTIDISCIPLINARY

- Multidisciplinary team members function as independent specialists who provide individual consultation and communicate to varying degrees with each other.
- The team has a “gatekeeper” member who determines which other disciplines are invited to participate in an independent, discipline-specific team that conducts separate assessment, planning, and provision of services.
- Each discipline submits findings and recommendations, sets unique discipline-specific goals, works within discipline-specific parameters to achieve these goals independently and attains discipline-specific goals which are directly or indirectly communicated to the rest of the team<sup>159</sup>.

According to Kuhlmann (2005), *“the multidisciplinary model has been shown to be suboptimal in dealing with complex medical problems ... clients may experience care in this model as fragmented at best”*.

#### INTERDISCIPLINARY:

- Characterised by increased professional communication, cooperation, and cohesion of approach.
- Goals are selected by individual team members, the interdisciplinary team meets regularly to exchange information and discuss goals.
- Establishing collaborative team goals produces a collaborative service plan.

In this model, team members are involved in problem-solving beyond the confines of their discipline. The interdisciplinary model streamlines the approach to client-centred support, but communication and social problems still exist, in the form of compartmentalization of services, professional protectionism and perceived status differences.

#### TRANSDISCIPLINARY:

- Values the knowledge and skill of team members.
- Is dependent on effective and frequent communication among members.
- Promotes efficiency in the delivery services.

Members of the transdisciplinary team share knowledge, skills, and responsibilities across traditional disciplinary boundaries in assessment and service planning<sup>160</sup>. Transdisciplinary teamwork implies cross-training and flexibility in accomplishing tasks; is based on free-flowing communication, and the transfer of knowledge and skills across discipline boundaries in the service of a common, client-centred goal; and is informed by a broader philosophy of care, in which the client’s goals are the focal point, and the team shares responsibility for client-centring, problem-solving and goal-setting. *“The transdisciplinary frame of unity replaces professional protectionism with collaborative communication, professional status differences with parity, and compartmentalization of services with holism”*<sup>161</sup>.

CMO providers may be approaching coordination of client supports from interdisciplinary or transdisciplinary frameworks, and NSW Health-as-provider uses a multidisciplinary framework, providing potential challenges for collaboration.

*Joint education for CMO and NSW Health employees in contemporary approaches to teamwork should be considered.*

155 NSW Health (2009)

156 Dyer, J.A. (2003)

157 Kuhlmann (2005)

158 Dyer (2003)

159 Dyer (2003)

160 Dyer (2003)

161 Kuhlmann (2005)

Although there are some commonalities between the transdisciplinary and interdisciplinary approaches, there are important differences in philosophy and practice, particularly with regard to problem-solving. The key difference lies in the transdisciplinary team’s ability to address case complexity within a frame of unity<sup>162</sup>.

Unique features of transdisciplinary teams include:

- Collaborative power sharing through role release and problem-solving;
- Close collaboration among team members;
- Comfortable sharing of expertise; and,
- Permeability of professional boundaries.

Kuhlmann (2005) suggests that in addition to a well-developed base of professional knowledge the transdisciplinary model requires superior communication skills including communication practices that promote trust and interdependence. In learning the cognitive maps of other disciplines to create shared meanings and goals, team members cross disciplinary boundaries. This process requires a commitment to collaborate by both individuals and the transdisciplinary team as a whole.

In NSW organisations are using multidisciplinary, interdisciplinary and transdisciplinary approaches to client-centred support. For example, a recent NSW Health job advertisement for a Mental Health Registered Nurse/Case Manager<sup>163</sup> for Community Mental Health had in its position summary “*Work as a case manager in a multidisciplinary mental health team*”. However, CMOs are beginning to speak about transdisciplinary teamwork in their job advertisements and position descriptions<sup>164</sup>.

If CMOs are providing services from an interdisciplinary or transdisciplinary framework and NSW Health a multidisciplinary framework, and each is not aware of the other’s perspective, then there is a huge challenge for collaboration in providing effective client programs. This is a key issue which must be considered in capacity building activity.

Hunter New England Area Health Service (HNEAHS) has developed, in the form of a working paper to be evaluated, “*NHEMH Clinical & NGO Non-clinical Roles: A Guide for Working Together to More Efficiently and Effectively Coordinate Care for Consumers*” (2009). The document was developed by CMO and HNEMH staff coming together through a series of workshops over three years.

Eleven issues are considered with the roles and expectations shown as “clinical/HNEAHS staff”, “NGO staff” and “shared”. For example, “*Exit/Transitioning from Hospital*” has the roles and expectations shown in Table 5. The delineations in this particular document

have not yet been validated. It may be worthwhile developing an expansive role delineation framework which incorporates day-to-day working expectations and risk management protocols around critical incident prevention, management and adaptation/recovery. The framework would be piloted and thoroughly evaluated prior to broad usage and may include provision for local variations.

TABLE 5: HNEAHS DELINEATION OF ROLES AND EXPECTATIONS FOR “EXIT/TRANSITION FROM HOSPITAL”

Clinical	
<ul style="list-style-type: none"> <li>• Assess consumers’ readiness for return to community and inform CMO of impending discharge</li> <li>• Facilitate involvement in ward rounds or case conference as appropriate</li> </ul>	
<ul style="list-style-type: none"> <li>• Ensure medication compliance of consumer</li> <li>• Ensure legal requirements are met</li> <li>• Liaise with stakeholders on discharge:                             <ul style="list-style-type: none"> <li>◦ Consumer’s GP, Mental Health Medical Officer, Family/carer, CMOs</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Coordinate discharge transition plan to either:                             <ul style="list-style-type: none"> <li>◦ Community Mental Health Service</li> <li>◦ Psychiatry Rehabilitation Service</li> </ul> </li> <li>• Consult NGOs regarding discharge plan</li> <li>• Follow up on discharge report in a timely manner</li> </ul>
Shared	
<ul style="list-style-type: none"> <li>• Develop a coordinated discharge plan</li> <li>• Provide support to family/carer</li> <li>• Liaise with inpatient staff</li> </ul>	<ul style="list-style-type: none"> <li>• Liaise with consumer’s General Practitioner</li> <li>• Ensure availability of medication</li> </ul>
NGO	
<ul style="list-style-type: none"> <li>• Visit consumer as appropriate</li> <li>• Participate in joint reviews</li> <li>• Advocate on behalf of consumer and family/carer</li> <li>• Refer family/carer to support services as required</li> </ul>	<ul style="list-style-type: none"> <li>• Upon invitation, attend ward rounds and/or case conferences</li> <li>• Provide consumer with transport home and assist in the set-up of home if necessary (e.g. domestic organisation, food available)</li> <li>• Provide consumer and family/carer with support</li> </ul>

<sup>162</sup> Kuhlmann (2005)  
<sup>163</sup> NSW Health (2009b)  
<sup>164</sup> LifeStart (2009)

## THE COMMUNITY MENTAL HEALTH SECTOR

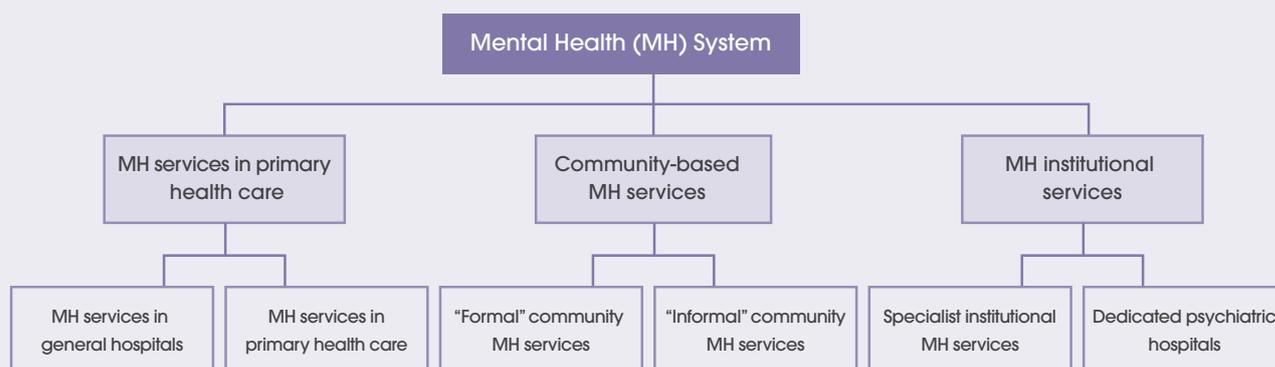
### THE WORLD HEALTH ORGANISATION MODEL FOR MENTAL HEALTH SYSTEMS

The World Health Organisation (WHO) provides a schematic representation typical of components of mental health systems across the world<sup>165</sup> and provides a context for community mental health services. The community mental health sector is described by WHO as having “formal” and “informal” mental health services<sup>166</sup> as shown in Figure 5.

The WHO model for mental health services promotes the involvement of individuals in their own mental health care, a community-based orientation, a human rights focus and embraces the following principles<sup>167</sup>:

- No single service setting can meet all population mental health needs;
- Essential components of any mental health system include: support, supervision, collaboration, information-sharing and education across different levels of support; and,
- Individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery.

FIGURE 5: COMPONENTS OF THE MENTAL HEALTH SYSTEM (WHO, 2003)<sup>168</sup>



An Optimal Mix of Services Pyramid was developed by WHO<sup>169</sup> in 2007 and indicates that: psychiatric hospitals should be the least frequently utilised service type in the mental health system; psychiatric services based in general hospitals and specialist community mental health services should be available; primary health care is an essential component supporting mental health; and, informal community mental health services provide broad based, general support.

### THE WORLD HEALTH ORGANISATION MODEL FOR COMMUNITY MENTAL HEALTH SERVICES

Figure 6 shows an extraction of the community mental health services components of the Optimal Mix of Services Pyramid which was elaborated by WHO and the World Organization of Family Doctors (WONCA) in 2008. The model indicates that “informal” mental health services (comprising “informal community care” and “self-care”) should be the most frequently used mental health support followed by mental health services through primary care and then “formal community mental health services”.

<sup>165</sup> World Health Organization (2003)

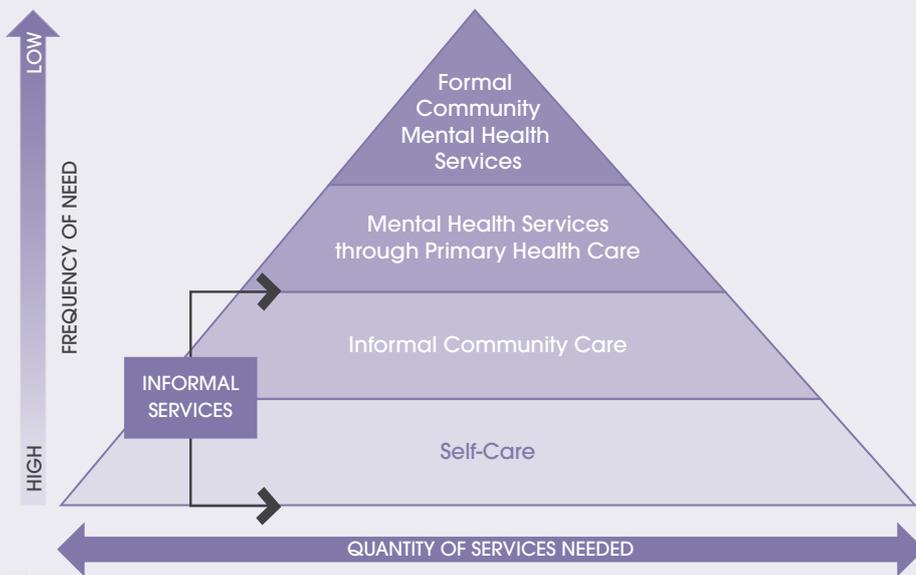
<sup>166</sup> World Health Organization (2003)

<sup>167</sup> World Health Organization WHO & World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians WONCA (2008)

<sup>168</sup> World Health Organization (2003)

<sup>169</sup> World Health Organization (2007)

FIGURE 6: COMMUNITY MENTAL HEALTH COMPONENT OF WHO (2008) OPTIMAL MIX OF SERVICES PYRAMID<sup>170</sup>



### Formal Community Mental Health Services

Formal community mental health services are specialised mental health services based in community settings<sup>171</sup> with programs delivered by a trained workforce<sup>172</sup>. In NSW, community-based specialised mental health programs delivered by a trained workforce include: Mobile Crisis Teams; Home-based Outreach Support; Accommodation Support & Outreach; Employment & Supported Employment; Vocational, Education, Social Inclusion and Leisure Programs (centre-based and in-situ); Counselling; Policy; Advocacy; Family and Carer Support programs; Help lines, Information Services & Websites.

