Submission

to the

Select Committee on Mental Health to inquire into

and report on

mental health services in NSW

from

Mental Health Coordinating Council

April 2002

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Abbreviations

CAG	Consumer Advisory Group
CCC	Community Consultative Committee
DADHC	Department of Aged, Disability and Home Care
DHAC	Department of Health and Aged Care
HREOC	Human Rights and Equal Opportunity Commission
MAP	Mapping Analysis and Performance
MHCC	Mental Health Coordinating Council
MH-OAT	Mental Health Outcome Assessment Training
NSWCAG	New South Wales Consumer Advisory Group
NGO	Non-government organisation
PDSS	Psychiatric Disability Support Services
QMS	Quality Management Services
SACS	Social and Community Services (award)
VICSERV	Psychiatric Disability Services of Victoria
WHO	World Health Organisation

Recommendations

The MHCC requests that the Select Committee consider the following recommendations, under each Term of Reference. The aim of these recommendations is to assist the mental health NGO sector to meet the needs of people with mental health disabilities through the provision of effective and sustainable services.

a) The changes which have taken place since the adoption of the Richmond Report, and
b) The impact of changes in psychiatric hospitalisation and/or asylum

1. It is recommended that NSW Health in partnership with MHCC, review the adequacy of service provision for people with mental health disabilities living in the community.

2. It is recommended that data on readmissions to psychiatric units be collected at three, six and 12 month intervals in addition to the 28 day readmission data already collected, to assist the planning of services with a relapse prevention focus.

3. It is recommended that carers of people with mental illnesses be assessed for their capacity to support consumers, be included in the planning of care programs and be assisted to access support for themselves.

c) Levels and methods of funding for mental health services in NSW, including comparisons with other jurisdictions

4. It is recommended that allocation of the $107.5 million of new mental health funding announced in April 2000 be discussed and accounted for in an open and transparent manner.

5. It is recommended that funding benchmarks for mental health NGOs in NSW are developed to ensure services be funded at financially viable levels for the delivery of high quality services. These benchmarks need to take account of award increases, insurance premiums, CPI and the effect of government legislation and regulation such as accreditation, compulsory superannuation payments and occupational health and safety requirements.

6. It is recommended that additional funds be allocated to the mental health NGO sector following a joint needs assessment and a fully costed mental health service plan in each Area Health Service. The NSW government should use this process to allocate sufficient funds in the next two years to bring the mental health NGO sector in NSW into line with, at least, national average expenditures on mental health NGO services.

7. It is recommended that an independent funding committee with a community based NGO sector representative, a consumer representative, an Area Health Service representative and a NSW Health representative be formed to make decisions about the allocation of new funding.

d) Community participation in, and integration of, mental health services

8. It is recommended that NGO employees on government committees participate as representatives of the mental health NGO sector and as such are able to consult with their peers and member organisations.

9. It is recommended that NSW Health funds MHCC to review the structure and function of Community Consultative Committees in each Area Health Service to ensure there is a mechanism for genuine consultation with consumer, carer, NGO and community representatives.

10. It is recommended that NGOs be recognised as providing a base and an opportunity for contributions from volunteers and that this function be adequately resourced to provide appropriate training, support and coordination of voluntary workers.

11. It is recommended that the mental health NGO sector is consulted about 'Whole of Government' decisions which could impact on the sector.

e) Quality control of mental health services

12. It is recommended that, following an accreditation review, mental health NGOs are funded to bring their services up to the required standards, particularly in relation to occupational health and safety standards.

f) Staffing levels in NSW mental health services

13. It is recommended that MHCC is funded to investigate work force issues in the mental health NGO sector and develop solutions to the issues that affect the ability of the sector to recruit and retain staff.

g) The availability and mix of mental health services in NSW

14. It is recommended that the role of the mental health NGO sector is clearly defined within the mental health system of care, including recognition of the sector's present responsibilities in caring for people with mental health disabilities and the case management services already provided.

15. It is recommended that an NGO sector development position be funded for a period of three years to coordinate the joint planning of NGO and public mental health services within each Area Health Service catchment area. This position should be based at MHCC and work closely with NSW Health, individual Area Health Services and the broad non-government sector.

16. It is recommended that there be equitable access to services for people with mental health problems and disorders, especially for people in rural and remote areas. The sector development officer (recommendation 15) would work in partnership with Area Health Services to develop flexible and creative solutions to address gaps in service provision.

17. It is recommended that the policy to refer stabilised clients to general practitioners for ongoing mental health care be reviewed to discover whether all clients have adequate access to a general practitioner who can provide skilled and effective mental health care services at no direct cost to the client.

h) Data collection and outcome measures

18. It is recommended that NSW Health in collaboration with mental health NGOs research and field test suitable outcome measures for the various types of services provided by the mental health NGO sector.

19. It is recommended that the mental health NGO staff are provided with adequate training in the use of relevant outcome measures for the sector and funding is provided to resource the process of data collection and collation.

1. Mental Health Coordinating Council

The Mental Health Coordinating Council (MHCC) is the peak body for the mental health non-government sector in NSW. The mission of the MHCC is to provide leadership and an independent public voice on mental health issues, facilitate intersectoral linkages and operate as an information clearing house for mental health service providers, consumers and carers within NSW.

2. MHCC Response to the Terms of Reference

2.1 The changes which have taken place since the adoption of the Richmond Report *and* the impact of changes in psychiatric hospitalisation and/or asylum (a) and (b)

The first two Terms of Reference are closely related and have been considered together.

The Richmond Report was released in 1983. It is usually perceived by the community as synonymous with deinstitutionalisation and the discharge of most patients from long stay wards in psychiatric hospitals into the community. The main purpose of the Richmond Report however was to acknowledge that, with significant improvements in pharmacological treatments for people with mental illness especially anti-psychotic medications since the late 1950s, most people with 'serious mental illness' were already living in the community. Because patients with serious mental illness no longer needed to spend long periods in psychiatric hospitals, the focus of care needed to move from hospital to community care.

