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Audit Report No.48 2012–13  
Performance Audit

# **Management of the Targeted Community Care (Mental Health) Program**

**Department of Families, Housing, Community Services  
and Indigenous Affairs**

Australian National Audit Office

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Canberra ACT  
19 June 2013

Dear Mr President  
Dear Madam Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Families, Housing, Community Services and Indigenous Affairs with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit to the Parliament. The report is titled *Management of the Targeted Community Care (Mental Health) Program*.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—<http://www.anao.gov.au>.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Ian McPhee', is positioned above the printed name and title.

Ian McPhee  
Auditor-General

The Honourable the President of the Senate  
The Honourable the Speaker of the House of Representatives  
Parliament House  
Canberra ACT

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# Abbreviations

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ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
APS	Australian Public Service
APY Lands	Anangu Pitjantjatjara Yankunytjatjara Lands
CALD	Culturally and Linguistically Diverse
CDs	Census Collection Districts
CGGs	Commonwealth Grants Guidelines
COAG	Council of Australia Governments
CRCC	Commonwealth Respite and Carelink Centre
DoHA	Department of Health and Ageing
DSP	Disability Support Pension
EST	Eligibility Screening Tool
FaHCSIA	Department of Families, Housing, Community Service and Indigenous Affairs
FOFMS	FaHCSIA's Online Funding Management System
FMA Regulations	<i>Financial Management and Accountability Regulations 1997</i>
FMHSS	Family Mental Health Support Services
HACC	Housing and Community Care
LGA	Local Government Area

MHR: CS	Mental Health Respite: Carer Support
MHSC	Mental Health Standing Committee
NGO	Non-government-organisation
NO	National Office
NMHPSC	National Mental Health Performance Subcommittee
NRDF	National Respite Development Fund
PHaMs	Personal Helpers and Mentors
PBS	Portfolio Budget Statement
SACS	Social and Community Services Award
SEIFA	Socio-Economic Index of Disadvantage
SPRI	Strategic Program Reform Initiative
SQPS	Safety and Quality Partnership Subcommittee
STO Network	State and Territory Offices Network
TCC Program	Targeted Community Care (Mental Health) Program



# Glossary

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COAG Roadmap for mental health reform	An initiative of the Council of Australian Governments setting out the policy directions for all governments in Australia in relation to improving mental health services over the period 2012–22.
Commonwealth Grant Guidelines	The Commonwealth Grant Guidelines establish the grants policy and reporting framework for all departments and agencies subject to the <i>Financial Management and Accountability Act 1997</i> .
Kessler K10	A self reported or interviewer administered measure of distress based on ten questions about anxiety and depressive symptoms that a person has experienced in the most recent four week period. The K10 is used widely in mental health surveys.
Mental health	Describes the capacity of individuals and groups to interact, inclusively and equitably with one another and with their environment, in ways that promote subjective wellbeing and optimise opportunities for development and use of mental abilities.
National Respite Development Fund	A component of the Targeted Community Care (Mental Health) Program providing respite options for carers of people with severe mental illness/psychiatric disability and carers of people with intellectual disability.
Peer Support Worker	A person who has had a lived experience of mental illness and is able to share this experience to support another mental health sufferer.

Socio-Economic Indexes for Areas (SEIFA) Index of Disadvantage	A statistical product developed by the Australian Bureau of Statistics that ranks areas in Australia according to relative socio-economic advantage and disadvantage.
SmartForm	An electronic form used by service providers to report to FaHCSIA under the terms of their funding agreements.

## **Summary and Recommendations**

# Summary

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## Introduction

1. Mental illness is a significant health issue in Australia affecting the lives of individuals, their carers and the wider community<sup>1</sup>. Awareness of the scale of mental illness, and its extensive social impact, has increased substantially over the past decade, both by governments and the general population.<sup>2</sup> The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) has estimated the annual cost of productivity losses attributable to mental illness to range from \$10 billion to \$15 billion.<sup>3</sup>

2. Almost half the Australian population aged 16 to 85 years has experienced a mental illness episode at some point in their life<sup>4</sup> and for most people who experience mental illness in adult life, the illness has its onset in childhood or adolescence.<sup>5</sup> In 2006, following two reports<sup>6</sup> highlighting the need for services to assist people with mental illness and to increase coordination between clinical and community-based services, the Council of Australian Governments (COAG) agreed on a whole-of-government approach to mental health. This was implemented through the National Action Plan on Mental Health 2006–11 (Action Plan).