### Mental Health Services through Primary Health Care

Primary mental health care services are first line interventions provided as an integral part of general health care<sup>173</sup>. In Australia most primary health care is provided in general practice and through various Commonwealth and State funded programs involving public mental health services, private allied health practitioners and telephone and online based services.

### Informal Services

**Informal community care:** includes supports provided by local community members who may have little or no formal mental health training<sup>174</sup>. Informal supports are not part of the formal health and welfare system and are provided in the community<sup>175</sup>. In NSW, examples could include: self-help & mutual support groups; peer support programs; consumer network groups; professionals in

other sectors such as teachers, police and local health workers; mainstream CMOs; and, family associations.

**Self-Care:** is self-management of mental health, with support from family or friends<sup>176</sup>. It is the foundation of the WHO service pyramid, upon which all other support is based, emphasising people’s active roles in their own mental health care.

**World Health Organisation model for mental health systems**

- No single service setting can meet all population mental health needs;
- Support, supervision, collaboration, information-sharing and education are essential components of any mental health system
- Individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery

*Ensure the NSW community managed mental health sector incorporates these underpinning three principles.*

### Recovery

The term ‘recovery’ has many different meanings. In the mental health sector it could be interpreted as being either “recovery from” or “recovery in” the experience of mental illness<sup>177</sup>. The *US Consensus Statement* defines recovery, along with its fundamental components as shown in Box 3.

170 WHO & WONCA (2008)  
 171 WHO & WONCA (2008)  
 172 World Health Organization (2003)  
 173 WHO & WONCA (2008)  
 174 World Health Organisation (2003)  
 175 WHO & WONCA, (2008)

176 WHO & WONCA, (2008)  
 177 MHCC (2008)

## BOX 3: FUNDAMENTAL COMPONENTS OF RECOVERY (SAMSHA, 2004)

*“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential”*

<p><b>Self-Direction:</b> Consumers lead, control, exercise choice over, and determine their own path of recovery by optimising autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.</p>	<p><b>Strengths-Based:</b> Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.</p>
<p><b>Individualised and Person-Centred:</b> There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.</p>	<p><b>Peer Support:</b> Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.</p>
<p><b>Empowerment:</b> Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.</p>	<p><b>Respect:</b> Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.</p>
<p><b>Holistic:</b> Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.</p>	<p><b>Responsibility:</b> Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.</p>
<p><b>Non-Linear:</b> Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognises that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.</p>	<p><b>Hope:</b> Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.</p>

According to Slade (2009), in the *Personal Recovery Framework* the person experiences recovery through undertaking recovery tasks such as: developing a positive identity outside of being a person with a mental illness; developing a personally satisfactory meaning to frame the experience which professionals would understand as mental illness; taking personal responsibility through self-management; and, acquiring previous, modified or new valued social roles.

A view emerging from people who use mental health services is that *"the mental health system is commandeering the user-developed concept of recovery: incorporating the term without undergoing the fundamental transformation it requires"*<sup>178</sup>. MHCC<sup>179</sup> states that it is essential to ensure that services are practically, rather than just philosophically, recovery-oriented. Further, *... a positive culture that reflects and demonstrates the principles of recovery means individuals will feel supported as they attempt to develop new meaning and purpose as they move beyond the effects of mental health problems"* (MHCC, 2008).

Recovery-focused support attempts to change the service provision for people experiencing mental illness from a system focused on force, coercion, institutionalisation and maintenance to a system which is innovative and life-enhancing, focusing on life transformation<sup>180</sup>. This view is supported by Slade (2009), who holds that mental health professionals should be oriented around the following recovery support tasks: fostering relationships, promoting well-being, offering treatments and improving social inclusion.

### Evidence-Based Practices

Evidence-based practices (EBPs) are *"... programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence and the values of the persons receiving the services. These programs or practices will have consistent scientific evidence showing improved outcomes for clients, participants or communities. EBPs may include individual clinical interventions, population-based interventions, or administrative and system-level practices or programs"*<sup>181</sup>.

It has been proposed that mental health service authorities and providers should be held accountable for providing supports consistent with EBPs<sup>182</sup> as the efficacy of a wide range of mental health programs is supported by a substantial body of outcomes research. A wide array of effective supports should be available within a community because, even when supports are equally effective on average, many of them are not

equally effective for each individual at different phases of the journey towards wellbeing.

The United States Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA)<sup>183</sup> has developed the National Registry of Evidence-based Programs and Practices (NREPP). The NREPP provides an online searchable database providing a range of objective information about research conducted on particular interventions. If, for example, a person wants to access a program which is run by people who have experienced similar challenges then a search of "consumer/family operated care" results in a list of programs with that criterion along with information about each program such as: study populations; settings; implementation history; replications; adaptations; adverse effects; domain (public or proprietary); costs; outcomes; ratings of individual outcomes targeted by the intervention; and, readiness for dissemination (availability and quality of training, implementation materials and quality assurance).

Evidence has been established in the following areas and SAMHSA has developed EBP "toolkits" to assist in implementing evidence-based supports<sup>184</sup>:

- **Illness Management and Recovery** (including medication) which emphasises helping people to set and pursue personal goals and to implement action strategies in their everyday lives.
- **Assertive Community Treatment** which aims to help people stay out of the hospital and to develop skills for living in the community so that their mental illness is not the driving force in their lives.
- **Family Psychoeducation** which involves a partnership among consumers, families and supporters, and practitioners to enable families and supporters to help consumers in their recovery.
- **Supported Employment** which is a well-defined approach to support people with mental illness find and keep competitive employment within their communities.
- **Integrated Treatment for Co-Occurring Disorders** which supports people to recover when they are experiencing both mental illness and a substance abuse addiction, by offering both mental health and substance abuse services at the same time and in a single setting.

There is also rapidly emerging evidence and plans for toolkit development for<sup>185</sup>:

- Supported Accommodation;
- Consumer-Operated Services;

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178 Slade (2009, p367)

179 MHCC (2008)

180 Sterling, von Esenwein, Tucker, Fricks & Druss (2009).

181 Oregon Addictions and Mental Health Division (2007)

182 Lehman, Goldman, Dixon & Churchill (2004)

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183 Substance Abuse and Mental Health Services Administration (2007)

184 Substance Abuse and Mental Health Services Administration (2010)

185 Substance Abuse and Mental Health Services Administration (2010)

- Treatment of Depression in Older Adults;
- Supported Education; and,
- Promotion and prevention.

In the USA, those who want to find information about programs using EBPs in their local area can do so via the internet. For example, in Oregon easy access to information about mental health support services is provided via an online State map which enables users to click on their county to find EBP providers in their local area. A full list of approved practices is also provided.

NSW Health's approach to EBP is outlined in NSW: A New Direction for Mental Health (2006) whereby EBPs are considered to be "... interventions for which there is consistent scientific evidence showing that they improve client outcomes ... all mental health interventions used in community mental health services and models of care implemented under the Strategy are based on the latest Australian and international evidence. Research indicates that community care clearly works but only where it has been implemented in accordance with the evidence."

Barriers preventing use of EBPs in CMOs include<sup>186</sup>:

- Disagreement over what constitutes EBPs;
- Lack of consistent guidelines for selection and implementation of relevant practices;
- Lack of knowledge about the conditions of practice in the community setting;
- Lack of communication between practitioners and researchers;
- Insufficient funds and resources;
- Practitioner burn-out and lack of motivation;
- Professional development issues and inadequately trained staff;
- Organisational barriers to adopting new practices; and,
- Poor fit between organisational values and the new technology.

## CORE SERVICE AREAS FOR THE NSW MENTAL HEALTH CMO SECTOR

There have been calls for a more strategic approach to mental health service delivery whereby individual countries define 'core' mental health services and set evidence-based, country-specific resource targets related to these<sup>187</sup>. In *NSW: A New Direction for Mental Health* (2006) it is clearly stated that the aim is to develop "Specialist Community Mental Health Services" - delivered across public mental health and specialist mental health NGO sectors - which comprise:

**Core programs** for people of all ages, across all service settings including:

- Mental health promotion, prevention and early intervention programs
- Consumer, family and carer participation strategies
- The Family and Carer Mental Health Program
- Specific strategies and programs for Aboriginal and Torres Strait Islanders, people from CALD backgrounds, and people from rural and remote communities

**Core services** for people of all ages, across all service settings including:

- Emergency response and acute care services
- Rehabilitation services
- Forensic mental health services

**Specialist community services** for particular age groups:

- Children
- Adolescents and youth
- Adults
- Older people

NSW Health<sup>188</sup> indicates that they are the provider, rather than the funder, of emergency and acute psychiatric supports and that CMOs may be funded to operate programs in service areas such as: social and leisure; self-help and peer support; accommodation support; disability and employment support; mental health promotion, prevention and early intervention; family & carers; consumer participation; and, people from rural and remote communities.

This review proposes that government funded core service areas for CMOs include:

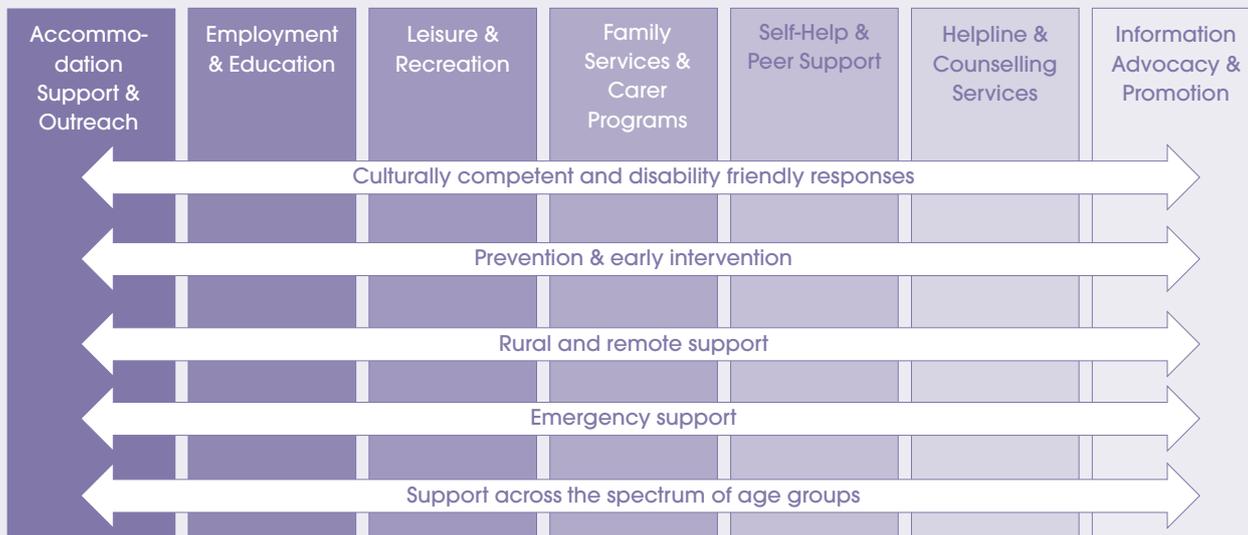
- Accommodation Support & Outreach;
- Employment & Education;
- Leisure & Recreation;
- Family Services & Carer Programs;
- Self-help & Peer Support;
- Helpline & Counselling Services;
- Information, Advocacy & Promotion.

<sup>186</sup> Franklin & Hopson (2007)

<sup>187</sup> Pirkis, Harris, Buckingham, Whiteford & Townsend-White (2007)

<sup>188</sup> NSW Health (2006)

FIGURE 7: CORE SERVICE AREAS FOR NSW GOVERNMENT FUNDED CMOs



As shown in Figure 7 all core service areas will incorporate:

- Culturally competent and disability friendly responses;
- Prevention & early intervention;
- Rural and remote support;
- Emergency support; and,
- Support across the spectrum of age groups.