Following the Richmond Report, state mental health policies (NSW Department of Health, 1985a) and a forward plan (NSW Department of Health, 1985b) were developed. This led to a significant increase in crisis and extended hours services, case management services and rehabilitation services although the level of need was greater than could be met by the resources provided.

Only relatively few patients were discharged from long stay wards to the community following the Richmond Report. The number of people residing in psychiatric hospitals in NSW in 1985 was 55 per 100,000 population and the total population was 5.6 million. Between October 1984 and October 1987, 208 long-term patients were discharged from hospitals and placed in supported group homes. At a follow up review, Andrews et al (1990) found that the majority was successfully living in the community, while 22 patients had been rehospitalised. At the time of the study the residents had been living in the community for varying lengths of time, ranging from three to 40 months post discharge.

The change in focus of care from the large psychiatric institutions to the community was accompanied by numerous evaluations of community mental health care. A number of studies showed that people with mental illness prefer living in the community (Hoult 1986; Andrews et al, 1990) and that their level of functioning improved (Stein and Test, 1980; Middleboe, 1997; Anderson et al, 1993) if they were provided with an adequate level of care.

The MHCC strongly supports a community focussed, non-institutional system of mental health care. As detailed in our response to Terms of Reference (c) and (g), MHCC's major concerns are related to the inadequate levels of community mental health services provided by the public health system and the shortage of psychosocial rehabilitation services. The latter services respond to a person's 'whole of life' needs in a community setting and include supported residential services, day centres which provide social and recreational activities and link clients to other such services in the community, outreach support services, vocational and employment services, and information and education services. Even though NSW Health has recently acknowledged in its draft document, *NGOs and Mental Health: a Framework for Partnership*, that these services are most appropriately provided by the non-government sector (NSW Health, 2002), there has been no indication that new funds will be allocated for this purpose.

With the focus of care now in the community, rather than the large psychiatric hospitals, some mental health commentators have expressed concern about the loss of places of asylum for people with mental health disabilities. While hospital may have provided asylum for some patients, many patients did not experience psychiatric hospitals as a place of asylum. There was little room within the large institutions to meet the individual needs of patients. The MHCC supports the notion of the need for 'places of asylum' and believes that these places should be available in community settings. Depending on the individual needs of a person the 'place of asylum' may be a supported residential facility, a day centre, a supported employment service or another facility where the person feels welcome, safe and supported and from where realistic linkages back into the community may be gradually achieved.

In the section *Values and Principles about Health Care*, the Richmond Report made some key statements that guided the provision of mental health services for at least a decade.

> "Wherever possible mental health services should give priority to the seriously mentally ill."
>
> "Public sector health services should give priority to the needs of the socially and economically disadvantaged" (Richmond, 1983: 3).

Within the last decade the direction of mental health services in NSW has moved away from a focus on care for the most disabled clients to a focus on health promotion and early intervention. MHCC sees promotion and intervention as important and useful. However MHCC is concerned that the apparent change of direction has resulted in neglect or down-grading of services for people with continuing and severe mental illnesses.

Further there appears to be a much greater focus in the public sector on treating depression and anxiety rather than psychosis. While it is acknowledged that the prevalence of depression and anxiety is much higher than the prevalence of psychotic illnesses, depression and anxiety are generally easier to treat and clients with these illnesses tend to be more reliable in following treatment regimes. Most of these clients were (and still are) treated by general practitioners and private psychiatrists.

The NSW Health mental health policy documents released in the last five years reflect this change in direction. The MHCC is concerned that the mental health NGO sector was not consulted about this change of direction that has had a direct impact on their services. The non-government sector is under increasing pressure to support the most disabled clients with psychotic illnesses in the community with inadequate resources and inadequate clinical back up from the public sector.

Families and friends of people with mental illnesses are similarly under increasing pressure to fill the gaps in necessary care and support. Family support groups frequently bemoan the lack of response from emergency and case management services and the lack of access to psycho-social rehabilitation services. Assessment of the capacity of carers to support consumers and their inclusion in planning care programs needs to be formalised. The impact of caring for a family member or friend experiencing mental illness can, itself create mental health problems in carers. Carers may experience fear, anxiety, guilt and depression and may in some circumstances have real concerns for their personal safety. There is currently inadequate consideration and support given to carers of people experiencing mental health problems.

As well as being associated with deinstitutionalisation, the Richmond Report has also been associated with increasing levels of homelessness among people with mental illness. In NSW the inpatient census in psychiatric hospitals fell from 256 to 55 per 100,000 population between 1950 and 1985, the latter rate being lower than the rates of other developed countries. The follow up study of the 208 long stay patients discharged into supported accommodation following the Richmond Report found that no patients had drifted to a refuge for the homeless (Andrews et al, 1990). However prevalence studies of homeless people in inner city refuges found that the proportion of people with schizophrenia has increased from 16 per cent in 1983 (Doutney et al, 1985) to 26 per cent in 1988 (Teesson and Buhrich, 1990) to 29 per cent in 1997 (Hodder et al, 1998). The above studies support Lamb's argument that people with mental illness do not necessarily become homeless as a result of deinstitutionalisation, but they do so if suitable accommodation and support is not provided in the community (Lamb, 1984).

In 1993 the Human Rights and Equal Opportunity Commission (HREOC) in Australia published a major two volume report called *Report of the National Inquiry into the Human Rights of People with Mental Illness*, known as the Burdekin Report. The report found that people affected by mental illness are among the most vulnerable and disadvantaged in our community. They suffer from widespread, systematic discrimination and are consistently denied the rights and services to which they are entitled. The report concluded that a major injection of resources would be needed before Australia was in a position to comply with our international obligations under the United Nations Principles for the Protection of Persons with Mental Illness (HREOC, 1993).