3. The four key outcomes of the Action Plan were to:

- reduce the prevalence and severity of mental illness in Australia;
- reduce the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;

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<sup>1</sup> Australian Institute of Health and Welfare, 2007. *The burden of disease and injury in Australia*, AIHW, Canberra. Levels of death and disability from a comprehensive set of diseases, injuries and risks to health are combined to measure the total health 'burden'. Following cancers and cardiovascular diseases mental disorders are the third leading cause of overall disease burden in Australia, accounting for 13.1 per cent of Australia's total burden of disease and injury.

<sup>2</sup> COAG National Action Plan for Mental Health 2006–2011, *Fourth Progress Report covering implementation to 2009–10*, May 2012, p. 16.

<sup>3</sup> Department of Families, Housing, Community Services and Indigenous Affairs, Targeted Community Care (Mental Health) Program Guidelines, *Part A – June 2011*, p. 6.

<sup>4</sup> Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, cat. no.4326.0, Canberra.

<sup>5</sup> *The Mental Health of Young People in Australia*, Sawyer et al, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.

<sup>6</sup> Mental Health Council of Australia, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Canberra, 2005. The Senate, Select Committee on Mental Health, *A National Approach to Mental Health – From Crisis to Community*, Final Report, April 2006.

- increase the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
  - increase the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.<sup>7</sup>
4. Supporting this agreement, in 2006–07 the Australian Government committed a total of \$1.8 billion for 19 initiatives to assist people with mental illness, their families and carers over the five year period 2006–07 to 2010–11. Within this funding, FaHCSIA was allocated \$554.7 million for the Targeted Community Care (Mental Health) Program (TCC). The program was directed at the Action Plan’s primary aim of improving mental health and the recovery from illness through a greater focus on promotion, prevention, early intervention and access to mental health services.<sup>8</sup>
5. The Australian Government committed an additional \$2.2 billion for National Mental Health Reforms in May 2011. As part of the Government’s additional funding, \$269.3 million was allocated to FaHCSIA over five years to provide further support to community mental health by expanding the TCC Program to include additional service types and locations.

## Targeted Community Care (Mental Health) Program

6. The objective of the TCC Program ‘... is to implement community mental health initiatives to assist people with mental illness and their families and carers to manage the impact of mental illness.’<sup>9</sup> FaHCSIA’s strategy to achieve the objective is to provide accessible, responsive, high quality and integrated community-based mental health services that improve the capacity of individuals, families and carers to manage the impacts of mental illness on their lives and improve their overall wellbeing.<sup>10</sup> FaHCSIA considers that progress towards this outcome will be demonstrated by the social and

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<sup>7</sup> COAG *National Action Plan for Mental Health 2006–2011*, 14 July 2006. [http://archive.coag.gov.au/coag\\_meeting\\_outcomes/2006-07-14/docs/nap\\_mental\\_health.pdf](http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf) [accessed 15 January 2013].

<sup>8</sup> *ibid.*

<sup>9</sup> Families, Housing, Community Services and Indigenous Affairs, *Portfolio Budget Statement 2012–2013*, p. 94. [http://resources.fahcsia.gov.au/budget/2012-13/FaHCSIA\\_PBS\\_2012-13.pdf](http://resources.fahcsia.gov.au/budget/2012-13/FaHCSIA_PBS_2012-13.pdf) [accessed 5 February 2013].

<sup>10</sup> Department of Families, Housing, Community Services and Indigenous Affairs, Targeted Community Care (Mental Health) Program, *Part A: Program Guidelines*, November 2012.

economic participation of people with a mental illness, together with their carers and families.