The Australian Healthcare and Hospitals Association (AHHA)<sup>189</sup> proposes EBPs relevant to the proposed CMO core service areas as shown in Table 6:

189 AHHA (2008)

**TABLE 6: AHHA EVIDENCE-BASED PRACTICES AND STRUCTURES RELATED TO THE 7 CORE SERVICE AREAS**

Core Service Area	Evidence-based (or promising) Supports
<b>Accommodation Support &amp; Outreach</b>	<ul style="list-style-type: none"> <li>• Living in your own home wherever possible</li> <li>• A range of different levels of supervision in residential settings such as:               <ul style="list-style-type: none"> <li>• Support in your own home</li> <li>• 24 hour supervised community residential care plus medium to long-term residential cluster home scheme</li> <li>• Medium to long-term community homes with partial supervision</li> <li>• 24 hour supervised community-based residential respite facility, as an alternative to hospital admission, plus step up and down care</li> </ul> </li> </ul>
<b>Employment &amp; Education</b>	<ul style="list-style-type: none"> <li>• Expert vocational rehabilitation counsellors operating individual placement</li> <li>• Coping, resilience, buoyancy, work/life balance, hope instilling skills training</li> </ul>
<b>Leisure &amp; Recreation</b>	<ul style="list-style-type: none"> <li>• Leisure/recreation/aerobic physical activity programs</li> </ul>
<b>Family Support &amp; Carers</b>	<ul style="list-style-type: none"> <li>• Family education, support, communication &amp; problem-solving skills including surrogates, confidantes and support persons conducted by teams which can systematically provide staff to work with families out of office hours</li> </ul>
<b>Self-help &amp; Peer Support</b>	<ul style="list-style-type: none"> <li>• Consumer peer support specialists               <ul style="list-style-type: none"> <li>• certified training</li> <li>• placement in clinical teams</li> </ul> </li> <li>• Consumer choices take precedence, where possible, in developing own individual plan</li> </ul>
<b>Helpline &amp; Counselling Services</b>	<ul style="list-style-type: none"> <li>• Telephone help lines</li> <li>• Delivery and supervision network plus monitoring for fidelity of:               <ul style="list-style-type: none"> <li>• Cognitive behaviour therapy</li> <li>• Interpersonal therapy</li> <li>• Dialectical behaviour therapy</li> <li>• Neurocognitive remediation</li> <li>• Supportive psychotherapy</li> </ul> </li> <li>• Financial counselling service</li> </ul>
<b>Information, Advocacy &amp; Promotion</b>	<ul style="list-style-type: none"> <li>• Proactive approach to prevention, early detection and intervention seeking:               <ul style="list-style-type: none"> <li>• Mental Health First Aid Course</li> <li>• Web-based mental health information</li> <li>• Community awareness &amp; education</li> <li>• Challenging stigma and discrimination</li> </ul> </li> </ul>

## THE COMMUNITY MANAGED MENTAL HEALTH SECTOR

*"... match support to a person's needs ..."*  
 Australian Fourth National Mental Health Plan  
 (2009, p29)

The Mental Health Council of Australia found that: the community managed sector plays a vital role in community mental health services; CMOs cannot provide community support alone; and, that no one single model of community mental health support can meet all population needs<sup>190</sup>. This resonates with the WHO's principles for mental health systems.

### FOURTH NATIONAL MENTAL HEALTH PLAN

We need to "match support to a person's needs" - a clear, meaningful statement made in the Fourth National Mental Health Plan<sup>191</sup>. The ability to ascertain what people need and work together to bring the type, amount and quality of support needed is indicative of a healthy community mental health sector.

The Fourth National Mental Health Plan has commitment by all Australian State/Territory governments to implementation of the following vision for mental health:

*"... a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community."*

*Government funded NSW mental health core CMO service areas:*

- Accommodation Support & Outreach;
- Employment & Education;
- Leisure & Recreation
- Family Support & Carer Programs;
- Self-help & Peer Support;
- Helpline & Counselling Services; and,
- Information, Advocacy & Promotion.

*All NSW mental health core CMO service areas will incorporate:*

- Culturally competent and disability friendly responses;
- Prevention & early intervention;
- Rural and remote support;
- Emergency support; and,
- Support across the spectrum of age groups.

The Plan adopts a *population health framework* which recognises: contributors to mental health and illness; the nature of supports; developing support services, proposing that service development should strive to ensure equitable access, and achieve the best possible outcome.

Implementation of the National Health and Hospitals Reform Commission recommendations and the Fourth National Mental Health Plan will impact on NSW mental health CMOs in ways that are not yet clear

*The NSW mental health CMO sector should position itself to contribute to, and adapt to, changes which are in the best interests of the community*

### FINAL REPORT OF THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION

The Final Report of Australia's National Health and Hospitals Reform Commission<sup>192</sup>(NHHRC, page 128) recommends *"that the Commonwealth Government assumes full responsibility for primary health care services. This includes all existing community health services currently funded by State, Territory and local governments covering family and child health services, alcohol and drug treatment services and community mental health services"*. It is envisaged that Comprehensive Primary Health Care Centres and Services would be available throughout Australia. People with a long-term mental illness would experience the continuity, coordination and range of multidisciplinary care required by enrolling with a single primary health care service. However, at a Federal level, decisions about mental health services - and specifically community mental health services - have been delayed until 2011. At the time of this publication, the States are developing mental health implementation plans for consideration by the Commonwealth.

If the NHHRC recommendations are implemented there will be a major impact on community mental health services funding and monitoring as well as a shift in the relationship between community mental health CMOs and government mental health service providers. A list of recommendations relating to mental health is provided as Appendix 3.

In all States and Territories (Tasmania<sup>193</sup>, Victoria<sup>194</sup>, Queensland<sup>195</sup>, Western Australia<sup>196</sup>, South Australia<sup>197</sup>,

192 National Health and Hospitals Reform Commission (2009)

193 Department of Health and Human Services (2009a)

194 Mental Illness Fellowship Victoria (2005f)

195 Mental Illness Fellowship Victoria (2005d)

196 Mental Illness Fellowship Victoria (2005g)

197 Mental Illness Fellowship Victoria (2005e)

190 Mental Health Council of Australia (2006)

191 Fourth National Mental Health Plan Working Group (2009a)

the Australian Capital Territory<sup>198</sup>, New South Wales and the Northern Territory<sup>199</sup>) the government is the major provider of acute services for people with serious mental illness with CMOs predominantly providing community mental health supports such as employment, placement, support, information, day and residential programs, support groups, information, advocacy and family respite<sup>200</sup> - although these services are also provided by the Commonwealth. Most jurisdictions have areas or zones within which most mental health services are administered with the provision for state-wide or central administration. Of note is the development in Western Australia where a Mental Health Commission has been established. It will focus on mental health strategic policy, planning and procurement of services. The aim of such a commission is to increase accountability, coordination, and centralisation of stakeholder input.

## ALIGNMENT WITH THE PRINCIPLES OF THE FOURTH NATIONAL MENTAL HEALTH PLAN

There is some alignment in jurisdictional planning with the principles of the Fourth National Mental Health Plan. Elements such as recovery, prevention and early intervention, service access, coordination and continuity of care are featuring in planned approaches to mental health prevention and support across Australian governments.

## NSW MENTAL HEALTH CMO SECTOR

The NSW mental health CMO sector provides a broad range and choice of programs available to the community. CMOs support people to participate fully in community living using a client-centred approach oriented towards supporting each person to realise a meaningful life.

CMOs bring expertise and a broad range of perspectives through the use of volunteers who provide professional, peer and lay support to clients, boards, management, administration and employees. The NSW mental health CMO workforce was quantified by MHCC in a 2006 sector training needs analysis and estimated it to be about 3000 FTE (with recent growth this figure is now thought to now be 5000 FTE). Managers had an average of 14 years industry experience and 96% had a tertiary qualification - 54% had a university level qualification. 70% of direct care staff also had tertiary qualifications, however, 68% of these qualifications were not considered mental health specific.

## CMO HUMAN RESOURCES

CMOs bring expertise and a broad range of perspectives through the use of employees and volunteers who provide professional, peer and lay support to clients, boards and employees. Some voluntary positions in the CMO sector seem to have been replaced with paid positions, possibly due to complex tendering and accountability requirements<sup>201</sup>. The Productivity Commission (2010) found that CMOs in the community services sector experience great challenges in attracting and retaining employees and volunteers.

## HUMAN RESOURCES: CMO EMPLOYEES

It is not only the quantity but the quality of staff which impact on responsive, relevant, client-centred program delivery. Over the past few decades many CMOs have lifted workforce standards, engaging more professionally qualified employees. The *“demand for staff with higher level qualifications is expected to continue growing as clients present with more complex needs and community expectations of standards of care rise”*<sup>202</sup>. The Department of Health and ageing is currently developing a *National Mental Health Workforce Strategy and Plan* which is inclusive of the CMO sector. In a related activity, the National Health Workforce Taskforce (NHWT) is undertaking a *Mental Health NGO Workforce Study* which aims to develop an understanding of the existing CMO mental health workforce and to anticipate what the future needs of the workforce may be. The NHWT will design and test a methodology to support mental health workforce planning for the CMO mental health sector.

Demand for CMO staff with higher level qualifications is expected grow.

*Keep up-to-date with development of the National Mental Health Workforce Strategy/ Plan and the progress of the National Health Workforce Taskforce CMO Mental Health Workforce Study.*

There are few career paths for employees.

*Develop sector-wide career paths for CMO employees.*

CMO service delivery employees may become CMO managers (without sufficient management skills).

*Facilitate access to training in CMO leadership and management.*

198 Mental Illness Fellowship Victoria (2005a)

199 Mental Illness Fellowship Victoria (2005c)

200 Mental Illness Fellowship Victoria (2005e)

201 Productivity Commission (2010)

202 Productivity Commission (2010, p249)

Australian research on CMO employees suggests that while salary and conditions are poorer in the community managed sector the levels of qualifications and experience are generally high, some career progression does occur and CMO sector managers are motivated by a combination of personal development and social contribution<sup>203</sup>.

CMOs are currently experiencing: strain from the global economic crisis; a leadership drain as older executives retire; and, high turnover among younger CMO staff<sup>204</sup>. There is substantial movement of employees from CMOs to the public sector which may be due to uncertainty of position tenure created by government contracts and relatively low CMO wages<sup>205</sup>.

The Productivity Commission (2010) notes that: the small size of many CMOs can result in fewer career paths for employees, contributing to high staff turnover; staff development expenses are frequently not regarded by funding bodies, or the public, as a necessary part of service delivery; and, many CMOs are unable to sufficiently invest in training their staff. Facilitating career paths which are both attractive and recognised by new entrants is likely to contribute to retention of high quality workers within the sector<sup>206</sup>.

Career paths have begun to be addressed by the *MHCC Learning and Development Unit* (LDU) - established in 2007 by MHCC in partnership with NSW Health in recognition of the need for sector workforce development. The LDU provides professional development opportunities and qualification pathways for workers engaged in the provision of community mental health services and delivers nationally recognised qualifications including:

Certificate IV in Mental Health Work - which is the NSW CMO mental health sector industry-recognised minimum qualification for mental health support staff<sup>207</sup>;

- Certificate IV in Alcohol and Other Drugs (AOD) Work;
- Diploma of Community Services (Mental Health);
- Diploma of Community Services (AOD and Mental Health); and,
- Advanced Diploma of Community Sector Management ("*Leadership in Action*").

The *Professional Development Scholarship Program* (PDSP) 2010 – 2012 is a three year initiative making available \$1.6M from NSW Health and administered by MHCC. Scholarships are for vocational, university, direct care, leadership and trainer/assessor professional development opportunities for existing workers, consumers and carers.

A widespread concern is that management in the CMO

sector is "*often made up of service delivery employees looking for career advancement who may not necessarily have sufficient management skills*"<sup>208</sup>. Training in CMO business management should alleviate this concern. In addition, leadership skills have been recognised as a critical factor in system and service reorientation to provide community-based and recovery-oriented mental health services<sup>209</sup>.

## HUMAN RESOURCES: CMO VOLUNTEERS

When channelled correctly, volunteering can be a highly valuable asset. However, there are rising costs of recruiting, managing and training volunteers<sup>210</sup>. Unfortunately, volunteers are often not viewed as strategic assets and communities have not yet developed ways to take full advantage of them. In fact, most CMOs are losing volunteers each year<sup>211</sup>. The Productivity Commission (2010, p249) found that most Board members of CMOs volunteer their time and expertise, and may lack the skills required to conduct their duties; "*greater training and support for boards would help enhance the effectiveness of [CMOs]*".

## HUMAN RESOURCES: CONSUMER RUN SERVICES

The involvement of employees who have direct experience of mental illness in the provision of mental health services has been recognised as an important element in the improvement of mental health supports<sup>212</sup>. Organisations run by people with a history of mental illness who draw upon their experience to provide services to others with similar mental health problems occupy a unique place in the mental health sector<sup>213</sup>.