The main development in mental health care since the release of the Burdekin Report nine years ago has been the National Mental Health Strategy. The strategy provided policy and strategic directions for mental health services throughout Australia and a community awareness campaign. Key documents include the *National Mental Health Policy*, the *Mental Health Statement of Rights and Responsibilities*, the first *National Mental Health Plan* (1992-1997) and the *Second National Mental Health Plan* (1998-2003). Funding for mental health services was made for specific services and to meet certain targets in the

Strategy but the overall funding for mental health services continued to fall far short of what was needed to meet the needs of people with mental illness living in the community.

Some people with mental illness have frequent admissions to hospital. This is known as the 'revolving door' syndrome. Currently mental health services are required to collect statistics on readmissions within 28 days of discharge. A number of mental health services examine why readmission was required, with a particular focus on the adequacy of the discharge plan. While these data are useful and should form standard reporting in all services the availability of readmission data at three, six and 12 month intervals would enable NSW Health and the NGO sector to assess more fully the extent of the 'revolving door' syndrome. Analysis of these data would assist health planners to identify factors, interventions or services that could prevent readmission. These readmission figures are currently not reported but could be accessed from clients' records.

Recommendations

1. It is recommended that NSW Health in partnership with MHCC, review the adequacy of service provision for people with mental health disabilities living in the community.

2. It is recommended that data on readmissions to psychiatric units be collected at three, six and 12 month intervals in addition to the 28 day readmission data already collected, to assist the planning of services with a relapse prevention focus.

3. It is recommended that carers of people with mental illnesses be assessed for their capacity to support consumers, be included in the planning of care programs and be assisted to access support for themselves.

2.2 Levels and methods of funding for mental health services in NSW (c)

The MHCC is particularly concerned about the levels and methods of funding for the non-government mental health sector. However the lack of adequate public mental health services in NSW, especially crisis and extended hours services, acute inpatient units and case management services, also has a significant impact on the non-government sector. This is discussed under Term of Reference *g) The availability and mix of mental health services.*

2.2.1 Level of funding for mental health NGOs

In NSW there has been no systematic approach to the development of the NGO sector. While the government has drafted the document *NGOs and Mental Health: a Framework for Partnership*, there is no state government plan that identifies the volume and type of mental health NGO services required on a population and/or catchment area basis.

The lack of guidelines and planning means that:

- there is little imperative to provide adequate funding to the mental health NGO sector in NSW, and
- the current distribution of mental health NGOs does not reflect the needs of the population.

The National Mental Health Strategy has been collecting comprehensive data on expenditure in mental health services since 1992-93 financial year. These data are derived from "the development of nationally agreed measures of performance in relation to the objectives of the Strategy" (DHAC, 2000:8).

Six National Mental Health Reports have provided funding data under the National Mental Health Strategy. The latest report published in 2000 provides data for 1997-98 financial year. Table 1 below shows the change in the percentage of total mental health service expenditure on mental health NGOs and per capita expenditure between 1992-93 and 1997-98.

Table 1. Expenditure on mental health NGOs, 1992-93 and 1997-98

	1992/93	1992/93	1997/98	1997/98
	Percentage of total mental health expenditure spent on mental health NGOs	Per capita expenditure on mental health NGOs	Percentage of total mental health expenditure spent on mental health NGOs	Per capita expenditure on mental health NGOs
	%	$	%	$
NSW	1.3	0.82	1.7	1.16
Victoria	2.9	2.24	9.6	7.49
Queensland	1.3	0.67	5.2	3.47
Western Aust.	2.4	1.55	5.6	4.86
South Aust.	1.6	1.11	2.0	1.64
Tasmania	3.0	1.96	3.5	2.73
ACT	2.5	1.32	5.9	1.60
Nth Territory	1.0	0.54	5.1	3.78
National average	1.8	NA	5.0	3.66

NA – not available (DHAC, 2000)

Table 1 shows that NSW spends a markedly lower proportion of its total mental health service expenditure, and a lower per capita expenditure, on mental health NGO services than other states/territories spend. On both measures, NSW was below the national average.

At the NGO mental health conference, *NGOs, Mental Health and Community: Focussing on the Future*, in September 2001 the keynote speaker Mr Phil Nadin, Executive Director of the Psychiatric Rehabilitation Association, summarised the data as follows:

In 1998, the most recent year for which figures are available, the NGO share of NSW's mental health budget was a miserable 1.7 per cent. Not only is this figure the lowest in the country, it's less than half the national average. NSW's performance in this regard was the worst of all states and territories when the National Mental Health Plan commenced, and since then we've fallen further behind. In the six years of the strategy's reporting, the NSW figure has grown by only 48 per cent compared to a national increase of 201 per cent (Nadin, 2001).

In April 2000 the NSW Minister for Health Mr Craig Knowles announced an additional $107.5 million dollars over three years for mental health services and specifically mentioned that funding for the NGO sector would be increased. Unfortunately the press release did not indicate the size of the increase. However at the time of the Minister's announcement, the NGO sector felt confident that the increase would bring funding for the mental health sector in NSW into line with at least the national average.

MHCC has not been able to ascertain how this funding has been allocated to mental health services, especially mental health NGOs. We are aware of new funding for only three programs, totalling about $450,000. This figure will have little impact on the overall proportion of total mental health funding available for the NGO sector in NSW.

At the Health Estimates Committee hearing of the Legislative Council's General Purpose Standing Committee on 20 June 2001, a senior NSW Health departmental officer reported that the increase in funding to mental health NGOs in 2000-2001 was 1.2 per cent. As the CPI for 2000-2001 was 2.5 per cent, this meant the mental health NGO sector sustained a funding cut in real terms. When asked about funding for mental health NGOs in 2001-2002, NSW Health was only prepared to say that there was an assumption in the mental health budget was that there would be a 9 per cent increase in funding for mental health services in NSW. No indication was given about how much of this funding increase would be allocated to mental health NGOs (NSW Legislative Council, 2001).

