CHAPTER 4

COMMUNITY SECTOR INVESTMENT

4.1 One of the main strengths of the COAG National Action Plan was that significant funding was finally channelled into community-based mental health services through NGOs. Such funding recognised that a broad range of supports, along with clinical care, are needed to assist people with mental illness to live in the community. However, the committee received evidence about strain within the NGO sector, due to the pace at which funding had been rolled out and successive rounds of competitive tendering.

4.2 In this chapter the committee considers the contribution of the COAG Plan to community-based mental health care in general. It first reviews support for the COAG Plan and the difference that funding to the community sector is making. The committee then considers evidence about the competitive tender process used to distribute funding for community-based programs. In the next chapter the committee considers in detail the largest of the COAG Plan community programs, the Personal Helpers and Mentors Program.

Community sector funding

4.3 The COAG National Action Plan put significant money into the community sector, as outlined by the Mental Health Community Coalition ACT:

> The COAG Mental Health package 2006 allocated about $800 million mainly through FaHCSIA programs and some DoHA programs to community sector services. That initiative by itself more than met the combined allocation from the states and territories to specialist mental health community support provision. We think that that was a strategic development of an extremely high order in terms of the reform process.[1]

4.4 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc commented on the increased funding:

> I think the amount of community based service that is available has increased radically. The fact that we were at such a small base means that perhaps to the broader public that is not so noticeable. In Queensland this year the amount of funding to the non-government sector has quadrupled. So the federal government in just one year is now investing more in non-government organisations than our state government. There has been a massive increase.[2]

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1 Mental Health Community Coalition ACT, *Proof Committee Hansard,* 16 May 2008, p. 17.

2 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard*, 26 March 2008, p. 7.

4.5 Many witnesses considered that the new funding was having a notable effect and had improved service access for some consumers.

Effect of the new funding

4.6 The Mental Health Coordinating Council summarised that the Commonwealth funding to NGOs through the COAG Plan has had three substantial outcomes:

- it has increased assistance for people who are unable to get service from public health services because their illness is not acute and for those who do not wish to engage with clinical approaches;
- it has allowed the field of NGO mental health providers to increase, with capacity building in mental health occurring in a number of mainstream organisations as well as mental health specialist organisations; and
- there has been a rebalancing of the mental health system, with the role of NGOs being given greater value and recognition.[3]

4.7 In relation to this last point, Ms Bateman Chief Executive Officer of the Council, noted:

> Funding FaHCSIA and DoHA to do community mental health was a huge step towards creating a more balanced mental health system that understands that social inclusion, connection to family and friends, occupation and a decent place to live are as important as medication and clinical care to recovery from mental illness.[4]

4.8 Witnesses observed that some of the COAG federal initiatives were making a difference in terms of service availability. Ms Edwardson from the Queensland Alliance Mental Illness and Psychiatric Disability Groups commented:

> With some of this federal money coming down it has been really good to be able to say, 'Well, your first port of call is PHaMs [Personal Helpers and Mentors]. Here are the numbers to ring.' Whether or not they can take on all the people is a different story, but at least having an option to give people instead of sending them away empty-handed has been terrific. I know there are some people who have successfully got onto that program from referrals that we have done.[5]

4.9 Ms Carmody from Ruah Community Services in Western Australia commented on the difference for service providers:

> It has been uplifting and encouraging. We have seen some agencies that have been working on a shoestring resource base for their programs for

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3 Ms Jenna Bateman, CEO, Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2008, p. 33.

4 *Proof Committee Hansard*, 27 March 2008, p. 35.

5 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard,* 26 March 2008, p. 3.