In the USA, mental health consumers operate or play a major role in a wide range of programs such as "*self-help groups, drop-in centres, clubhouses, independent living centres, advocacy organisations, case management services, employment agencies, supported housing, and information and referral lines*"<sup>214</sup>. Mental health consumers in NSW are not involved in such a large way.

Internationally, there has been significant progress in recognising the benefits of CMOs employing consumers as service providers<sup>215</sup>. The benefits apply to people being supported by consumer-providers<sup>216</sup>, to consumer-providers themselves and to the system as a whole<sup>217</sup>. Although there are some consumer-run organisations in NSW there is much work to be done to bring about more public discussion and awareness of consumer provided services.

208 Productivity Commission (2010, p272)

209 Anthony & Huckshorn (2008)

210 Productivity Commission (2010)

211 Eisner et al (2009)

212 Hardiman (2007)

213 Chinman, Young, Hassell, & Davidson (2006)

214 Greenfield, Stoneking, Humphreys, Sundby & Bond (2008).

215 Brown (2009)

216 Chinman et al (2006)

217 Carlson, Rapp, & McDiarmid (2001)

203 Centre for Australian Community Organisations and Management (2009)

204 Eisner et al (2009)

205 Productivity Commission (2010, p249)

206 Carson, Maher & King (2007)

207 Themhs (2009)

In the mental health CMO sector, employees who have direct experience of mental illness <sup>218</sup>:

- By virtue of their personal journey, instil hope to those who receive services; and,
- Are role models - success with employment, education, and independent living reinforces the belief that recovery is possible.

Consumer-run organisations may be stigmatised and devalued in the professional marketplace. Referral and collaborative activity may be hindered by lack of provider awareness about, and willingness to use, consumer-run resources<sup>219</sup>. Solutions have been proposed to address potential barriers to utilising and hiring employees who have direct experience of mental illness. Barriers can include perceived consumer-provider dual relationships, role conflict and confidentiality. Solutions can include clarity of policies and job descriptions, creation of structures and expectations for dialogue and provision of supports like quality supervision and training.

Internationally, mental health consumers operate or play a major role in providing a wide range of programs. Mental health consumers in NSW are not yet playing such a major role.

*In order to ensure that the NSW mental health CMO sector is prepared to meet future demands, workforce development for consumer-providers (consumers utilised in consumer run organisations and other CMOs) should be firmly on the sector capacity building agenda.*

It is likely that the number of people who have direct experience of mental illness employed by consumer run organisations and other CMOs will increase. In order to ensure that the NSW mental health CMO sector is prepared to meet future demands, workforce development for employees who have direct experience of mental illness (consumers utilised in consumer run organisations and other CMOs) should be included in the sector capacity building agenda.

Many CMOs are losing volunteers each year.

*A more strategic approach to attract, utilise, develop and retain CMO volunteers is required.*

CMO Board members may lack governance skills.

*Training and support for boards is required.*

## PARTNERSHIPS & COLLABORATION

Donnelly (2009) <sup>220</sup> indicates that the key to delivering mental health improvement at the local and national level is through partnership - particularly through Community Planning Partnerships and Community Health Partnerships.

As in England, Community Health Partnerships (CHPs) were established by NHS Boards in Scotland to have a vital role in partnership, integration and service redesign and provide<sup>221</sup>:

- Opportunities for partners to work together to improve the lives of the local community;
- A focus for the integration between primary care, specialist services and social care; and,
- Assurance that local population health improvement is placed at the heart of service planning and delivery.

*"Governments, nonprofits, philanthropies, and businesses all talk about the value of partnering to maximize the impact of their resources. Ironically, in day-to-day life, the ways in which people actually work together often fail to reflect that philosophy of partnership".*  
(Henderson, Whitaker, and Altman-Sauer, 2003)

Some partnership mechanisms are in place within the NSW mental health CMO sector.

*Recovery-focused partnerships are required.*

NSW Health has Clinical (Mental Health) Partnership Coordinators in AHS, the role of which is to *"provide leadership and direction in the strategic planning and development of key partnerships between mental health services and other agencies and in ensuring the clinical effectiveness of planned-coordinated service delivery"*<sup>222</sup>.

MHCC has the *"Meet Your Neighbour"* program<sup>223</sup>, the aim of which is to encourage organisations to meet, learn more about each other and find ways to work better together. This program supports NSW CMOs to work collaboratively to improve referral pathways, collaborate on service delivery, and to build social capital at the local level.

The Clinical (Mental Health) Partnership Coordinators focus on *"ensuring clinical effectiveness"*. Clinical outcomes ensure that medical treatment is relevant and effective. However, more is required to support clients to move beyond achievements resulting from medical treatment. Facilitation of partnerships focusing on the promotion of life-transformation will support clients to realise dreams and aspirations.

<sup>220</sup> Donnelly (2009)

<sup>221</sup> Scotland National Health Service (2009)

<sup>222</sup> NSW Health (2006)

<sup>223</sup> MHCC (2009)

<sup>218</sup> Carlson et al (2001)

<sup>219</sup> Hardiman (2007)

## RISK MANAGEMENT

Many CMOs are struggling to embed risk management through the organisation due to a lack of skill, inability to secure commitment and insufficient time to invest in developing arrangements or anticipating what the next risk might be<sup>224</sup>. PKF (2008) found that the types of risk that CMOs find most difficult to manage are changes in government or local government policy and reductions in contract income. Further, when faced with the choice of accepting a higher level of risk exposure or cutting back on activities, a better option for CMOs is to be able to strengthen risk management further so that more risk can be taken on without increasing the real exposure.

*Training and support are required for risk assessment & management at client and organisational levels.*

The Productivity Commission (2010) found that very large and complex CMOs which have high risk profiles may have difficulties attracting directors with the required level of abilities. In addition, it reported that a CMO survey of CMO Board members found that greater development and training was needed in business planning, financial management and risk management.

Risk assessment also has a particular meaning when applied to direct care in the mental health sector - ascertaining the likelihood that someone will experience a psychiatric crisis and/or harm themselves or someone else. Parsons (2007) notes that *"dignity of risk"* is a concept which acknowledges the fact that *"accompanying every endeavour is the element of risk and that every opportunity for growth carries with it the potential for failure"*. When people experiencing mental illness are denied the dignity of risk they are being denied the opportunity to learn and recover. The views of clinicians, psychiatrists, family members and carers and other service providers should certainly be heard and acknowledged but it is important that it is not done to the exclusion of the consumer and in effect denying their free will (unless there is a legal compulsion to do otherwise)<sup>225</sup>.

The aim for service providers is to support reasonable risk. Training which is sensitive to the rights of individuals, focusing on risk assessment & management, should be provided to employees in the mental health sector<sup>226</sup>

## PUBLIC ACCESS TO INFORMATION ABOUT NSW COMMUNITY MANAGED MENTAL HEALTH PROGRAMS

For a member of the public, finding information about CMOs providing community mental health programs in NSW is not easy. The NSW Mental Health Association developed and maintains *"Way Ahead"* – a directory containing up-to-date information on more than 2000 mental health and welfare related services across NSW<sup>227</sup>. However, a person needing to know about programs immediately cannot access the information quickly, directly and freely through the Mental Health Association's website.

Finding information about CMOs providing community mental health programs in NSW is difficult.

*Information about NSW mental health CMOs should be easy to access.*

*HSNet* (Human Services Network)<sup>228</sup> is a free, secure website for staff working in the NSW human services sector providing a central location for sharing information across government agencies and CMOs. *ServiceLink* is a comprehensive online directory of human services across NSW available to members of *HSNet*. The directory provides organisational and service information across a variety of sectors including health, welfare, community services, education, disability, aged care, legal and housing. *ServiceLink* aims to help human services workers quickly and efficiently find information about the services available to assist their clients. However, a member of the public cannot access this information.

*NSW Health's Health Services Directory*<sup>229</sup> enables users to search for health services according to: service name; service type ("Mental Health Service" is a service type - other examples are "Oral Health Services", "Aged Care"); location (suburb); postcode; phone number; Area Health Service; and, sector ("Public Health Services", "Private Health Services", or "NGO"). The directory includes 443 mental health services across NSW of which: 438 are categorised as "Public Health Services"; three categorised as "private services"; and, two are categorised as "NGOs"<sup>230</sup>. There may be some categorisation errors – but it is clear that mental health CMOs are not well or accurately represented in this directory.

General Practitioners also have difficulty knowing about mental health CMO programs. Local Divisions of GPs had to develop service directories in the past but do not have the capacity to continually update them as CMOs change and new programs emerge<sup>231</sup>.

224 PKF (2008)

225 Parsons (2007).

226 Commonwealth of Australia (2009b, p24)

227 Mental Health Association NSW (2009)

228 Human Services Network (2009)

229 NSW Health (2009c)

230 NSW Health (2009c)

231 Personal Communications with the author (2009)

# GOVERNMENT RESOURCING OF THE COMMUNITY MANAGED MENTAL HEALTH SECTOR

## INTERNATIONAL APPROACHES

### Canada

The Canadian Government delegates funding responsibilities across the continuum of care to the Provinces/Territories with planning and delivery of mental health services primarily being the responsibility of Provincial and Territorial governments<sup>232</sup>. In Ontario, 14 Local Health Integration Networks (LHINs, not-for-profit corporations) work with local health providers and community members to determine the health service priorities of regions. LHINs plan, integrate and fund local health services including mental health services.

### USA

According to Osher & Levine (2005),<sup>233</sup> the term mental health "system" in the USA refers to a fragmented network of programs, services, and funding streams. States in the USA have principal responsibility for the administration of mental health services, usually residing in a mental health authority or an agency in a larger department responsible for health or human services. Services may be delivered through locally based, state run providers, or by local for-profit and/or community agencies which are either overseen directly by the State or monitored at the County level. The US managed healthcare industry comprises approximately 3,000 companies with a combined annual revenue of around \$350 billion. Large companies include Aetna, UnitedHealth Group, and Humana as well as non-profits such as Kaiser Permanente<sup>234</sup>.

### New Zealand

In New Zealand there are many types of mental health services funded by the government through the local District Health Boards (DHBs). Most mental health services are provided outside hospitals in the community and are run either by the DHB itself or by CMOs<sup>235</sup>. Access to mental health services is often coordinated through primary health services<sup>236</sup>.

### England

In England, funding for mental health services is allocated via the Department of Health to local purchasers called Primary Care Trusts (PCTs) with the budget being based on the size of the local population, the relative needs of the population and the cost of delivering services in that area<sup>237</sup>.

Mental health as a proportion of total local purchaser allocations in 2003/2004 varied from 22.48% to 8.12%

with the average being 11.56% and some of this variation is due to the additional finance provided for remaining long-stay institutions.

### Europe

The Mental Health Economics European Network (MHEEN) group reviewed resource allocation methods for mental health funding in 17 western European countries finding that these were based on historical precedents or political judgements rather than objective measures of population health needs<sup>238</sup>. This means it is unlikely resources are targeted to areas where they are most likely to be effective and inequities may be allowed to persist.

Use of diagnostic related group (DRG) tariffs for reimbursing service providers for mental health-related services has led to underfunding for mental health as reimbursement rates have not always fully taken into account all of the costs associated with the needs of people who require ongoing mental health support<sup>239</sup>.

In central and eastern Europe "*financial resource allocation systems... still link funding for mental health services directly to bed occupancy allowing little flexibility and providing little incentive for local planners to develop community-based alternative services*"<sup>240</sup>.

According to McDaid et al (2005, p7), even where deinstitutionalisation is taking place:

- Funds may not be transferred to the provision of community-based services. It is common for mental health funds to leak into other areas of the health care system; and,
- There may be incentives for discharging individuals who cost the most to support and for keeping low-cost (and therefore the least appropriate) individuals within institutions without transferring funds to community-based care.

According to WHO (2003b), 6% of the health care budget in Australia and the USA was devoted to mental health compared to 11% in New Zealand and in Canada.

## POPULATION BASED PLANNING

In England, population-based planning includes weightings which are based on age profiles and measures of health care need including use of a specially developed mental health need index. The mental health need index combines a number of indicators of population needs used to allocate funding to local government together with evidence on patterns of mental health care need from the annual Health Survey for England<sup>241</sup>.