Adequate funding of the mental health NGO sector should be seen as a cost-effective option for the government. The MHCC contends that specialist mental health NGOs providing support to people with mental health disabilities living in the community focus on relapse prevention, increase the level of independence and employment prospects of their clients and reduce their need for hospitalisation.

2.2.2 Funding formula

There is no funding formula for mental health NGOs in NSW. This has resulted in very low levels of funding for both staffing and operating costs in most NGOs. There is no additional funding for rising insurance premiums and compulsory superannuation payments. In relation to salary award increases, the government has provided supplementary funding for services employing staff under the Social and Community Services (SACS) award, which covers most NGO employees. However, it has not been granted to services that have entered into Enterprise Agreements unless the service formally stated that the Agreements are linked to the SACS Award, or to NGOs funded under Commonwealth grants. The absence of supplementary funding has resulted in NGOs having to consider reducing their staffing levels to meet award rates of pay or replacing staff who resign with less qualified staff on lower pay rates.

In contrast the Department of Human Services in Victoria has set benchmarks for the funding of their Psychiatric Disability Support Services (mental health NGOs). The benchmarks include 80 per cent for basic salary, 12.5 per cent for salary on-costs and 7.5 per cent for operating costs. The two benchmarks are:

- Home Based Outreach (per full time equivalent staff member) $52,600 per annum
- Day Programs (per full time equivalent staff member) $53,900 per annum

While these levels of funding appear reasonably generous to the mental health NGO sector in NSW, the peak body for mental health NGOs in Victoria (VICSERV) is in the process of lobbying to increase the funding benchmarks. The current levels are seen as inadequate for the delivery of high quality services by the NGO sector (VICSERV, 2002).

2.2.3 Funding decisions

The mental health NGO sector is concerned about what they perceive as a major conflict of interest where Area Health Services are both purchasers and providers of services. Under the current system NGOs and Area Health Services compete for the same funds, but it is often Area Health Services who decide or influence decisions about whether or not NGOs receive any new funding. This occurs because NGOs are requested to submit funding applications through the Area Health Service. This would not be such a problem if funding decisions were made on jointly agreed and costed mental health plans to ensure that funds were spent where they were most needed. Alternatively a small independent committee with a community based NGO sector representative, a consumer representative, a Area Health Service representative and a NSW Health representative should be formed to ensure NGOs receive a fair share of new funds to meet the needs of their target groups.

Recommendations

4. It is recommended that allocation of the $107.5 million of new mental health funding announced in April 2000 be discussed and accounted for in an open and transparent manner.

5. It is recommended that funding benchmarks for mental health NGOs in NSW are developed to ensure services be funded at financially viable levels for the delivery of high quality services. These benchmarks need to take account of award increases, insurance premiums, CPI and the effect of government legislation and regulation such as accreditation, compulsory superannuation payments and occupational health and safety requirements.

6. It is recommended that additional funds be allocated to the mental health NGO sector following a joint needs assessment and a fully costed mental health service plan in each Area Health Service. The NSW government should use this process to allocate sufficient funds in the next two years to bring the mental health NGO sector in NSW into line with, at least, national average expenditures on mental health NGO services.

7. It is recommended that an independent funding committee with a community based NGO sector representative, a consumer representative, an Area Health Service representative and a NSW Health representative be formed to make decisions about the allocation of new funding.

2.3 Community participation in, and integration of, mental health services (d)

2.3.1 Community participation

Community participation is an integral component of capacity building in the mental health NGO sector. Community participation occurs through a number of structures as outlined below.

Board of Directors or a Management Committee
Members of these boards or committees usually represent key community organisations and government services providing complementary and related services such as Area Health Services, NSW Department of Community Services, NSW Department of Housing, local government, clergy, local businesses, community members, and carer and consumer groups. Together they provide a wide range of expertise in management, grant administration, fundraising and client related issues. The structure provides a formal mechanism for the development of partnerships with the agencies most commonly accessed by clients of the service.

Mental health NGO representatives on government planning committees
MHCC or other member organisations are asked from time to time to participate in government or Area Health Service planning processes to represent the non-government mental health sector. MHCC fully supports the opportunity to participate in these committees and processes.

At other times individuals, rather than representatives from MHCC or member organisations, are asked to participate in planning processes. The individual is unable to consult their organisation or member organisations. In fact they are often precluded from discussing the issues raised within the meeting with anyone outside the meeting. This lack of open discussion and consultation marginalises the input of the mental health NGO sector.

Consumer groups and Community Consultative Committees
The peak body for the mental health consumer movement is the NSW Consumer Advisory Group (NSWCAG). There are various structures in place for communication between consumers, the peak body and government. Many areas have a local Consumer Advisory Group that represents the interests of consumers at various Area Health Service committees.

Structures and mechanisms for broader representation from consumers, carers, NGOs and community members vary from area to area. The main mechanism for community consultation is through Community Consultative Committees (CCCs) which have been established in most Area Health Services. Some areas have well developed and supported CCCs which meet to discuss local issues and contribute to the planning and evaluation of services to ensure they relevant to the needs of consumers and carers. In other areas, CCCs struggle without resources, support or due recognition. A review of CCCs and other mechanisms for consumer, carer and community input across NSW is needed to ensure avenues for consultation between major stakeholders and mental health services are operating to enhance service delivery to consumers and carers.

Volunteers
Volunteers are a valuable resource in the NGO sector in that they increase the capacity of services and broaden their perspective on the provision of care and support to clients. Many NGOs use volunteers to expand the range of services and resources provided. It should be recognised however that an effective volunteer program is resource intensive as volunteers need coordination, training, supervision and support to provide quality services.