> many years that have the opportunity now to extend that, such as through the Health and Ageing Support for Day-to-Day Living in the Community program. Groups like Richmond Fellowship and Ruah, which had a base already, have been able to apply for things like the Personal Helpers and Mentors program. We see more counselling opportunities happening for people.[6]

4.10 Mr Dempster, from the Northern Territory Mental Health Coalition described the energy created by new funding to the community sector:

> …there is a sense of, 'Let's go for it.' People are saying, 'Right, we're getting some things that we can do for people,' and consumers are saying, 'Okay, there's this option and that option.' So there seems to be a positive view about it. It is not all gloom and doom.[7]

4.11 Similarly, Ms Bateman observed a 'renewed energy, commitment and confidence' in the community sector stemming from the COAG Plan and relevant state government initiatives. She noted increases in NGO training, in the number of organisations implementing consumer outcome monitoring and quality improvement systems, improvements in professionalism and more involvement in research and linkages with universities and other academic institutions. Ms Bateman summarised that 'the COAG initiatives provided the sector with an enormous boost to morale and the opportunity to meet some of the glaring unmet need not targeted by state NGO programs'.[8]

4.12 Evidence to the committee suggests that in some areas the COAG Plan community funding has helped provide new paths to reach people who were not receiving mental health care and to provide some continuity of care. The Mental Illness Fellowship of South Australia commended the connections occurring between some of the COAG initiatives:

> …there are people in the community who do not see themselves has having a mental illness or do not want to connect with services. Things like the respite program allow us to come in at a different angle and offer some recreational, fun activities…we are working towards transitioning them into the PHaMs program…From there, often once they have built their confidence they enter the Support for Day-to-Day Living in the Community program or the activity programs options where people build skills or relearn skills in terms of social, recreational and recovery based programs.[9]

4.13 The committee was encouraged by the positive response within the community sector to the COAG Plan. At the same time, the committee's evidence indicates that further investment is required to develop and sustain adequate

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6 *Proof Committee Hansard*, 7 May 2008, p. 46.

7 *Proof Committee Hansard*, 1 May 2008, p. 5.

8 *Proof Committee Hansard*, 27 March 2008, p. 34.

9 *Proof Committee Hansard*, 8 May 2008, p. 37.

community-based services. Some witnesses, such as Ms Colvin from the Council of Official Visitors in Western Australia noted that even with additional funding to the community sector, programs are not reaching those in desperate need:

> The people in hostels are the sorts of people we would expect to see getting access to these programs and we are just not seeing it. People in hostels sit around basically all day long with nothing to do. They have great difficulty, first of all, finding the programs and, then, getting transport to the programs. Sometimes they are not able to use the transport system, or the cost is prohibitive.[10]

4.14 The need for more community-based care is discussed further in chapter 8, Shortfalls and gaps.

Competitive tendering

4.15 Despite the improved access to some services and positive outlook generated by the COAG Plan funding, the distribution of this funding has been somewhat tumultuous. The committee heard evidence that the rollout of large amounts of new funding through competitive grants has fractured the mental health community sector. Mr Cheverton of the Queensland Alliance Mental Illness and Psychiatric Disability Groups observed:

> …because all this money was put up incredibly quickly and through tender processes, the coordination and cooperation that was already there has diminished. The organisation that you had been working with down the street was suddenly your competitor on the Day to Day Living tender and then on the PHaMs tender and then on the Community Living tender. I think there are 18 federal initiatives, but there are 26 Queensland initiatives. So the experience of community organisations has been for wave after wave of tender applications, which takes a lot of time and energy away from service delivery and is, in some cases, a bit of a lucky dip.[11]

4.16 Similarly, Ms McGrath, representing Survivors of Torture and Trauma Assistance and Rehabilitation Service SA, considered that the tender process had been 'very destructive'. She explained:

> There are always going to be limited resources available for any type of human services or welfare services. What governments need to be doing is promoting cooperation not competition. Competitive tendering processes promote competition, and that means that services that should be working together actually cannot, or there are limits to how much and how well they can work together.[12]

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10 *Proof Committee Hansard*, 7 May 2008, p. 67.

11 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard,* 26 March 2008, p. 4.

12 *Proof Committee Hansard*, 8 May 2008, p. 76.