232 Public Health Agency of Canada (2009)

233 Osher, F & Levine, I. (2005)

234 Reuters (2009).

235 Mental Health Commission (2009)

236 Mental Health Commission (2009)

237 Department of Health (2009)

238 McDaid et al (2005)

239 McDaid et al (2005)

240 McDaid et al (2005, p7)

241 McDaid, Knapp & Curran (2005, p13)

In NSW, the Mental Health Clinical Care and Prevention (MH-CCP) model ten year forward planning process is based on the generic needs of a nominal town with a population of 100,000 people, with a certain number of hospitals and also supported accommodation beds per 100,000 people. At this stage, prevention, promotion and early intervention community based directions are not planned for using the MH-CCP process which are planned and funded in an ad-hoc manner. A related concern with the process is that it does not take into account the unique socio-demographic characteristics or existing resource and infrastructure issues that exist for local communities.

Population based service planning needs to be clearly informed by known evidence based practice. Community based approaches and the funding mechanisms that support mental health CMOs are not easily incorporated into the MH-CCP structure other than for contracted "bed based" programs such as the Housing and Accommodation Support Initiative (HASI). However, population based planning approaches can be extensively used and include participation of all key stakeholders including consumers and carers. This could occur at State-wide, AHS, regional and/or LGA levels.

The Toronto District Health Council states<sup>242</sup> that *"when health data are presented for the region ... as whole, the disparities in health status and access to health services that may exist in different population subgroups are obscured. Thus, it is difficult to plan comprehensive and relevant health care on the basis of aggregate population need"*.

An approach in which necessary community managed mental health programs are planned on a population basis (for example, per 100,000 people) and taking into account the unique socio-demographic characteristics and existing resource and infrastructure capabilities for local communities would improve the way community managed mental health services are planned and increase the likelihood of program equity across NSW.

## PERSPECTIVES ON FUNDING IN AUSTRALIA

In Australia, States and Territories continue to bear the major responsibility for mental health care for people affected by mental illnesses both through direct provision of services and indirectly through funding of CMOs to provide services. A central issue is how best to allocate limited resources and gain maximum value for individuals, families, and society<sup>243</sup>.

CMOs in NSW generate revenue from a diverse range of sources, including:

- Commonwealth government;
- State government;
- Local government;

- Sponsorship;
- Donations;
- Fees-for-service;
- Grants from trusts & philanthropic foundations; and
- Interest earned on investments.

The NSW Government spends over \$5 billion in grants each year<sup>244</sup>. Of the grants included in a recent NSW performance audit of grants administration, the average grant size was around \$194,000. NSW CMOs included in the audit each received on average five grants - worth on average a total of \$724,000<sup>245</sup>.

The Final Report of Australia's National NHHRC recommends that the Commonwealth Government assumes full responsibility for primary health care services including community mental health services<sup>246</sup>. The NHHRC also proposes that:

- Grant funding will support multidisciplinary services and care coordination for that service tied to levels of enrolment of people with chronic and complex conditions;
- There will be payments to reward good performance in outcomes, including quality and timeliness of care, for the enrolled population; and,
- Over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based payments for episodic care.

The Australian Social Inclusion Board consulted with representatives from the mental health sector and found that *"the government funding model for NGOs doesn't support a holistic approach and is based on provision of units of a specific service, not outcomes for the client. [We need to] build accountability through measures of outcomes for individuals"*<sup>247</sup>

The Victorian Government utilises CMO contract, cross-agency models of care coordination and case management models in which the service provider is contracted to provide care/program coordination for mental health and justice system clients on an outcomes basis<sup>248</sup>. The Victorian Department of Human Services allocated 10% of its 2008-09 health budget to the CMO/PDRSS Program using a unit cost for specific program types. For example:

- *Intensive services* such as 24 hour and non-24 hour accommodation support are costed as "bed days".
- *Less intensive service*, such as drop-in support, outreach, day programs, respite, self-help services, etc. are costed "per client contact hour". In addition,

244 The Productivity Commission (2009b)

245 Productivity Commission(2009b), p11.14

246 National Health and Hospitals Reform Commission (2009, p128)

247 Australian Social Inclusion Board (2008) p4

248 AHHA (2008)

242 Toronto District Health Council (2004), pi

243 Lehman, Goldman, Dixon, & Churchill (2004)

for each hour of client contact the program is funded an additional hour for liaison with other agencies and administrative costs.

- A small number of programs are funded as block grants, such as *information services*<sup>249</sup>.

The AHHA states that in Australia, resource distribution does not follow need and there are no unified standards or methods for funding or staffing allocations. Accordingly, the AHHA recommends that mental health funding be allocated by the Commonwealth, States and Territories to *Regional Mental Health Funding Authorities (RMHFAs)* which would have the features shown in Box 4<sup>250</sup>.

#### BOX 4: PROPOSED FEATURES OF REGIONAL MENTAL HEALTH FUNDING AUTHORITIES (RMHFAs) (AHHA, 2008)

- Cover a population area of up to 500,000.
- Align with current or revised health service boundaries.
- Be independent health authorities, or arms-length bodies auspiced by the state/territory health department with a management board comprising representatives of the public health service, government social services, non-government services, division of general practice, consumer and carer representatives and other key stakeholders.
- Using a needs-based model, receive pooled funds from MBS, State/Territory mental health services, Commonwealth mental health programs and other government funds.
- Develop a service plan that demonstrates an understanding of the mental health needs of the catchment population.
- Commission and contract mental health services as required across the continuum of care.
- Incentivise service providers to collaborate, coordinate and provide quality care in the most risk appropriate and least restrictive environment possible (based on international commissioning and pay for performance models).
- Monitor performance and manage service providers against the contracted services, including independent random audits of the quality and range of services purchased.
- Report and benchmark on quality, safety, consumer & carer experience, operational & financial performance with dual reporting to State/Territory Health Departments and the AMHB.
- Publicly report on performance to the community served.

The Productivity Commission's issues paper on the not-for-profit sector notes several issues affecting funding decisions and CMO effectiveness:

- Adequate funding levels and security of funding periods increases CMOs capacity to provide efficient services;
- Regulations and reporting requirements add complexity for CMOs although they increase their attractiveness for donors and government;
- CMOs do not have a profit motive for providing efficient services but being able to demonstrate cost-effectiveness attracts further grants and donations;
- CMOs have potential for innovation and responsiveness but may lack the capacity to do so or be constrained by regulations; and,
- The trend towards governments preferring to deal with fewer and larger CMOs can lead to amalgamation of smaller CMOs. This limits diversity within the sector and may also limit opportunities for innovation<sup>251</sup>.

There are three major ways that CMOs are generally funded by government to provide specialist mental health support<sup>252</sup>:

- **Collaborative (contracted) programs** - where NSW Health develops tenders for specific program models (ie. HASI, NGO Grant Program, Family & Carers Program, Resource & Recovery Services Program);
- **Historical Grants** - which involve specific grants from NSW Health for individual CMO services (eg, recurrent grants approved by the Minister for Health, ad hoc grants, sponsorship grants and other grants); and,
- **Federally** - through the Council of Commonwealth Governments (COAG) process (eg, Personal Helpers and Mentors/PHAMS, Day to Day Living, Carer Respite, Community Based Activities).

#### NSW Health's NGO Program

Grants may be provided to CMOs by NSW Health centrally from the Mental Health Drug and Alcohol Office (MHDAO), through any of the eight AHSs or through other public health organisations providing state-wide or specialist health services such as the Ambulance Service of NSW or Justice Health.

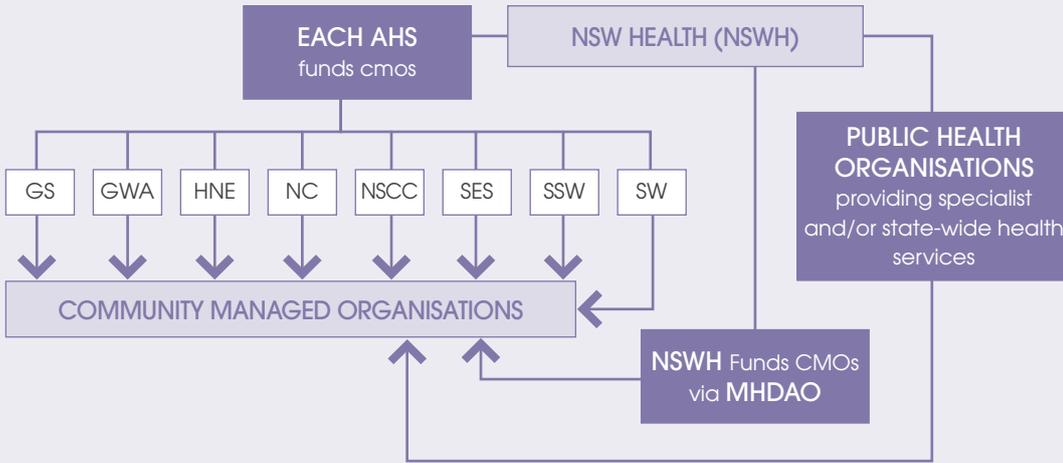
249 State Victoria (2008)

250 AHHA (2008)

251 Productivity Commission (2009a) pp26-32.

252 NSW Health Strategic Development Division Primary Health & Community Partnerships Branch (2009)

FIGURE 8: FUNDING RELATIONSHIP BETWEEN NSW HEALTH AND NON-GOVERNMENT ORGANISATIONS



NGO Coordinators play a key role in most AHSs, managing grant administration and liaising with CMOs within that AHS. Policy branches within the Department manage grants normally associated with larger state-wide CMO services.

The majority of CMO programs funded by NSW Health are funded recurrently (normally over three years) and receive quarterly financial allocations. CMOs are required to complete funding applications when funding agreements expire and most CMO re-applications have been supported. One-off grants for specific projects have also been made available.

In 2004-05, NSW Health spent \$748.3 million on mental health services<sup>253</sup> (approximately \$111.27 per capita)<sup>254</sup>. In 2007-08, NSW Health spent \$1.05 billion on mental health services (approximately \$154 per capita).<sup>255</sup> This shows a growth in funding from 2004-05 to 2007-08 of 40% overall and 38% per capita. The UK average per capita expenditure in 2007-08 was £169 (equivalent to \$343.07AUD).<sup>256</sup>

Funding to CMOs increased between 1993 and 2005 with NSW being slightly below the national average of CMO funding as a percentage of total spending on mental health services in 1995 and well below average in 2005.

In 2006, NSW Health supported a recommendation to include mental health under its health resource distribution formula.<sup>257</sup> This formula was developed in the 1980s as a population-based approach for redressing inequitable access to health services. Over time, studies show that there has been a gradual shift towards equity between AHSs although it is recognised it is only one of several factors in improving equity.<sup>258</sup> The next step may be to ascertain how systematically the formula is being

applied to the health system and to gain data on progress on its application for the mental health sector.<sup>259</sup>

FIGURE 9: FUNDING TO NGOS AS A % OF TOTAL SPENDING ON MENTAL HEALTH SERVICES<sup>260</sup>



Challenges for funding and resource allocation are described by McDaid et al (2005, p8-9):

- *Resource insufficiency*: not enough financial resources;
- *Resource distribution*: services are poorly distributed;
- *Resource inappropriateness*: services do not match what is needed or preferred, (eg, large psychiatric institutions which account for high proportions of available mental health budgets while supporting only small proportions of the total populations in need);

253 Department of Health and Ageing (2007)

254 Department of Health and Ageing (2007) Table 11.

255 NSW Health Annual Report (2007-08)

256 Mental Health Strategies (MHS) for Department of Health (2009)

257 NSW Health, March 2009 (revised) p44

258 Gibbs. A, et al. 2004

259 Pavey, M, Dec 2008

260 Department of Health and Ageing (2007)

- *Resource inflexibility*: care or support arrangements may be too rigidly organised; Resource dislocation: services are poorly coordinated; and,
- *Resource timing*: improvements in practices take a long time to get to cost savings or improved health outcomes.