Volunteers also play an important role in increasing community awareness of mental health issues and decreasing discrimination experienced by people with a mental illness. For example, a mental health NGO on the North Coast of NSW invited artists to conduct workshops on art therapy, drawing for pleasure, etc. The artists in turn invited people living with a mental illness to exhibit their work and donated the proceeds of exhibitions to the NGO. The artists reported that this project has led to greater awareness of mental health issues within the artistic community.

2.3.2 Integration of mental health services

The integration of mental health services with other human services such as housing, child protection, disability, employment, income support and youth services is an important part of the 'Whole of Government' strategic direction. The integration of human services will assist to break down some of the demarcations between services and provide clients with a more seamless system of care. The intention of the 'Whole of Government' approach is laudable and success stories have been documented in government reports such as *Working Together in the Public Sector. Guidelines for Collaboration and Integrated Services* (Premiers Department, 1999).

The 'Whole of Government ' approach is compatible with the NGO sector's aim to assist clients to meet their 'whole of life' needs as described in *Term of Reference a).*

The mental health NGO sector however has two key concerns about the 'Whole of Government' strategic direction.

Role of non-government funded services in 'Whole of Government'
The non-government sector, largely funded by government and providing complementary human services, does not have a seat at 'Whole of Government' meetings. This means the sector is often excluded from decisions that may have a direct impact on its services. For example the NGO mental health sector is aware that discussions have taken place about which government department should be responsible for funding non-government services for people with mental health disabilities, ie. NSW Health or the Department of Aging, Disability and Home Care (DADHC). Any decision to change funding responsibilities would significantly affect service provision for the sector's client group and as such MHCC's input into such decisions is critical.

Risks associated with 'Whole of Government' for NGO sector
Closely related to our concern that the NGO sector may be excluded from critical decision making is the risk that if services such as mental health services are deemed to be a 'Whole of Government' responsibility, then no government department will accept ultimate responsibility and services will become fragmented. Our concern is that this may lead to 'buck passing', the very thing the 'Whole of Government' approach is attempting to avoid.

Recommendations

8. It is recommended that NGO employees on government committees participate as representatives of the mental health NGO sector and as such are able to consult with their peers and member organisations.

9. It is recommended that NSW Health funds MHCC to review the structure and function of Community Consultative Committees in each Area Health Service to ensure there is a mechanism for genuine consultation with consumer, carer, NGO and community representatives.

10. It is recommended that NGOs be recognised as providing a base and an opportunity for contributions from volunteers and that this function be adequately resourced to provide appropriate training, support and coordination of voluntary workers.

11. It is recommended that the mental health NGO sector is consulted about 'Whole of Government' decisions which could impact on the sector.

2.4 Quality control of mental health services (e)

Historically, participation by NGOs in quality improvement programs was on a voluntary basis. However, most organisations are now required to participate in quality review programs as a condition of continued funding.

In the mid-1990s, with the introduction of the NSW Disability Services Standards (developed to implement the NSW *Disability Services Act 1993*), the then Ageing and Disability Department (now DADHC) funded the review of supported residential and other disability services against the NSW Disability Services Standards. A number of MHCC member organisations achieved a three-year accreditation while others were required to develop transition plans.

For NGOs funded by NSW Health, the Conditions of Grant state that "organisations must be willing to undergo an ongoing formal accreditation process that is mutually negotiated and agreed to." A number of mental health NGOs are currently undergoing this process with Quality Management Services (QMS), a non-profit organisation providing an accreditation service to a range of government and non-government services. NSW Health has assisted this process by partially funding QMS to provide the accreditation service. Most NGOs undergoing accreditation also contribute to the costs of the service provided by QMS.

Accreditation with QMS involves compliance with a core module of service management standards and one or more other modules specific to the type of service. For example a service may then be monitored against the National Mental Health Standards, the Disability Services standards and/or the Women's Health Standards.

In addition, the Disability Services Amendment (Improved Quality Assurance) Bill 2002 was recently passed through the Senate. The Bill requires funded organisations (by the end of 2004) to demonstrate to an independent auditor that they comply with the Disability Service Standards in each state and territory.

The NGO mental health sector is fully supportive of the need for continuous quality improvement and many services have developed internal processes to ensure ongoing compliance with relevant standards. The main issue for mental health NGOs in relation to continuous quality improvement is the lack of infrastructure funding to enable their services to meet the required standards. This includes:

- funding for staff to complete the work and administer the processes required by the accrediting bodies; and
- operational funds to assist services to comply with Occupational Health and Safety Standards.

Compliance with legislation such as the *Occupational Health and Safety Act 2000,* the *Superannuation Act 1993,* the Commonwealth *Privacy Act 1988 and* the NSW *Privacy and Personal Information Protection Act 1998* increases the administrative costs of not for profit NGOs. Increased administrative costs of this nature are often absorbed by the organisation through further appeals to the generosity of benefactors or the erosion of trust capital which may ultimately weaken the long term financial viability of organisations.

While all relevant legislation impacts on the cost of running NGOs, the cost of compliance with the *Occupational Health and Safety Act 2000* is often prohibitive and cannot be implemented without significantly compromising the current levels of NGO services. In order to comply with such legislation NGOs must be better resourced, both in terms of training and operational funding. A report commissioned by MHCC examined the statutory obligations of the Commonwealth *Occupational Health and Safety Act 2000,* ie "to identify, eliminate or control any foreseeable hazard...that has the potential to harm...any employee...or...any other person legally at the employees place of work" (Lambert, 2002: 4). To discharge these obligations, NGOs will have little option but to shift resources from direct service delivery to clients, to the job of risk assessment and review.

Recommendation

12. It is recommended that, following an accreditation review, mental health NGOs are funded to bring their services up to the required standards, particularly in relation to occupational health and safety standards.