4.17 Mr Warner, UnitingCare Wesley Port Adelaide, agreed:

> …competitive tendering does create some form of friction. You keep a lot of your own knowledge to yourself; you will not spread it around. You are not going to share with another organisation the models that you have designed and spent months if not years of intelligence developing. Part of my philosophy in the organisation is that we are not there for ourselves; we are there for the clients. Really what we should be doing is spreading that information and intelligence around to all organisations so that we get the best model and the best practice to provide the best service to the consumer out there who is marginalised and disadvantaged.[13]

4.18 Some of the key concerns raised by NGOs about the competitive tendering process included undervaluing of local knowledge and collaboration when assessing tenders, the onerous amount of information required in the tender process, a perceived preference for generalist providers and the sustainability of services.

Valuing local knowledge

4.19 Submitters were concerned that tender processes for COAG Plan community programs have favoured large organisations with the capacity to formulate tenders that suit the department's preference and criteria, rather than organisations with good local knowledge, linkages and an understanding of what is actually achievable.[14] Ms Bateman, CEO of the Mental Health Coordinating Council assessed:

> …the open tender process which occurred under COAG has worked against recognition of the importance of local connections in a number of areas, with tender-writing skills, rather than local connections, being prioritised in the awarding of tenders.[15]

4.20 Mr Quinlan, Executive Director Catholic Social Services Australia commented:

> …local services that have been part of the local community for many years, often offering a broad range of services, can lose out on a particular program to agencies that are essentially just coming into town to deliver that program. The merits of that could be argued both ways, but the impact on the local community can be enormous.[16]

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13 *Proof Committee Hansard,* 8 May 2008, p. 76.

14 For example, Sisters Inside, *Proof Committee Hansard,* 26 March 2008, p. 67; The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard,* 26 March 2008, p. 17; UnitingCare Wesley Port Adelaide, Survivors of Torture and Trauma Assistance and Rehabilitation Service and Carers SA, *Proof Committee Hansard*, 8 May 2008, p. 55.

15 *Proof Committee Hansard.,* 27 March 2008, p. 34.

16 *Proof Committee Hansard,* 16 May 2008, p. 69.

4.21 Mr Calleja, Western Australian Association for Mental Health (WAAMH), observed that a large number of agencies without a track record of delivering services in mental health had won tenders. He raised questions about how long it takes such agencies to start to deliver services and the initial learning required, particularly if agencies are to have a recovery focus.[17]

4.22 The Queensland Alliance Mental Illness and Psychiatric Disability Groups suggested that select, rather than open, tenders would be a better method of awarding funding. Submitters also advocated that local knowledge and history of involvement in a community be given greater weighting in the assessment of tenders. Ms Bateman, CEO of the Mental Health Coordinating Council suggested:

> …perhaps there should be consideration of a more select tender process where, if you are planning on putting services up in the northern area of New South Wales, organisations operating in that area are prioritised and there is, perhaps, a weighting for organisations that can actually demonstrate their local linkages, because to create local linkages takes time and energy.[18]

4.23 Ms Kilroy, from Sisters Inside, suggested that in assessing tender applications it is important to consider who the organisation is currently working with, what outcomes they have achieved in other programs and what evaluations they can provide.[19] Ms Carmody, from Ruah Community Services also advocated finding additional ways to assess a tender, not only on the written application.[20] Ms Bateman suggested that support for the tender from other local organisations could be taken into account:

> I think they should go to the smaller organisations or other groups and agencies in the local area and ask them to submit support for the organisation, because I think a lot of organisations can say they have links but when you actually come down to it they are pretty scant—it might have been a phone call two days before the tender went through or something like that.[21]

4.24 There was a common view that generic program models will not fit across the whole of Australia; the tender process needs to be sensitive to local need, to local knowledge and local linkages. At the same time, it was recognised that if NGOs do not exist in an area, that area may continue to miss out on services unless new providers, often large organisations, are encouraged to set up services.[22]

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17 *Proof Committee Hansard,* 7 May 2008, p. 51; See also Queensland Government, *Submisson 49*, p. 81.