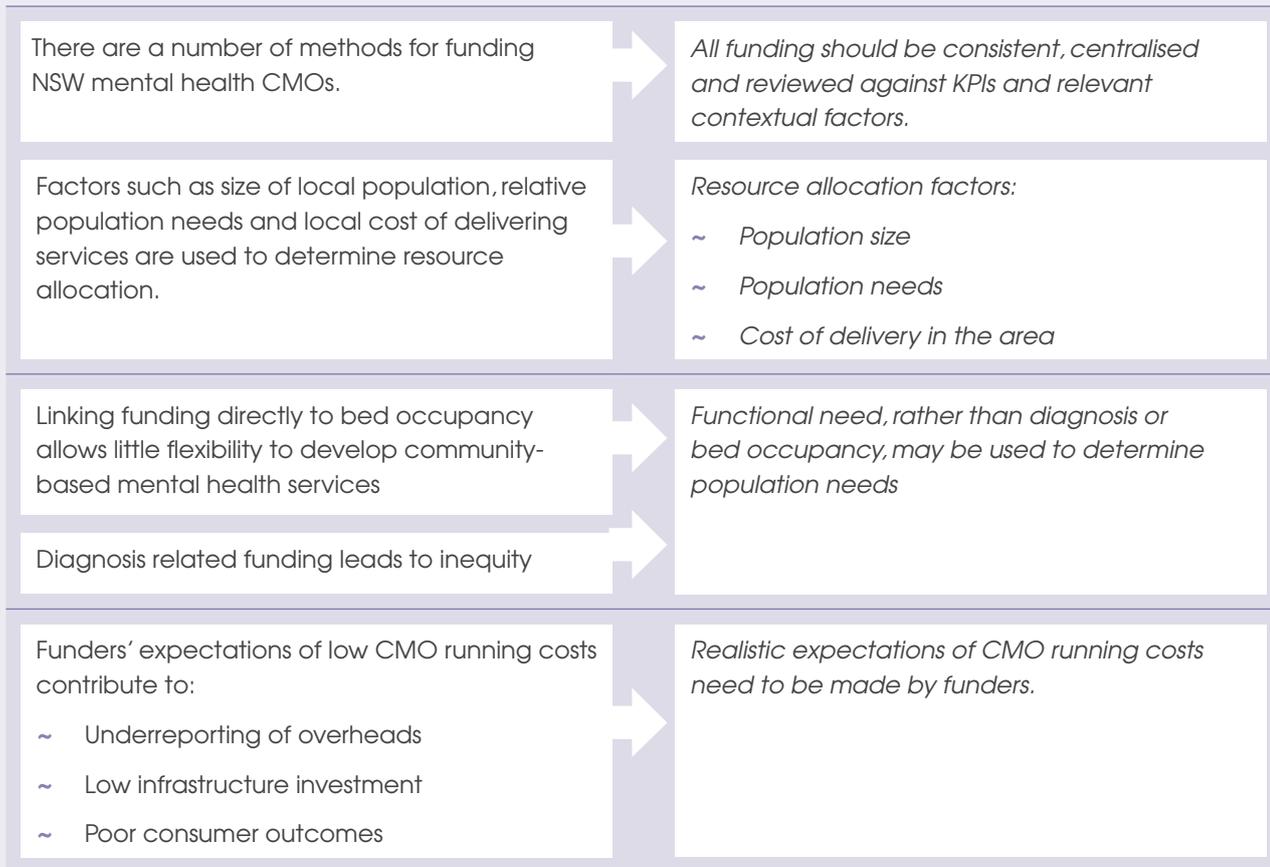
In a simplistic sense, solutions to challenges for funding and resource allocation may be based on factors such as those shown in Figure 12.

FIGURE 10: POTENTIAL SOLUTIONS TO CHALLENGES FOR FUNDING AND RESOURCE ALLOCATION



The NSW Government's November 2008 mini-budget included an initiative to reform grants to CMOs through efficiencies and limiting new arrangements. This led to a review, commencing mid-2009, with the aim of developing the most efficient, effective and responsive NSW Health NGO Program practicable<sup>261</sup>. The review process involves community peak stakeholders and senior NSW Health personnel working collaboratively to identify effective CMO contracting, infrastructure and planning mechanisms.

FIGURE 11: METHODS FOR FUNDING NSW MENTAL HEALTH CMOs



### RISK FACTORS AND FUNDING OF CMOs

CMO age, life cycle stage, size and asset base are mentioned by Young (2006) as characteristics which may contribute to an understanding of CMO risk preference.

Keating, Gordon, Fischer, & Greenlee (2003) reviewed over 11,000 audits of non-profits observing that there were differences according to organisational size, age of relationship with government and previous audit performance. They found that smaller nonprofits, those that are new to government grants and those with prior audit findings have a significantly higher rate of adverse audit findings<sup>262</sup>.

The NSW Office of Fair Trading (OFT) is establishing two categories of CMOs for reporting purposes based on annual income up to, or above, a proposed \$200,000 threshold<sup>263</sup>:

- Larger (Tier 1) associations will have income above the threshold; and,
- Smaller (Tier 2) associations will have income up to the threshold.

CPA Australia<sup>264</sup>, QCOSS<sup>265</sup> and NCOSS (2009) propose that CMO size is based on annual income as shown in Table 7.

262 Keating, Gordon, Fischer, & Greenlee (2003)  
 263 NSW Government Office of Fair Trading (2009)  
 264 CPA Australia (2009)  
 265 QCOSS (2009)

TABLE 7: CMO SIZE BASED ON ANNUAL INCOME (ACCORDING TO OFFICE OF FAIR TRADING, CPA, QCOSS, NCOSS)

	OFT	CPA	QCOSS	NCOSS
Less than \$5K	TIER 2 (SMALL)	TIER 1	SMALL	CAT 1
\$5K - \$49.9K				CAT 2
\$50K - \$99.9K		TIER 2	MEDIUM	CAT 3
\$100K - \$149.9K				CAT 4
\$150K - \$200K	CAT 5			
\$200K - \$299.9K	TIER 1 (LARGE)	TIER 3	LARGE 1	CAT 6
\$300K - \$499.9K			LARGE 2	
\$500K - \$1.5M			LARGE 3	CAT 7
\$1.5M - \$2M				
\$2M - \$5M				
Over \$5M				

The Productivity Commission states that more than 60% of NFPs lodging goods and services tax (GST) returns have an annual turnover of \$150,000 or less indicating the majority are small to medium size organisations when income is the indicator of organisational size<sup>266</sup>.

CMO size may also be based on the number of employees. Barraket (2005) defines the size of CMOs according to the number of staff:

- **Small CMO:** Less than five staff;
- **Medium CMO:** Between five and 15 staff; and
- **Large CMO:** More than 15 staff.

Australia's Corporations Act 2001 defines the size of proprietary companies on the basis of gross assets and number of employees at the end of the financial year and annual gross operating revenue<sup>267</sup>.

The NSW Government states that the Small Business Fair Dismissal Code applies to businesses (including Companies Limited by Guarantee, Incorporated Associations and Co-operatives) with fewer than 15 fulltime equivalent (FTE) employees.

CMO age, life cycle stage, size, asset base and experience with government grants contribute to an understanding of CMO funding risk factors. However, there is little agreement about what constitutes CMO size.

*CMO funding risk factors need to be defined along with a mechanism for indication of how risk factors will impact on CMOs receiving or applying for government funding.*

266 Productivity Commission(2009b), p4.5

267 Commonwealth Corporations Act 2001 (division 5A, section 45A, 2 & 3)

## EVALUATION OF GOVERNMENT FUNDED COMMUNITY MANAGED MENTAL HEALTH PROGRAMS

In the non-profit world, CMOs are so diverse that they do not share a common indicator of program effectiveness. In the absence of this indicator, many funders try to understand an organisation's efficiency by monitoring overheads and other easily obtained (but faulty) indicators.

NSW Health manages grant funding to CMOs through Funding and Performance Agreements (FPAs). Use of outcome measures by CMOs is promoted through a Key Performance Indicator (KPI) assessment process with KPIs agreed to by the CMO and NSW Health.

According to Gregory and Howard (2009), funders need to refocus their attention on impact by asking *"What are we trying to achieve?"* and *"What would define success?"* In so doing, they will signal to their grantees that impact matters more than anything else. *"Even focusing on approximate or crude indicators is better than looking at cost efficiencies as focusing on the latter may lead to narrow decisions that undermine program results"*<sup>268</sup>.

Scotland is adopting a clearer outcomes focus whereby logic models are developed using a collaborative methodology in which stakeholders participate to ensure the models are evidence informed, logical and achievable. A series of logic models and other evaluation tools is being developed to identify the relevant short-term, intermediate and long-term outcomes in the mental health improvement field, the evidence base supporting them and the activities which will achieve them<sup>269</sup>.

Lehman, Goldman, Dixon & Churchill (2004) state that mental health services can be expected to provide EBPs in order to yield good outcomes and that outcomes should be monitored regularly by providers as a part of good practice.

In Australia, CMOs use a range of tools some of which could loosely be defined as outcome measures. These include: the Health of the Nation Outcome Scales (HoNOS); Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA); Health of the Nation Outcome Scales 65+ (HoNOS65+); Life Skills Profile 16 (LSP-16); Kessler-10 Plus (K-10+); Camberwell Assessment of Need - Short Appraisal Schedule (CANSAS); the 24-Item Short Form Health Survey (SF24); Depression Anxiety Stress Scales (DASS); Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL); Children's Global Assessment Scale (CGAS); Mental Health Inventory (MHI); Behaviour and Symptom Identification Scale 32 (BASIS-32®); Strengths and Difficulties Questionnaire (SDQ); the 12-Item Short Form Health Survey (SF12); Global Assessment of

Functioning Scale (GAF); the Department of Employment & Workplace Relations IT platform for employment outcomes (EA3000); the Beck Depression Inventory (BDI); the Beck Scale for Suicidal Ideation (BSI); Brief Treatment Outcome Measure (AOD); Satisfaction with Life Scale; and, a variety of other tools including some internally developed measures.

Dickens (2009, p290) states that *"with some exceptions ... completion rates of routine outcomes ratings are poor and some argue that current tools are not sufficiently service user-oriented ... new measures of recovery and growth could be integrated with existing scales to allow stakeholders to assess service effectiveness"*.

According to Clarke, Oades, Crowe, Caputi, & Deane (2009) the Recovery Assessment Scale (RAS) is a 41-item scale, completed by the consumer, measuring aspects of recovery. The RAS has five subscales: Personal Confidence and Hope; Willingness to Ask for Help; Goal and Success Orientation; Reliance on Others; and, Not Dominated by Symptoms. For example, items include *"I have purpose in life"* and *"I like myself"*. Items are rated on a five-point scale from 0 (Strongly Disagree) to 4 (Strongly Agree). However, recovery cannot be easily deconstructed into measurable outcomes as one person's journey to recovery will be vastly different to the next person<sup>270</sup>.

Completion rates of routine outcomes ratings are low & some argue that current tools are not sufficiently service user-oriented.

*Develop an outcomes measurement strategy that more strongly reflects a service-user perspective.*

Perry & Gilbody (2009) attempted to develop outcome domains solely from the point of view of service users and propose that further research could use identified themes as the basis of an outcomes measurement strategy that more strongly reflects a service-user perspective.

More research will be needed to ensure measures of recovery oriented outcomes are valid and reliable in order to ascertain whether recovery-led services deliver positive outcomes.

The Productivity Commission (2010) proposes a nationally agreed measurement and evaluation framework for CMOs as well as establishment of a Centre for Community Service Effectiveness to improve knowledge on good evaluation practice.

<sup>268</sup> Gregory and Howard (2009, p.52)

<sup>269</sup> Donnelly (2009) p10

<sup>270</sup> MHCC (2008)

## RESEARCH AND INNOVATION

The Productivity Commission (2010) notes that the natural inclination of CMOs to take innovative approaches to social problems is limited by: the increasingly risk averse attitudes of funders and Boards; resources; constraints on investments in knowledge; and, reluctance to collaborate with other CMOs. Further, it is recommended that the Centre for Community Service Effectiveness assemble and disseminate evaluations based on an agreed national measurement framework for CMOs.

In Australia, the Cooperative Research Centre Program has supported collaborative research on social issues since 2008<sup>271</sup>. Despite being well suited to address some of the most critical issues in mental health services, practice-based research networks (*collaborations of practice settings that decide to work together to generate research knowledge*) are underused in mental health services research<sup>272</sup>.

Privacy requirements and IT capacity may be preventing CMOs from using data collaboratively. However, sharing data to collaborate: allows individuals and organisations to resolve collective problems; enables communities to operate more efficiently; expands awareness of how organisations' fates are linked; establishes networks and other structures that facilitate the flow of information required to facilitate the accomplishment of goals; and, produces a positive impact on individuals' lives<sup>273</sup>. Using data to collaborate will build sector capacity.