2.5 Staffing levels in NSW mental health services (f)

Staffing levels reflect both the levels of funding for mental health services and the ability of services to recruit and retain staff. Issues related to the funding of mental health services in NSW are discussed in Term of Reference (c). The recruitment and retention of staff in mental health services in both the public and NGO sectors are major problems across Australia, particularly so in rural and remote areas. It appears that employment in human services is becoming an increasingly unattractive employment option for young people choosing careers and for older workers who have been in the human services industry for some years.

In the non-government sector the reasons for difficulties in recruiting and retaining staff include:

- poor pay levels which do not reflect the skills required of staff
- inadequate support and supervision to assist staff cope with the emotional demands of their positions
- lack of tertiary courses that adequately prepare staff to work in mental health services in the non-government sector
- lack of support and funds for professional development training
- lack of infrastructure funds to adequately support staff to do their jobs. For example staff often have limited access to computers and other equipment and administrative support
- critical shortage of mental health nurses across NSW
- increasing levels of violence in some NGOs due to services caring for people who are acutely unwell while waiting for a response from emergency services in the public mental health sector
- lack of adequate funds to ensure services meet Occupational Health and Safety Standards and staff are trained in matters of safety
- lack of a suitable minimum data set that would give staff timely and relevant feedback on the effectiveness of their work.

Despite these difficulties there are many people who are committed to providing high quality services in the mental health NGO sector. The concern is that the past level of commitment cannot be sustained in light of the difficulties outlined above.

Recommendation

13. It is recommended that MHCC is funded to investigate work force issues in the mental health NGO sector and develop solutions to the issues that affect the ability of the sector to recruit and retain staff.

2.6 The availability and mix of mental health services in NSW (g)

In a non-institutionalised mental health system, the vast majority of people with mental health problems and disorders spend most of their lives in the community. Many of the services that provide the ongoing support necessary for people with mental health problems to live successfully in the community are provided by NGOs, both specialist mental health NGOs and generalist NGOs.

Services provided by specialist mental health NGOs are specifically aimed at improving the quality of life and the 'independent living' capacity of people with mental health disabilities and reducing the likelihood of relapse. The services also work with family members and other carers to support them to meet the needs of their relatives and friends.

The generalist NGOs include organisations such as the Salvation Army, Mission Australia and St Vincent de Paul who provide a broad spectrum of welfare services some of which have a mental health component.

Equitable access to services for people in need of mental health support in the community, especially in rural and remote areas, has not been achieved in NSW. Services are few and

far between in some areas and non-existent in others (MHCC, 2000). Strategies to improve access to services in rural and remote areas include:

- building the capacity of mainstream NGOs to work with clients with mental health problems;
- enhancing existing mental health NGOs to broaden their catchment areas and set up satellite agencies;
- enhancing existing specialist and mainstream health services to broaden their catchment areas and set up satellite agencies; and
- enhancing the nurse practitioner program to achieve more timely and locally based clinical interventions.

2.6.1 Specialist mental health NGOs

In 2000, MHCC published a report called "Pathway to Partnerships" on the Mapping, Analysis and Performance (MAP) Project. The purpose of the MAP Project was to document for the first time:

- the distribution of specialist mental health NGOs in NSW
- the main types of services provided
- consumer mix and consumer profile
- met and unmet needs from a consumer perspective and
- key planning and funding issues for specialist mental health NGOs (MHCC, 2000).

The MAP Project identified the range of service types in the mental health non-government sector. These include:

- Supported residential services
- Day centres and drop in centres (including Clubhouses)
- Consumer support groups (illness related)
- Carer support groups
- Advocacy, education and information services
- Telephone support services
- Consumer networks
- Respite services
- Outreach services
- Open employment services
- Supported employment services.

2.6.2 Public mental health services

The core public mental health services are hospital and community based acute care services, case management services and hospital based residential rehabilitation for people with severe mental disorders. They also provide some community based rehabilitation and supported residential services.

Mental health NGOs increasingly are under pressure to fill the gaps in public mental health services. For example numerous NGOs have reported to MHCC the difficulties in obtaining a timely response from Extended Hours Teams or other emergency psychiatric services providing after hours cover. This has meant that NGOs have had to continue to provide a service in the interim. The other main area where mental health NGOs are feeling pressure to fill the gap is in case management or outreach support services given that provision by public mental health services is becoming more scarce. A number of

NGOs already provide case management services but are neither recognised nor funded as providers of these services.

Extended hours and emergency psychiatric services
Most Area Health Services have introduced a 1800 intake number for emergency services but it is not uncommon for NGOs to wait for over an hour for a response. In rural and remote areas there may be a delay of up to 48 hours or no response at all. At other times, mental health services may refuse referrals seen as inappropriate. There are huge inconsistencies between area Health Services in the interpretation of the urgency of referrals and the consequent responses by acute care team members. This situation is untenable for mental health NGOs who find themselves managing situations they have not been funded to perform and for which they are not acknowledged as having the expertise to perform.

In the report *A Long Road to Recovery* released by the St Vincent de Paul Society (Robinson, 2001), the following information was provided by services in the Hastings Valley:

It is of great concern to us in the Hastings Valley (population approximately 87,000) the mental health staff are unable to offer crisis support outside the Port Macquarie Base Hospital. They are unable to offer any form of continuing case management and no longer visit their clients at our homeless person's refuge. Some people with mental illness have been moved to other areas to get the assistance they require. This is apparently referred to as 'geographical cure'.

Case management services
There are two main impacts on mental health NGOs when inadequate case management services are provided by public mental health services.

1. When a client is receiving services from an NGO, the case manager from the public mental health service usually provides a minimal service on the basis that the client is already receiving a level of support in the community, particularly when the client is living in supported accommodation. NGOs recognise that they are often in the best position to provide a case management service, as they have most contact with their clients. However this role needs to be acknowledged and funded by the government.

2. The recently proposed policy of 'episodic care' in public mental health services means that clients with continuing mental health conditions no longer receive ongoing case management services. The public services now provide only 'episodic care' and then refer the patient to his or her general practitioner once they consider that the client has 'stabilised'.