18 *Proof Committee Hansard*, 27 March 2008, p. 37.

19 *Proof Committee Hansard,* 26 March 2008, p. 69.

20 *Proof Committee Hansard*, 7 May 2008, p. 51.

21 *Proof Committee Hansard*, 27 March 2008, p. 37.

22 *Proof Committee Hansard*, 27 March 2008, p. 42.

4.25 Mr Lewis, Group Manager FaHCSIA, stated that while there may be an impression that there is a preference towards awarding tenders to larger organisations, in his experience this is not the case:

> …over some four or five years, across three or four major programs of billions of dollars that I have been involved in, it has not always been the larger ones that have got the contracts. It certainly has not. In many cases, and certainly in the PHaMs situation, there are many smaller organisations who have the bona fides in terms of practice and experience, are genuinely new, are small and have done very well in the tender processes.[23]

4.26 While this may be the case, the committee's hearings gave some insight into the tension within the NGO sector that is running counter to the positive momentum derived from the availability of more funds for mental health programs. An energised, well resourced and inter-connected NGO sector stands to improve outcomes for people with mental illness; fracturing of the sector will not. In this context the committee urges efforts to improve the tendering process, such as increased transparency as to the weighting given to local knowledge and linkages and looking at improving opportunities for collaborative tendering.

Collaborative tendering

4.27 The Australian Mental Health Consumer Network described circumstances where larger NGOs, without a local presence or experience in providing mental health services, turn to smaller NGOs *after* receiving funding, for advice and assistance in delivering the programs. Ms Gardner, a board member for WAAMH and Chairperson of the Bay of Isles Community Outreach in Esperance provided an example of the kinds of requests made of local NGOs:

> …other groups that have obtained funding do not have the capacity or experienced staff to man some of what they want to do and are looking for us to provide that training. We are such a small group that we cannot include that in what we are currently able to do, and they are not prepared to pay to employ other people to replace our staff while we try to do that…[24]

4.28 A more positive arrangement would be collaborative and alliance tendering, with larger NGOs able to auspice smaller NGOs that have specialist skills and local knowledge. Ms Richardson, Community Services Manager Carers South Australia, said 'I think the encouragement of collaborative partnerships with other organisations when they are working across the regions to be able to put in joint submissions would be very beneficial'.[25]

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23 *Proof Committee Hansard,* 16 May 2008, p. 87.

24 *Proof Committee Hansard,* 7 May 2008, p. 7; see also Australian Association of Social Workers, *Proof Committee Hansard,* 20 May 2008, p. 41.

25 *Proof Committee Hansard,* 8 May 2008, p. 76.

4.29 Mr Wright, Director of Mental Health Operations South Australia, saw opportunities for more collaborative tendering in South Australia:

> I have brought some new experience from New Zealand, where we have a non-government sector that has been up and running for a lot longer. I think we have learned a lot of things about how to get a new organisation to partner with a more experienced organisation and to put in a joint tender, with the view that we are developing the capacity of the new organisation. We still need to do that in South Australia.[26]

4.30 However, Mr Quinlan Executive Director Catholic Social Services Australia, saw challenges in collaborative tendering:

> …it is a very tricky process to realistically establish consortiums in the community between agencies that often have very different values bases, very different histories and very different raisons d'etre.[27]

4.31 Dr Gurr, CASP, raised concerns about grants based funding at a systemic level. Because of the rigid nature of contracted services, Dr Gurr argued that providers are not able to adapt in response to changing needs:

> You can end up with one organisation…swimming in money because they do not actually need to provide the level of service but they have been given the money for it. But their auditors will not let them use the money in some other way because it is not the purpose of the contract.[28]

4.32 Similarly, the Mental Health Coordinating Council argued that the long-term effect of current funding models will be 'a loss of responsiveness to the changing needs of the community served by the NGO'.[29]

4.33 Dr Gurr also noted that the current competitive tendering approach results in a plethora of providers all contributing elements to a person's support, care and treatment. He suggested that Australia may need to learn from other countries and look at more consolidated service provision:

> If we think about packages, we have got to get more sophisticated about how we think about purchasing packages. I think this is the issue in New Zealand. They have gone through this whole phase—they have experienced the purchasing and having multiple contractors providing for it—and they ended up with too much fragmentation. I think they are going back now towards saying, 'We need a bit more of a consolidated view about how we do this.'[30]

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26 *Proof Committee Hansard,* 8 May 2008, p. 96.