7. There are three components to the TCC Program:

- **Personal Helpers and Mentors (PHaMs).** This initiative is designed to assist people whose lives are severely affected by mental illness by providing support: to manage daily activities; gain access to needed services such as accommodation, social support, health, welfare, and employment services; and increase connections with their community;
- **Family Mental Health Support Services<sup>11</sup> (FMHSS).** This initiative provides early intervention support to assist vulnerable families with children and young people who are at risk of, or affected by, mental illness. These services aim to support parents to reduce family stress and enable children and young people to reach their potential; and
- **Mental Health Respite: Carer Support<sup>12</sup> (MHR: CS).** This initiative funds 650 respite care places which provide a range of flexible respite and support options for carers and families of people with severe mental illness and carers of people with an intellectual disability.

8. The TCC Program complements clinical health services by providing support options that seek to promote social inclusion and recovery. Grant funding is awarded under the TCC Program to community-based not-for-profit organisations and established national charitable organisations to deliver services in sites across Australia. Table S1 shows the number of service sites funded in 2011–12, the number of clients FaHCSIA estimates it has assisted and the funding allocation by each service type.

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<sup>11</sup> Originally known as Mental Health Community Based.

<sup>12</sup> Originally known as Mental Health Respite.

**Table S.1****Targeted Community Care (Mental Health) Program 2011–12**

<b>Mental Health Services</b>	<b>Number of service sites</b>	<b>Number of clients assisted</b>	<b>Funding allocation \$million</b>
Personal Helpers and Mentors	175	13 219	85.6
Mental Health Respite: Carer Support	195	28 745	50.0
Family Mental Health Support Services	54	82 104	20.3
<b>Total</b>	<b>424</b>	<b>124 068</b>	<b>155.9</b>

Source: FaHCSIA.

Note: Number of clients assisted includes remote participants.

Number of service sites is as at 30 June 2012.

Of the 175 PHaMs sites, 95 were in metropolitan areas, 69 were in non-metropolitan areas and 11 were in remote areas.

9. FaHCSIA is currently implementing the expansion of the TCC Program in a staged manner. The department completed four grant selection processes in 2012 – two PHaMs rounds and one each of FMHSS and MHR: CS – and finalised two further FMHSS and MHR: CS rounds in April 2013.

## **Audit objective, scope and criteria**

10. The objective of the audit was to assess the effectiveness of FaHCSIA's administration and management of the Targeted Community Care (Mental Health) Program.

11. The audit focused primarily on the program's administration and management since 2010–11. This period included the:

- finalisation of the original program measures; and
- commencement of program expansion measures.

12. Three high level criteria were used to conclude against the audit objective. These were whether FaHCSIA:

- established and used structured and appropriate planning processes to support the targeting of the program;
- managed the selection of service providers consistently with Australian Government requirements; and

- developed and implemented satisfactory performance reporting arrangements for program effectiveness and accountability.

## Overall conclusion

13. The Targeted Community Care (Mental Health) Program (TCC) is a series of community-based services designed to support people with a mental illness, and their families and carers. The TCC Program was developed to complement the provision of clinical-based mental health services and, accordingly, to increase access to a range of mental health services. Since 2006–07, the Australian Government has committed over \$800 million to services provided through the TCC Program. With this funding, services have been established in 424 locations across Australia, leading to greater access to community-based mental health services. Further expansion is underway which will lead to the establishment of additional service models and locations and increased access to services.

14. Overall, FaHCSIA's administration of the TCC Program has been generally effective. In determining site locations for the initial program and for the subsequent expansion, the department has drawn on available statistical data to identify areas of high relative need and to target specific populations within communities in line with government priorities. The expansion of the program from 2011 was supported by the development of an appropriate implementation approach which included strategies for stakeholder communication and consultation along with details of site priorities, development of new service delivery models and funding levels for each service site. Timetables setting out the sequenced implementation of the expansion were developed and revised to reflect actual implementation experience, program resources and changing program priorities.