   In recent years general practitioners have been provided with financial incentives for training and support to increase their ability to work with people who have mental health problems and disorders. Despite this expenditure, problems with general practitioners providing ongoing care for consumers and their carers remain.

Specifically:

- some general practitioners may actively discourage patients with mental illness as they see them as difficult to manage or potentially disruptive in the waiting room;
- some clients are not reliable enough to turn up to an appointment with a general practitioner;
- some clients have no insight into their illness and thus see no need to see a general practitioner for ongoing treatment;
- many general practitioners no longer bulk bill, especially in rural NSW, which has serious access implications for financially disadvantaged people; and
- many general practitioners are still inadequately trained and skilled to care for patients with a mental illness, especially those with psychotic illnesses and dual diagnoses.

The mental health NGO sector believes that if a client is deemed stable enough to no longer require clinical case management from pubic mental health services then they should be assessed for outreach support from a mental health NGO. Outreach support would ensure that clients with mental health disabilities remain stable and are assisted with 'whole of life' needs. NGO case managers assist clients to get their house in order, pay bills, link to community based activities, training and employment, and resolve conflicts with neighbours and family members. This 'whole of life' management assists those with mental health disabilities, for whom organisation and motivation can be highly challenging, to maintain their well-being.

While case management or outreach support provided by NGOs includes an understanding of medication issues and referrals for medical assessments and reviews, the greatest advantage of NGO outreach support workers is their willingness and ability to assess and work with the whole person, not just their clinical needs. NGO staff have a strong focus on relapse prevention and a strong belief that one of the keys to maintaining wellness is building a sense of community for people accessing their services.

It should be noted that many staff working in NGOs have clinical or health care backgrounds and/or many years of experience of working with people with mental health problems.

2.6.3 Interface between public mental health and NGO mental health sectors

The interface between public mental health services and mental health NGOs is not clearly defined in NSW. The main areas of overlap between the public mental health sector and the NGO mental health sector are in supported residential and psychosocial rehabilitation day programs. Historically most of the rehabilitation services and some of the supported residential services were managed by public mental health services. In the past decade supported residential services have been established mainly by the non-government sector. In recent years there has been an increased focus on NGO based psychosocial rehabilitation day programs with the emergence of the Clubhouse model and supported employment services (MHCC, 2000).

In determining those services most suitable for the NGO sector and those best managed by the public health sector, it is useful to consider the International Classification of Impairments, Disabilities and Handicaps (WHO, 1980) and apply it to people accessing psychiatric services. Impairments relate directly to the symptoms of mental disorder or

illness. Disabilities are the consequence of a mental illness and affect a person's ability to perform the activities and tasks of everyday living and develop and maintain fulfilling personal and social relationships. Handicaps are the social disadvantages that limit or prevent a person with a mental illness or mental health disability fulfilling their desired social roles. As disability and handicap often co-exist for people with a mental illness they are collectively referred to as mental health disability for the purposes of this submission.

In broad terms it can be argued that acute care services and those requiring a high level of clinical expertise should remain in the public mental health sector and those providing services for people with mental health disabilities should primarily be provided in the non-government sector (MHCC, 2000). This distinction is clearly made in Victorian Mental Health Services where the role of the public mental health sector is clearly defined and focuses on acute clinical care. The mental health NGO sector comes under the broad category of Psychiatric Disability Support Services (PDSS) (VICSERV, 2002). In NSW many of the services for people with a mental health disability continue to be managed and supported by the public sector mental health services.

Supported residential services

Based on the World Health Organisation (WHO) distinction between impairments and disabilities, supported residential services[1] in community settings are clearly for people with mental health disabilities and thus should be provided by the NGO sector. The feasibility of these services being transferred to the NGO sector would depend on the availability of suitable local NGOs capable of providing the service.

There are three main types of supported residential services in the mental health NGO sector. In the first model the NGO employs staff to provide outreach support or continuous 'on site' support. In some instances houses are categorised as high, medium or low support houses and a set number of hours of support per week is allocated to each house. As residents' support needs change they move to a house with a different level of support or to independent housing. The more disabled clients often become long term residents of the service.

The NGO leases or owns the property but may contract the landlord responsibilities for the property to a Housing Association (a housing NGO). Separation of the landlord and support functions is seen by many NGOs to eliminate potential conflicts of interest between these two roles. However other NGOs prefer to maintain the landlord role as this can lead to great efficiencies. Further the management of rental funds often allows program development that could not otherwise be achieved.

The second model is based on a 'partnership between health, housing and NGO services'. In this model the houses are owned by the NSW Department of Housing, the support services are contracted out to a local NGO by the Area Health Service. In some services the NGO also provides the landlord function and in others a Housing Association is the landlord.

[1] The supported residential services referred to in this section do not include the long term and extended care services (also referred to as rehabilitation services) provided by the large psychiatric hospitals (Rozelle, Cumberland, Bloomfield, Kenmore and Morisset) for people with severe psychiatric disabilities.

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

In the third model clients may live in public housing, a rental property or a privately owned property and NGO staff provide outreach support to assist clients maintain their accommodation and successfully live in the community.

In all models described above, the public mental health services, in theory, provide the residents with case management or clinical care services. In practice, however, mental health NGOs report that case managers or similar staff rarely see clients living in supported residential services and that NGO key workers provide the case management service. The MAP Project reported that consumers of NGO supported residential services receive nearly all of their services from the NGO. This has probably developed due to staff in the public sector giving priority to clients with little or no other support (MHCC, 2000).

Psychosocial rehabilitation services or day programs
In recent years there has been a reduction in the number of Living Skills Centres provided by public mental health services and greater emphasis on assisting clients to access mainstream social and recreational activities. Some Area Health Services have closed all their Living Skills Centres while others have retained at least one centre in each geographical sector of their catchment area.