In NSW, an *Alcohol & Other Drugs and Mental Health Research Network* is in the stages of early formation. It is essential that EBPs are researched for more than just co-existing mental health and substance use problems. There is no dedicated community-based recovery-oriented research network for the range of other mental health problems and conditions in the sector.

Developing CMO sector partnerships with reputable research bodies will provide the basis on which relevant research projects can be carried out.

Easy access to research findings would enable CMOs to gain a balanced view on practices which effectively meet the needs of (and benefit) clients, staff, partners and funders. CMOs wanting to innovate are likely to require additional funding to pilot new projects.

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271 Productivity Commission (2010, p225)

272 McMillen, Lenze, Hawley & Osborne (2009)

273 Portwood, Shears, Eichelberger & Abrams (2009)

## A COMMUNITY MANAGED MENTAL HEALTH SECTOR FRAMEWORK

This review proposes that elements can be identified which contribute to a stronger community managed mental health sector.

Although the concept of community capacity building is rooted in an older approach known as “community development”<sup>274</sup>, community managed mental health sector capacity is not clearly defined in the literature and research on elements essential for strengthening the capacity of the community managed mental health sector is lacking.

A broad definition of community managed mental health sector capacity can be drawn from Smith, Peoples and Johnson 2009 who propose that service capacity as it relates to community mental health is “*the ability of community mental health facilities to respond ..... with adequate resources and capacity to meet community needs*”<sup>275</sup>.

The Centre for Community Service Effectiveness has been proposed by the Productivity Commission to assemble and disseminate evaluations based on an agreed national measurement framework for CMOs.

Practice-based research networks are underused in mental health services research. In NSW, an *Alcohol & Other Drugs and Mental Health Research Network* is in the stages of early formation. There is no dedicated research network for the broader community managed mental health sector in NSW.

*A broad community mental health research network should be developed in NSW. Sharing data to collaborate will build sector capacity.*

NSW Health has completed substantial work on capacity building in the health arena<sup>276,277</sup> and identified three different categories of capacity-building<sup>278</sup>:

1. Health infrastructure, service development (*structures, organisation, skills, resources*);
2. Program maintenance, sustainability (*continuing programs via a network of agencies*); and,
3. Problem-solving capability of organisations and communities (*identify health issues and develop mechanisms to address them*).

They describe organisational capacity as having at least the following elements<sup>279</sup>:

- **ORGANISATIONAL COMMITMENT:** As evidenced in available resources, job descriptions, mission statements, policies, number of parts of the organisation involved, number of levels of the organisation in which support for the program is evidenced, recurrent funding.
- **SKILLS:** Competence in handling specified program implementation and delivery functions, problem-solving capability.
- **STRUCTURES:** Networks within and across organisations, decision-making forums, communication, ways of acquiring new information (environmental scanning), ways of accessing additional skills, ways to construct new work processes evolving as a result of program (planning and review structures).

The Australian Social Inclusion Board has developed principles, which have been adopted by the Australian Government, to guide social inclusion<sup>280</sup>. They propose that the integration of resources and capacity through reciprocal links, cooperation and supportive relationships between various individuals, families and organisations - including CMOs - will assist in building community capacity<sup>281</sup>.

Turnock (2004)<sup>282</sup> describes public health system components<sup>283</sup>:

- Mission and Purpose;
- Structural Capacity (inputs including human resources, information resources, financial and physical assets, and appropriate relationships among the system components);
- Processes (collective practices or processes that are necessary and sufficient to assure that the core functions and essential services of public health are being carried out effectively including the key processes that identify and address health problems and their causative factors and the interventions intended to prevent death, disease, and disability, and to promote quality of life); and
- Outcomes (indicators of health status, risk reduction, and quality-of-life enhancement; e.g. long-term objectives that define optimal, measurable future levels of health status).

When considering community managed mental health sector capacity elements, the OECD states that it is important to ask “*Capacity for what?*” as well as: focus on specific capacities needed to accomplish clearly defined goals; use a “best fit” approach to capacity development using a systematic effort to think through

274 McGinty, S (2002)

275 Smith, Peoples, & Johnson (2009)

276 NSW Department of Health (2001)

277 NSW Department of Health (2000)

278 NSW Department of Health (2000)

279 NSW Health (2001).

280 Australian Social Inclusion Board (2009b)

281 Australian Social Inclusion Board (2009a)

282 Turnock, B J (2004)

283 Turnock, B J (2007)

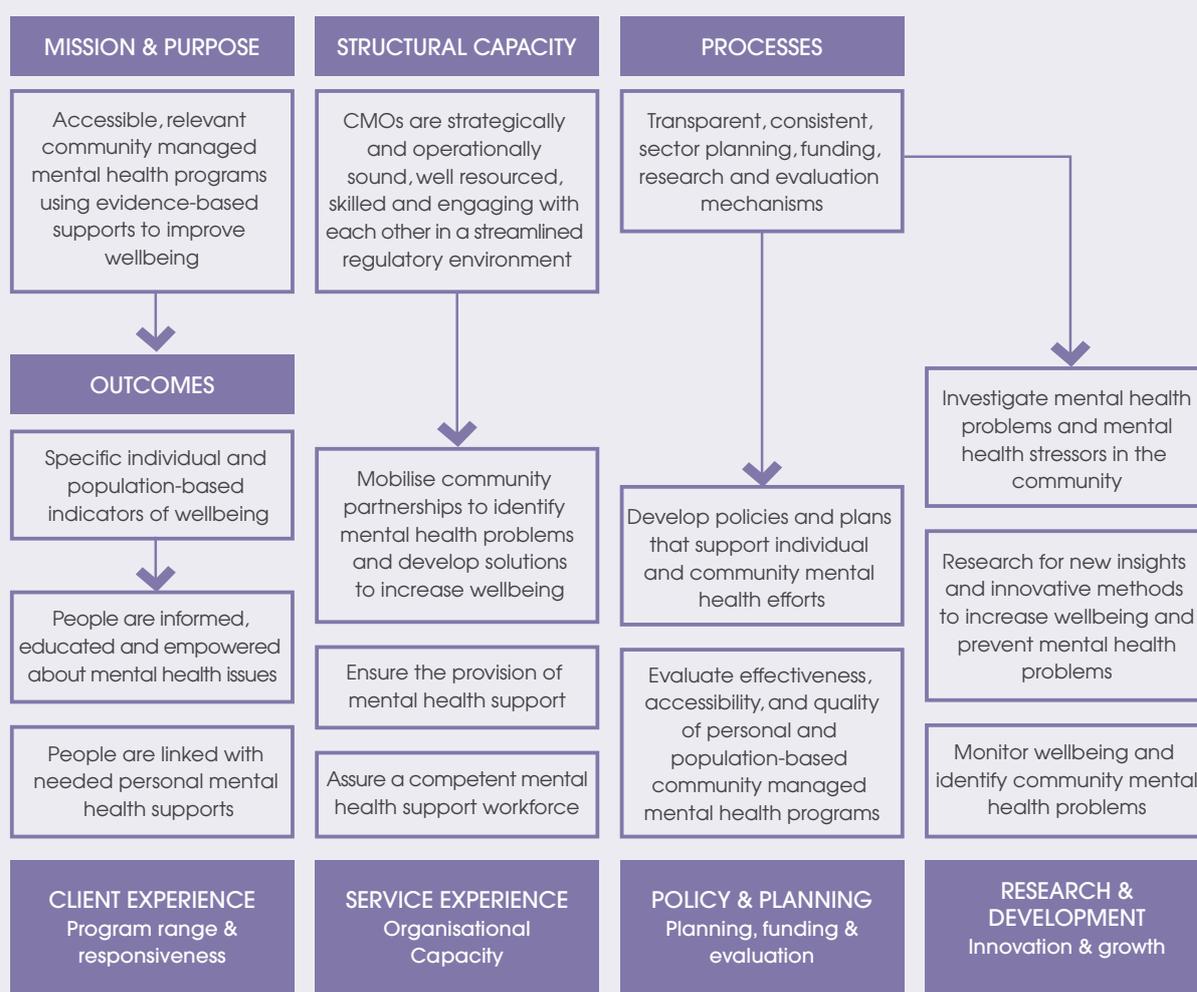
what might work in particular circumstances; and, ensure adequate attention is given to individual and organisational issues and to the enabling environment<sup>284</sup>.

Using the OECD's approach and applying Turnock's public health system components to the community managed mental health sector, concepts relating to overall community managed mental health sector capacity can be drawn from the literature, such as:

- **Mission and Purpose:** *Accessible, relevant community managed mental health programs using evidence based supports to improve the wellbeing of the people of NSW;*
- **Structural Capacity:** *CMOs are strategically and operationally sound, well resourced, skilled and engage with each other in a streamlined regulatory environment;*
- **Processes:** *Transparent, consistent, sector planning, funding, research and evaluation mechanisms; and,*
- **Outcomes:** *Specific individual and population-based indicators of wellbeing.*

Turnock's<sup>285</sup> Ten Essential Public Health Services<sup>286</sup> describe what is necessary to secure or maintain public resources for population-based, community-oriented prevention efforts that may serve as a basis for the funding of core public health functions. These have been adapted for the community managed mental health sector and applied to the concepts relating to community managed mental health sector capacity, leading to the emergence of *Sector Capacity Framework Elements* as shown in Figure 12.

FIGURE 12: EMERGING COMMUNITY MANAGED MENTAL HEALTH SECTOR CAPACITY FRAMEWORK ELEMENTS (ADAPTED & DEVELOPED FROM TURNOCK, 2007)



284 Organisation for Economic Co-Operation and Development (2006)

285 Turnock, BJ (2001)

286 Turnock, BJ (2007)

### Community Managed Mental Health Sector Capacity Framework

Drawing on the Australian Social Inclusion Board's principles<sup>287</sup>, the OECD's direction<sup>288</sup>, Smith, Peoples & Johnson's definition<sup>289</sup>, Turnock's public health system concepts<sup>290</sup> and NSW Health's<sup>291</sup> capacity descriptors four elements are identified which contribute to "community managed mental health sector capacity":

1. Client Experience (Program range & responsiveness);
2. Service Provision (Organisational capacity);
3. Policy & Planning (Planning, funding and evaluation); and,
4. Research & Development (Innovation & growth).

Each of these elements is not, in itself, enough to bring about effective sector performance and development; it is essential to strengthen all four sector capacity elements.

#### Details of Sector Capacity Framework Elements

##### CLIENT EXPERIENCE (PROGRAM RANGE & RESPONSIVENESS)

People are informed, educated and empowered about mental health issues, and linked with needed personal mental health supports. Accessible, relevant, well-coordinated, recovery oriented mental health programs, using evidence based supports, are available for people with mental health concerns and/or mental illness.

Programs are provided across the spectrum of age groups, in urban, rural and remote areas, using culturally and linguistically competent and disability friendly responses. Recovery oriented indicators of wellbeing are used to enable clients to monitor outcomes.

##### SERVICE PROVISION (ORGANISATIONAL CAPACITY)

CMOs are strategically and operationally sound, well resourced, skilled and engaging with each other in a streamlined regulatory environment.

Community partnerships are mobilised to: identify mental health problems, develop solutions to increase wellbeing, and to provide accessible, relevant, well-coordinated mental health supports. A competent mental health support workforce is in place.

##### POLICY & PLANNING (PLANNING, FUNDING AND EVALUATION)

Transparent, consistent, sector planning, funding and evaluation mechanisms are in place. Policies and plans that support individual and community mental health efforts are developed.

Evaluation of the effectiveness, accessibility, and quality of personal and population-based community managed mental health programs leads to progressive change in the sector.

##### RESEARCH & DEVELOPMENT (INNOVATION & GROWTH)

Transparent, consistent, sector research mechanisms are in place. Mental health problems and mental health stressors in the community are investigated. New insights and innovative methods to increase wellbeing and prevent mental health problems are researched. Wellbeing of the population is monitored and community mental health problems are identified.

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287 Australian Social Inclusion Board (2009b)

288 Organisation for Economic Co-Operation and Development (2006)

289 Smith et al (2009)

290 Turnock, BJ (2007)

291 NSW Department of Health (2000)

## CONCLUSION

The purpose of this Literature Review was to provide a context for the *NSW Mental Health Community Managed Organisation (CMO) Sector Mapping Project 2008-2010* and to inform recommendations to develop the capacity of the NSW community managed mental health sector.

The complexity of the NSW community managed mental health sector has required review of a broad range of literature and the development of a sector framework. A clear context for the *Sector Mapping Project* has been developed and a firm base has been provided to inform recommendations to develop the capacity of the NSW community managed mental health sector.