15. The Commonwealth Grant Guidelines (CGGs) provide the Australian Government's overarching framework for the management of grant programs by agencies, and agencies are required to advise Ministers of the requirements of the CGGs when Ministers are making decisions in relation to the awarding of grants. The TCC Program predates the introduction of the CGGs, which were first issued in 2009 and revised in 2013. However, FaHCSIA has in most key respects aligned its management of the program to the requirements of the CGGs.

16. The CGGs emphasise the benefit of undertaking competitive merit-based selection processes as a better practice approach to consistently



and transparently selecting grant recipients. The CCGs also recognise that there are circumstances when other selection processes may be appropriate, although agencies are expected to provide clear justification for not using competitive merit-based selection processes. Since the introduction of the program in 2006, FaHCSIA has made use of a combination of competitive grant selection processes as well as restricted and direct selection processes to select new providers and extend the funding agreements of existing providers.

17. While the CCGs emphasise the use of competitive merit-based selection processes, this same emphasis is not reflected in FaHCSIA's TCC Program guidelines. Further, in advising the Minister, FaHCSIA provided justification for the use of restricted and direct selection processes but did not include explicit advice on the preference in the CCGs for competitive merit-based selection processes or the impact that alternative approaches may have on the opportunities for other organisations to access grant funding opportunities.

18. Assessing the overall impact of the program is a challenging process given the individual nature of mental illness, and that the program is providing localised and specialised services in a range of different locations. Currently FaHCSIA assesses program performance in terms of the overall numbers of people accessing the funded services. This is supported by performance information relating to client satisfaction and client progress against personal goals, where this is relevant. Information on the use of services by Indigenous clients and those from culturally and linguistically diverse (CALD) backgrounds is also collected by FaHCSIA. To assist in further understanding the effectiveness of the program FaHCSIA has undertaken a comprehensive evaluation, the results of which were released in May 2011. However, there is currently limited regular information available on the specific contributions made by the three service streams to improvements in community level mental health. FaHCSIA has reviewed its performance framework for the TCC Program and is making changes which will take effect from July 2014. Integral to the proposed revised performance framework is the continuation of periodic program evaluations.

19. The majority of funding agreements with providers under the TCC Program expire in June 2014. In planning for any subsequent grant rounds, it will be important for the department to give appropriate consideration to the preference of the CCGs for competitive processes and the opportunities these afford to improve accessibility to grant funding. FaHCSIA is also currently implementing reforms to its departmental-wide approach to the administration of grant programs. There are opportunities to support a greater

focus on competitive processes at appropriate intervals and the ANAO has made one recommendation in this respect.

## Key findings by chapter

### Program planning and management (Chapter 2)

20. Over the period 2006–11 FaHCSIA made a number of adjustments to the TCC Program to reflect implementation experience and increased understanding of different needs for mental health services. The expansion of the program announced in 2011 is aiming to build on this base by expanding sites and the capacity of services. It further sought to refine the service delivery models and introduce program enhancements. In developing these enhancements, FaHCSIA has actively drawn on its own experience and that of service providers in the sector.

21. To support the expansion of the TCC Program, FaHCSIA has given appropriate consideration to key aspects of planning and administration. A detailed implementation plan was developed and covered essential elements such as: stakeholder consultation and communication; the development and refocusing of services models; the identification of risks; staged provider selection processes and the identification of high priority areas in which the expansion should be focused.

22. FaHCSIA has given appropriate attention to identifying areas with the greatest need for community-based mental health services such as areas with poorer socioeconomic conditions as these areas tend to have a greater incidence of mental illness than other areas.<sup>13</sup> Accordingly, to support the program's initial implementation and subsequent expansion, FaHCSIA has used data from the Australian Bureau of Statistics to identify areas of relative disadvantage<sup>14</sup> and to target groups such as Indigenous Australians, CALD groups and homeless people.