27 *Proof Committee Hansard,* 16 May 2008, p. 70.

28 *Proof Committee Hansard,* 27 March 2008, p. 61.

29 *Supplementary Submission 23,* p. 3.

30 *Proof Committee Hansard,* 27 March 2008, p. 61.

4.34 The committee is concerned that, following a history of underspending on mental health care delivered through the NGO sector, the injection of COAG Plan funds through competitive tendering has lead to fractures within the sector. The committee recommends that governments consider alternative forms of tendering which better promote collaboration and coordination.

Onerous application process

4.35 Some NGOs found the information requirements associated with tendering for community-based mental health programs quite onerous. The Northern Territory Mental Health Coalition commented that 'a lot of organisations, particularly the smaller ones, get scared off because there is so much to do and so much information to provide'.[31] Top End Association for Mental Health Inc observed that even though they are the largest NGO in the Northern Territory, they are still not a very big organisation and found the competitive tendering process 'extremely onerous'.[32]

4.36 Mr Quinlan suggested that much of the burden involved in applying for funding could be reduced if government departments coordinated with regard to the information required:

> It seems to me that, once you are deemed a suitable organisation to deliver Commonwealth programs, you should have jumped that hurdle. With appropriate regular accreditation you should not have to jump that hurdle every time you go for a particular funding grant. It should be similar at the state level. There could be enormous effort taken out of some of those tender processes if, on the funders' side, there was better coordination of information and effort so that agencies are not supplying the same information over and over again to a range of government departments that never speak to each other.[33]

4.37 Professor Calder, First Assistant Secretary DoHA, noted that while some of the details required in tender documents are about financial viability year to year and would need to be supplied repeatedly, there may be scope to reduce the demand for basic eligibility information. For example, it may be possible to establish a register of providers that have been assessed as meeting basic criteria. As eligibility requirements currently differ across departments, it would be a substantial undertaking to set up a consolidated register. The committee notes that it would greatly improve tendering processes if standardisation could be increased.

4.38 Mr Lewis, Group Manager FaHCSIA, noted that two reviews are underway which encompass some of the issues raised in the inquiry: a community grants review looking at how government does business with NGOs, and a red tape review looking at barriers to funding and issues such as pre-accreditation of providers for certain

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31 *Proof Committee Hansard,* 1 May 2008, p. 16.

32 *Proof Committee Hansard,* 1 May 2008, p. 40.

33 *Proof Committee Hansard,* 16 May 2008, p. 71.

purposes. Mr Lewis summarised 'We are cognisant of some of the issues and trying to do something, and we are looking across all of our grants processes.'[34]

4.39 The committee looks forward to the outcomes of the reviews currently underway and considers that they should include mechanisms to reduce the information burden placed on NGOs that tender for multiple programs and standardise requirements for information across different government departments.