## APPENDICES

### APPENDIX 1: Issues Raised by CMOs in Canada and Europe

#### Issues Raised by CMOs in a Recent Canadian Survey<sup>292</sup>

Regulatory, legislative charity, and government funding issues:

- *“Lengthy applications for short-term funding and small grants;*
- *Ever-complex reporting; Line-by-line restrictions on using funds;*
- *Impact of government auditor requirements;*
- *Multiple oversight, split jurisdictions;*
- *Restrictions in contract on advocacy/public policy participation; and,*
- *Conflicting legislative obligations e.g., employment, health and safety, and terms of grant”.*

#### Key Needs of CMOs Identified by the European Euclid Network<sup>293</sup>:

In “Good Third Sector Governance Across Europe” (November 2008) Euclid states that key needs of NGOs arising during participatory discussions were:

- *“Increase accountability and transparency amongst NGOs;*
- *Respect and preserve diversity within the sector across Europe;*
- *Invest in governance enhancement activities (such as tools for the assessment of governance, and the implementation of improvements);*
- *Demonstrate the relevance of good governance to the NGO sector;*
- *Deal with risks associated with governance and the potential role EU institutions might play, including ensuring governance and other capacity issues are met without unreasonable burden;*
- *Ensure the process is led by the sector;*
- *Learn from what has been done so far (not reinvent the wheel); and,*
- *Develop opportunities for partnership with other sectors within the EU and other international networks”.*

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292 Eakin, L., Graham, H., Blickstead, R. & Shapcott, M. (2009)

293 Euclid Network (2008)

## APPENDIX 2: Indicators for Australia's Fourth National Mental Health Plan

Priority Area	Indicators for Monitoring Change
SOCIAL INCLUSION AND RECOVERY	<ol style="list-style-type: none"> <li>1. Participation rates by people with mental illness of working age in employment</li> <li>2. Participation rates by young people aged 16–30 with mental illness in education and employment</li> <li>3. Rates of stigmatising attitudes within the community *</li> <li>4. Percentage of mental health consumers living in stable housing *</li> <li>5. Rates of community participation by people with mental illness *</li> </ol>
PREVENTION AND EARLY INTERVENTION	<ol style="list-style-type: none"> <li>6. Proportion of primary and secondary schools with mental health literacy component included in curriculum</li> <li>7. Rates of contact with primary mental health care by children and young people</li> <li>8. Rates of use of drugs that contribute to mental illness in young people</li> <li>9. Rates of suicide in the community</li> <li>10. Proportion of front-line workers within given sectors who have been exposed to relevant education and training *</li> <li>11. Rates of understanding of mental health problems and mental illness in the community*</li> <li>12. Prevalence of mental illness*</li> </ol>
SERVICE ACCESS, COORDINATION AND CONTINUITY OF CARE	<ol style="list-style-type: none"> <li>13. Percentage of population receiving mental health care</li> <li>14. Readmission to hospital within 28 days of discharge</li> <li>15. Rates of pre-admission community care</li> <li>16. Rates of post-discharge community care</li> <li>17. Proportion of specialist mental health sector consumers with nominated general practitioner *</li> <li>18. Average waiting times for consumers with mental health problems presenting to emergency departments *</li> <li>19. Prevalence of mental illness among homeless populations *</li> <li>20. Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities</li> </ol>
QUALITY IMPROVEMENT AND INNOVATION	<ol style="list-style-type: none"> <li>21. Proportion of total mental health workforce accounted for by consumer and carer workers</li> <li>22. Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards</li> <li>23. Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system</li> <li>24. Proportion of consumers and carers with positive experiences of service delivery *</li> </ol>
ACCOUNTABILITY – MEASURING & REPORTING PROGRESS	<ol style="list-style-type: none"> <li>25. Proportion of mental health service organisations publicly reporting performance data *</li> </ol>

\* These indicators require further development

### APPENDIX 3: NHHRC Mental Health Recommendations

The National Health & Hospitals Reform Commission (NHHRC) recommendations relating to supporting people living with mental illness include:

We recommend that a youth friendly community-based service which provides information and screening for mental disorders and sexual health be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.

We recommend that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

We recommend that every acute mental health service have a rapid-response outreach team for those individuals experiencing psychosis and subsequently have the acute service capacity to provide appropriate treatment.

We recommend that every hospital-based mental health service should be linked with a multidisciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.

We strongly support greater investment in mental health competency training for the primary health care workforce, both undergraduate and postgraduate, and that this training be formally assessed as part of curricula accreditation processes.

We recommend that each State and Territory government provide those suffering from severe mental illness with stable housing that is linked to support services.

We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.

We recommend that State and Territory governments recognise the compulsory treatment orders of other Australian jurisdictions.

We recommend that health professionals should take all reasonable steps in the interests of patient recovery and public safety to ensure that when a person is discharged from a mental health service that:

- there is clarity as to where the person will be discharged; and,
- someone appropriate at that location is informed.

We recommend a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.

We acknowledge the important role of carers in supporting people living with mental disorders. We recommend that there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery.

## APPENDIX 4: AHHA & MHCA and the Fourth National Mental Health Plan Priorities

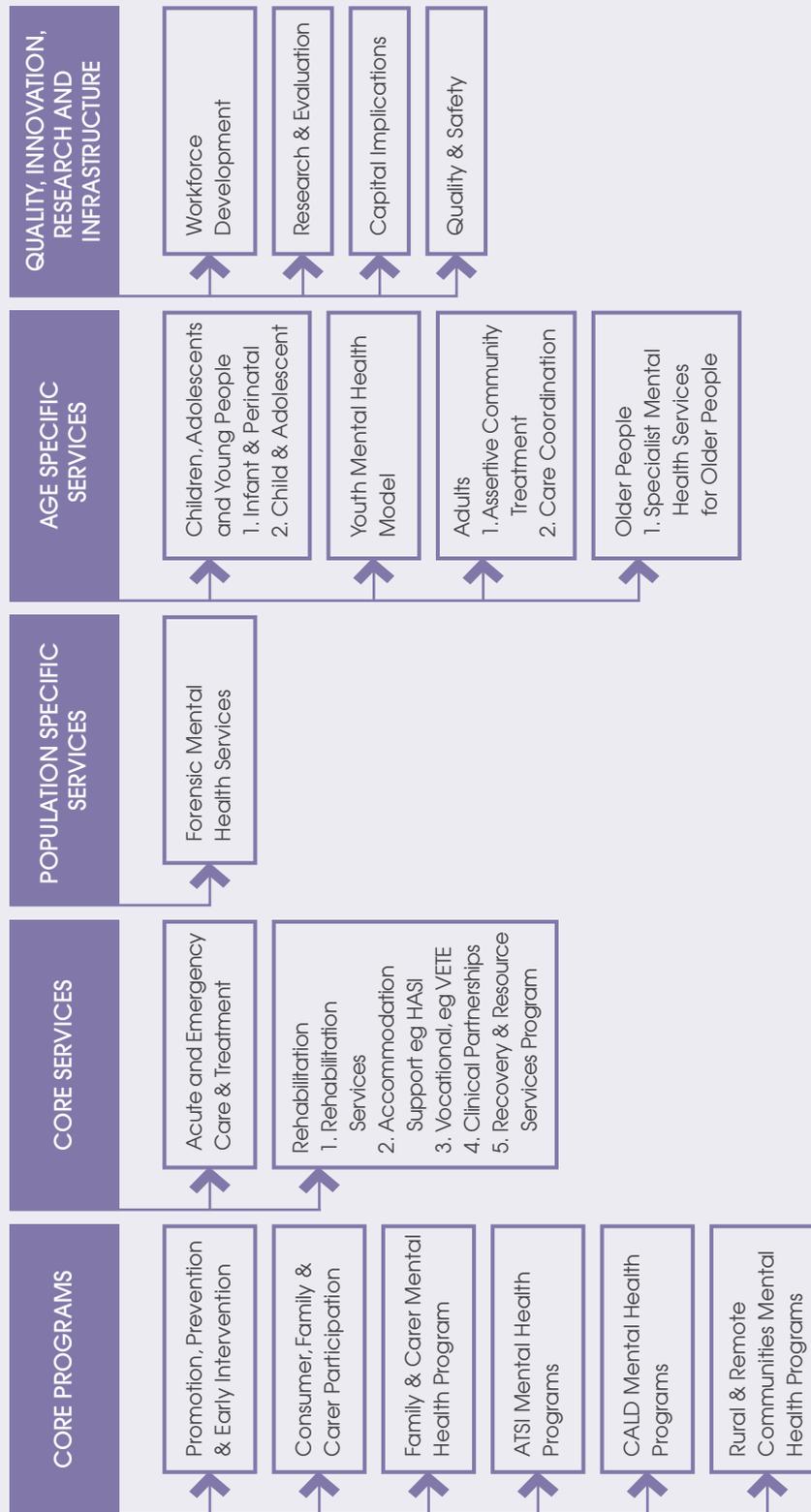
The Australian Healthcare and Hospitals Association (AHHA)<sup>294</sup> and Mental Health Council of Australia (MHCA) distilled elements common to various best practice models in order to build a foundation for a framework of community mental health supports in Australia<sup>295</sup>. These have been organised under the first three priority areas of the Fourth National Mental Health Plan below.

4th National MH Plan	AHHA	MHCA
1. Social inclusion and recovery	<ul style="list-style-type: none"> <li>• Recovery oriented services towards:               <ol style="list-style-type: none"> <li>a) growth throughout life;</li> <li>b) empowering service users;</li> <li>c) setting own goals, priorities;</li> <li>d) control over one's own life;</li> <li>e) social inclusion &amp; citizenship; and</li> <li>f) resilience.</li> </ol> </li> <li>• Holistic services.</li> </ul>	<ul style="list-style-type: none"> <li>• Responsive to individual need.</li> <li>• Enable self advocacy.</li> <li>• Valued social roles.</li> <li>• Holistic services:               <ol style="list-style-type: none"> <li>a) assisting people to live independently in their homes;</li> <li>b) assisting people to participate in education, employment and the social life of their community; and,</li> <li>c) services to address the complexity of issues affecting peoples' lives, including dealing with coexisting drug and alcohol issues.</li> </ol> </li> </ul>
2. Prevention and early intervention	<ul style="list-style-type: none"> <li>• Comprehensive services.</li> <li>• Holistic services.</li> </ul>	<ul style="list-style-type: none"> <li>• Holistic services:               <ol style="list-style-type: none"> <li>a) illness prevention and early intervention support when illness first strikes; and,</li> <li>b) the prevention of relapse following recovery.</li> </ol> </li> <li>• Work with natural supports.</li> <li>• Peer support.</li> </ul>
3. Service access, coordination and continuity of care	<ul style="list-style-type: none"> <li>• Comprehensive services.</li> <li>• Continuity over time.</li> <li>• Integrated, coordinated efforts .</li> <li>• Age-appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• Pathways supporting people into a range of services.</li> <li>• Continuity of support.</li> <li>• Active, collaborative.</li> <li>• High level interaction between all providers .</li> <li>• Positive engagement.</li> <li>• Services supported by good practice.</li> <li>• Trauma-informed care principles.</li> </ul>

294 AHHA (2008).

295 Mental Health Council of Australia (2006)

APPENDIX 5: NSW Health Community Mental Health Services Model



## APPENDIX 6: Summary of Productivity Commission Recommendations (2010)

1. **Smarter regulation of the not-for-profit sector**
  - a. *A national one-stop-shop to consolidate Commonwealth regulatory oversight and tax endorsement*
  - b. *Enhancing legal options for NFPs*
  - c. *Reduce compliance costs and improve effectiveness*
2. **Building knowledge systems**
  - a. *Promoting national data systems on the NFP sector*
  - b. *Building a better evidence base for social policy*
3. **Improving arrangements for effective sector development**
  - a. *Improving equity and effectiveness of tax concessions for philanthropy*
  - b. *Developing a sustainable market for NFP debt*
  - c. *Building sector capabilities to improve governance and enhance productivity*
  - d. *Addressing workforce issues*
4. **Stimulating social innovation**
  - a. *Building sector capabilities to support innovation*
5. **Improving the effectiveness of direct government funding**
  - a. *Providing clarity over funding obligations*
  - b. *Ensuring appropriate independence*
6. **Removing impediments to better value government funded services**
  - a. *Getting the model right*
  - b. *Improving procurement and management processes*
7. **Implementation of the proposed package of reforms**





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