23. In June 2012 FaHCSIA was funding 201 service providers in 424 locations across Australia. The program's widely dispersed and

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<sup>13</sup> Australian Bureau of Statistics, *Measures of Australia's Progress*, 2010, cat no. 1370.0, Canberra.

<sup>14</sup> Socio-Economic Indexes for Areas (SEIFA) Index of Disadvantage. The SEIFA is based on National Population Census data. Australian Bureau of Statistics, 2039.0 – *Information Paper: An introduction to Socio-Economic Indexes for areas (SEIFA)* [Internet], ABS, Australia, 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2039.02006?OpenDocument> [accessed 25 February]. SEIFAs based on 2011 Census data had not been released at the time of the audit.

community-based service delivery model requires clarity in the respective roles and responsibilities of FaHCSIA's national, state and territory offices and of the service providers. FaHCSIA's Common Business Model for Grants Management allocates the day to day management of service providers to FaHCSIA's state and territory offices while the overall administration and development of the program is the responsibility of FaHCSIA's national office. Funding agreements are in place with service providers which clearly set out their roles and accountabilities. Overall, the department's management arrangements provide a sound framework to support the ongoing administration of the program. The service providers interviewed as part of the audit considered the program was generally well managed from their perspective.

### **Grant Assessment and selection (Chapter 3)**

24. The CCGs, while noting that several selection methods are open to Australian Government agencies, indicate the Australian Government's preference for using open competitive merit-based selection processes when selecting grant recipients. Where an alternative method is chosen as the most appropriate to the circumstances, the CCGs emphasise that the selection methods need to promote transparent and equitable access to grants and that agreement on the process needs to be given by the Minister, chief executive or appropriate delegate. FaHCSIA informed the ANAO that a competitive merit-based grant process was the department's starting position for TCC Program grant rounds.

25. FaHCSIA has primarily undertaken open competitive merit-based selection processes to initially select service providers but has also made use of direct and restricted competitive processes in situations where the objective of the selection process was to support an expansion of existing services. Direct selection processes have also been used to extend a large number of existing funding agreements to align their expiry dates, with the result that most current providers have had their funding agreements renewed without a competitive process. The use of various selection processes is provided for in the FaHCSIA TCC program guidelines and Ministerial approval has been obtained in all cases in relation to the proposed selection methods.

26. Under the CGGs, agencies are required to advise Ministers of the requirements of the guidelines. This will necessarily involve advising on the policy aspects and obligations set out in the *Financial Management and Accountability Regulations 1997*.<sup>15</sup> Briefs provided by FaHCSIA to the Minister seeking approval did not routinely include reference to the CGGs, and in this context the preference for competitive merit-based selection processes. FaHCSIA's TCC Program guidelines also do not reflect the emphasis given in the CGGs to competitive merit-based selection processes. The TCC Program guidelines<sup>16</sup> list three possible selection methods but indicate that the choice of method is at the discretion of the department.

27. Under broader reforms, the Australian Government has committed to strengthening the contribution of the not-for-profit sector to the government's social inclusion agenda.<sup>17</sup> Streamlining contracting and funding arrangements are part of the overall reform approach but the government is also seeking to improve the sector's accessibility to grant funding opportunities. Open competitive selection processes would be expected to help in this regard, and it is important that agencies give appropriate consideration to ways of increasing access to grant opportunities, and that decision makers are advised accordingly.

## Reporting and monitoring (Chapter 4)

28. There is limited information available on the specific contributions made by PHaMs, FMHSS and MHR: CS to improvements in community level mental health. Assessing the overall impact of the TCC Program is challenging and FaHCSIA recognises the limitations of its current performance management framework. As part of ongoing program management and continuous improvement, in September 2010, the department reviewed the program's existing performance management information collections and its needs for future planning and monitoring. As a result of that review, the department identified the following priority activities to improve its performance framework. These are to:

- improve the capacity to report on Mental Health Reforms;

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<sup>15</sup> ANAO, Audit Report No. 21 2011–2012, *Administration of Grant Reporting Obligations*, p. 47.