The policy of assisting clients to access leisure and recreational mainstream services is desirable and has been successful for higher functioning clients. However, many of the more disabled clients do not access mainstream services. People with a mental health disability need to feel comfortable and supported to access these services. For this to occur clients require a support worker to assist them, particularly in the initial stages of contact with new environments and activities. In addition staff working in mainstream services need to be educated to understand mental health disability. Education and the provision of support staff have cost implications that must be recognised if people with a mental health disability are to successfully access mainstream services. These clients tend to become increasingly isolated if they are not assisted to access services and this in turn can lead to an exacerbation of symptoms and possible readmission to hospital.

In the Area Health Services where Living Skills Centres have closed the services usually have been replaced by home-based clinical rehabilitation for individual clients. While there has been a small increase in centre based psycho-social rehabilitation services in the non-government sector since the reduction of Living Skills Services there are only 14 drop-in centres, day centres or Clubhouses in NSW.

Day programs offering social, recreational and vocational activities are required to meet the varying needs of mental health consumers living in the community. Services specifically for people with a mental health disability should clearly be run by the non-government sector because of its focus on community integration, consumer choice and clients' 'whole of life' needs. Further the flexibility of service delivery in the NGO sector enables services to better respond to and coordinate care for consumers with complex needs including those with a dual disorder and those who have had contact with the criminal justice system.

In Victoria Psychosocial Rehabilitation Day Programs are planned on a state wide basis, run by the non-government mental health sector, and distributed throughout the state. Victoria is moving away from using a weighted population distribution formula to allocate health resources. Instead Community Health Plans are being developed across each health region. A component of the overall Community Health Plan is a Mental Health Plan, which is being developed by Area Mental Health Services in conjunction with the Psychiatric Disability Support Services. These plans will document the mix of mental health services required in each area to adequately meet the consumer needs and inform funding decisions.

The joint planning of psychosocial rehabilitation services by public and NGO mental health services in Victoria is commendable and will lead to genuine partnerships between the two sectors.

Recommendations

14. It is recommended that the role of the mental health NGO sector is clearly defined within the mental health system of care, including recognition of the sector's present responsibilities in caring for people with mental health disabilities and the case management services already provided.

15. It is recommended that an NGO sector development position be funded for a period of three years to coordinate the joint planning of NGO and public mental health services within each Area Health Service catchment area. This position should be based at MHCC and work closely with NSW Health, individual Area Health Services and the broad non-government sector.

16. It is recommended that there be equitable access to services for people with mental health problems and disorders, especially for people in rural and remote areas. The sector development officer (recommendation 15) would work in partnership with Area Health Services to develop flexible and creative solutions to address gaps in service provision.

17. It is recommended that the policy to refer stabilised clients to general practitioners for ongoing mental health care be reviewed to discover whether all clients have adequate access to a general practitioner who can provide skilled and effective mental health care services at no direct cost to the client.

2.7 Data collection and outcome measures (h)

In line with the National Mental Health Strategy there has been extensive research into suitable consumer outcome measurements and field testing of a range of measures to test their suitability for use in the public mental health sector (Andrews, 1994; Wing, 1996; Stedman, 1997; Morris-Yates and Andrews, 1997).

Following this research NSW Health developed a comprehensive training program for all mental health staff in the public sector called Mental Health Outcome Assessment Training (MH-OAT) (NSW Health, 2001). The purpose of MH-OAT is to support three initiatives.

They are to:

- improve the quality of mental health assessments by strengthening the mental health assessment skills of all direct care clinical staff
- introduce a standard clinical documentation format for mental health assessments
- implement standardised measures to measure the outcomes and casemix of mental health care.

While it appears that staff in the mental health NGO sector will be considered for training once training of all clinical staff in the mental health public sector is completed, the MHCC is concerned that many aspects of MH-OAT are not suitable for services provided by the non-government sector. They have been specifically designed for clinicians in the public sector. There was no consultation with the NGO sector in relation to the development of MH-OAT. Additionally MH-OAT will increase the workload of already stretched human resources and currently there are no plans to compensate the NGO sector for this.

There has been minimal field testing of consumer outcome measures suitable for the non-government mental health sector. Without adequate research and field testing of outcome measures it is difficult for the non-government mental health sector to know which instruments provide the best measures of outcomes for their clients. The only tool that has been formally tested in the NSW mental health NGO sector is the Camberwell Assessment of Need (CAN). A total of 133 mental health consumers of NGOs were surveyed from metropolitan and rural areas. The CAN measures physical and mental health disability and 'met and unmet needs' of consumers. From this one study it appears that the CAN provides useful outcome data for mental health NGOs providing psycho-social rehabilitation services but further research is required. This study was conducted as part of the MAP Project and is included in the *Pathway to Partnerships* report (attached as Appendix 1).

The MAP Project also conducted a survey of a small representative sample (n=11) of mental health NGOs to ascertain how they measured outcomes for clients of their services. Service providers were asked to identify formal measures of client outcomes and informal measures and observations. While most of the surveyed services regularly reviewed their clients' progress, there was little or no consistency in the type of measures or procedures used.

Victoria has developed a comprehensive data collection system specifically designed for the non-government sector. The Minimum Data Set for Psychiatric Disability Support Services has been used since the mid-1990s and provides a range of input and output data on consumers using the Psychiatric Disability Support Services. VICSERV is currently looking at how the minimum data set can be further developed so that outcome measurements more accurately reflect recovery rates from mental illness. They are looking at how standardised measures such as the Camberwell Assessment of Need could be introduced.

Recommendations

18. It is recommended that NSW Health in collaboration with mental health NGOs research and field test suitable outcome measures for the various types of services provided by the mental health NGO sector.

19. It is recommended that the mental health NGO staff are provided with adequate training in the use of relevant outcome measures for the sector and funding is provided to resource the process of data collection and collation.

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