Meeting the needs of specific groups

4.40 Some organisations were concerned that COAG Plan initiatives have been limited because they are generic and not targeted to specific population groups. Representatives from the Mental Health Coalition of South Australia were concerned that the tender specifications for community programs 'tend to encourage generalist applications and tend to exclude organisations that might have a specific expertise'. Examples included organisations that provide specialist services for people from culturally and linguistically diverse backgrounds, or for older people, which would find it hard to apply for current Commonwealth funding.[35] In Brisbane the committee heard from Sisters Inside, an organisation that works with women in prison and the justice system many of whom have mental illness and many of whom are not connected or engaged with mainstream health services. Ms Kilroy, from Sisters Inside commented:

> Because we are not specifically a fundamental mental health service we are actually not seen by the federal health department as an organisation that can provide those services. The money goes to the mental health services but those are services that the women actually move away from, do not engage with, and instead come to us.[36]

4.41 The committee suggests that in reviewing the COAG Plan community-based initiatives, the government give consideration to whether quarantining some funding for services targeted at specific population groups would achieve better mental health outcomes for the community than the current generic population approach. In chapter 9 the committee notes that the needs of a number of specific population groups are not adequately met by existing mental health initiatives.

Sustainability of services

4.42 An issue raised by several service providers was the uncertainty that accompanies grants based funding. This included frustration when requests for tenders were delayed, such occurred with the third round of PHaMs funding, and concerns as to whether programs would be renewed beyond their initial timeframe. In South Australia, for example, the committee heard about organisations that were awaiting

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34 *Proof Committee Hansard,* 16 May 2008, p. 87.

35 *Proof Committee Hansard,* 8 May 2008, pp. 4 and 6.

36 *Proof Committee Hansard,* 26 March 2008, p. 67.

funding decisions for both COAG Plan comorbidity projects and projects under the National Drug Strategy. Although tenders for some programs closed in December, by early May funding announcements had not been made. Ms Edwards, Executive Officer South Australian Network of Drug and Alcohol Services (SANDAS), commented that organisations were losing staff as programs were not funded beyond the end of June and therefore positions could not be guaranteed.[37] This stop-start funding approach is not helpful to achieving a connected and consistent system of care.

4.43 Ms Cassaniti, Centre Coordinator Transcultural Mental Health Centre NSW, observed that short-term funding can actually have negative effects in a community:

> With anything, trickles of money can at times do more damage than good, because they set up issues that are not sustainable without ongoing money and they set up false hopes. I think the longer pilot periods—if there is no money to do the recurrent—are for a five-year period, so we can at least build some evidence around what works and what does not work.[38]

4.44 Anglicare Tasmania noted that there had been some improvements in sustainability, but saw room for further improvement, particularly when re-tendering for programs:

> In the last two years we have moved from what used to be pretty much one-year contracts to three-year contracts. There has been some progress in that regard. Some retendering processes look a bit odd, particularly in a small state where there are not that many players after all and you wonder whether it is worth the disruption, and each time there is a change from one provider to another there is a tearing down of infrastructure and relationships and a restarting. There needs to be an assessment of threshold need before you retender, given that something is established on the ground.[39]

Concluding comments

4.45 Evidence to the committee's inquiry shows how pleased mental health NGOs are about the much needed new funding coming into the sector through the COAG Plan and the improvement in service access occurring in some areas as a result. However, the rollout of this funding has clearly had adverse consequences for the cohesiveness of the NGO sector. As with other parts of mental health care, continuity and coordination are critical to assisting people with mental illness in recovery. The sector needs to be supported in such a way as to promote this coordination.

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37 *Proof Committee Hansard,* 8 May 2008, p. 25.

38 *Proof Committee Hansard,* 27 March 2008, p. 27.

39 *Proof Committee Hansard,* 31 March 2008, p. 39; See also ARAFMI Hunter, *Submission 2*, p. 12.

Recommendation 7

4.46 The committee recommends that in purchasing non-government organisation services for future mental health initiatives, Australian, state and territory government departments do not rely exclusively on open tenders but also develop other procurement models such as collaborative and select tenders.

Recommendation 8

4.47 The committee recommends that the following issues be considered in future funding rounds:

- **the weighting given to local knowledge and linkages when assessing tenders;**
- **opportunities to increase collaboration;**
- **reducing the information burden associated with tendering for multiple programs; and**
- **addressing sustainability of services.**

4.48 Beneath these specific concerns is the broader issue of the remaining gaps in community support services for people with mental illness. This is discussed in chapter 8.