<sup>16</sup> Department of Families, Housing, Community Services and Indigenous Affairs, Targeted Community Care (Mental Health) Program, *Part B: Information for Applicants*, November 2012.

<sup>17</sup> Australian Government Initiative, National Compact, *working together*, part of the social inclusion agenda. <http://www.nationalcompact.gov.au/> [accessed 10 January 2013].

- streamline and reduce reporting demands on providers;
- prepare for the non-government-organisations' National Minimum Data Set;
- focus on outcome reporting; and
- move to client-level data over time.

29. FaHCSIA is taking important steps in the review of its current performance management framework. A draft framework was completed in 2011 and FaHCSIA undertook a pilot of its use with service providers. The department needs to maintain momentum to ensure its implementation by mid 2014. Once it is in place the new framework will assist FaHCSIA to better monitor the ongoing service performance of providers and to access higher level information required to report against outcomes and program objectives.

## Summary of agency response

30. FaHCSIA provided a formal response to the audit which is contained in full in Appendix 1. A summary of FaHCSIA's response was also provided:

It was beneficial for the Department to be involved in the audit during its peak phase of implementing new community mental health services nationally.

The Department provides comprehensive advice to the Minister in relation to grants selections and approvals. The Department's current Delivery Reform Agenda will provide opportunities to further strengthen advice to systematically provide explicit reference to the Commonwealth Grant Guidelines.

The Department's approach to continuous improvement through implementing a strengthened performance framework will assist in ensuring greater information is available on the impacts of the Targeted Community Care (Mental Health) Program.

# Recommendations

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## **Recommendation No. 1**

### **Paragraph 3.14**

In order to better support the Minister in relation to grant funding decisions, the ANAO recommends that FaHCSIA provides more explicit advice to the Minister on key aspects of the Commonwealth Grants Guidelines and that agency staff are better supported in providing this advice.

**FaHCSIA's response:** Agreed.

## **Audit Findings**

# 1. Introduction

---

*This chapter provides information about the prevalence and consequence of mental health issues. It also describes the policy intent of the Targeted Community Care (Mental Health) Program, and summarises the development of the program from its inception in 2006 to the 2011–12 mental health budget measures.*

## Background

### Mental health

**1.1** Mental disorders account for 13.1 per cent of Australia's total burden of disease and injury, the third leading cause of overall disease burden in Australia after cancers (19 per cent) and cardiovascular diseases (18 per cent).<sup>18</sup> The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) has estimated the annual cost of productivity losses attributable to mental illness to range from \$10 billion to \$15 billion.<sup>19</sup>

**1.2** Results from the 2007 National Survey of Mental Health and Wellbeing<sup>20</sup>, conducted by the Australian Bureau of Statistics, indicate that of the 16 million Australians aged 16 to 85 years, almost half (45 per cent or 7.3 million) had a lifetime mental disorder, that is, a mental disorder at some point in their life, and one in five people experience one of the common forms of mental illness (anxiety, affective or mood disorders, and substance use disorders) in the 12 months prior to the survey interview. The following figure shows the prevalence of mental illness in the Australian adult population.

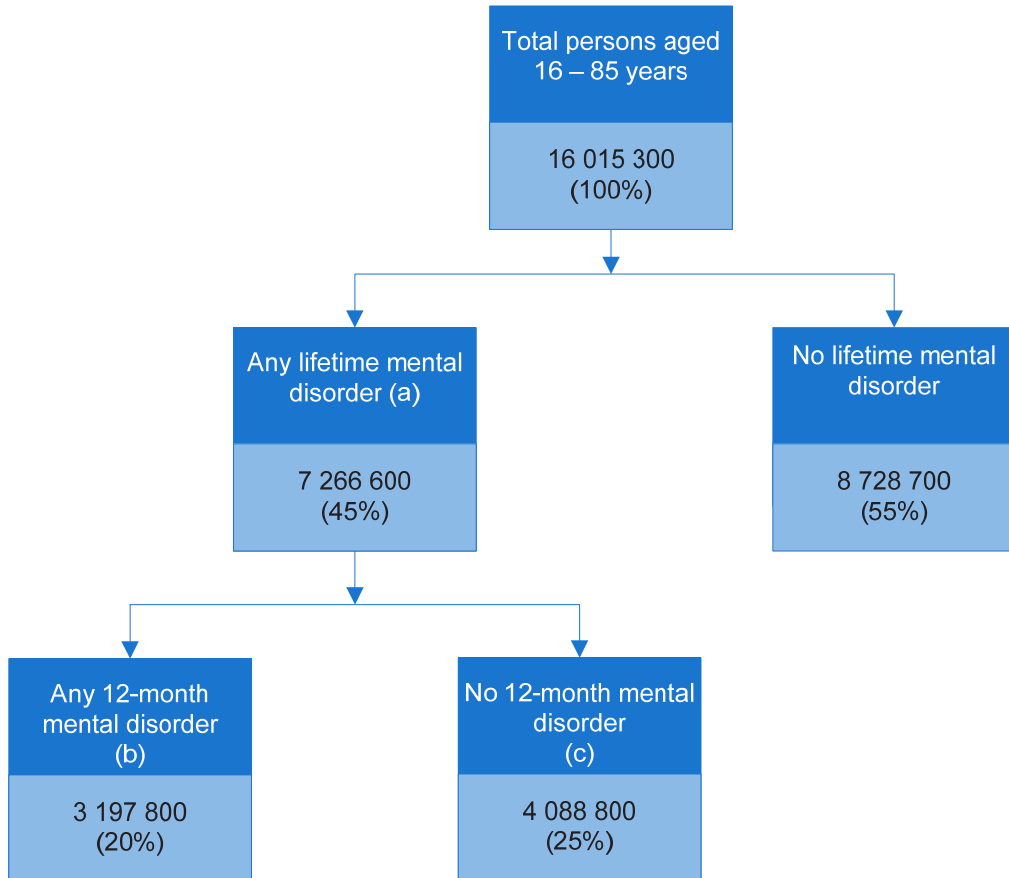
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<sup>18</sup> Australian Institute of Health and Welfare, 2007. *The burden of disease and injury in Australia*, AIHW, Canberra. Levels of death and disability from a comprehensive set of diseases, injuries and risks to health are combined to measure the total health 'burden'.

<sup>19</sup> Department of Families, Housing, Community Services and Indigenous Affairs, Targeted Community Care (Mental Health) Program Guidelines, *Part A – June 2011*, p. 6.

<sup>20</sup> Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, cat. no. 4326.0, Canberra.



**Figure 1.1****Prevalence of mental health disorders in Australia, 2007**

Source: Australian Bureau of Statistics<sup>21</sup>

(a) Experienced a mental disorder at sometime in their life.

(b) Experienced a mental disorder in the 12 months prior to survey interview.

(c) Experienced a mental disorder but did not have symptoms in the 12 months prior to the survey interview.

**1.3** For most people who experience mental illness in adult life, the illness has its onset in childhood or adolescence<sup>22</sup> and can have a very significant social and financial impact on their lives and the Australian community.

<sup>21</sup> Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, cat. no. 4326.0, Canberra.

<sup>22</sup> *The Mental Health of Young People in Australia*, Sawyer et al, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.

Unemployment, co-morbid<sup>23</sup> substance use and addiction, poor physical health and a shortened life span are all serious issues faced by many people living with severe mental illness.<sup>24</sup> Death rates for people with any mental illness are 2.5 times higher than for the general population<sup>25</sup> and suicide is the main cause of premature death.

**1.4** People with mental illness are also over represented in the homeless and prison populations. Australian data indicates that up to 75 per cent of homeless adults have a mental illness and, of these, about a third (approximately 29 000 people) are affected by severe disorders. Additionally, Australian studies have found that around 40 per cent of prisoners have a mental illness and that 10 to 20 per cent are affected by severe disorders.<sup>26</sup>

**1.5** Mental health is a significant area of government expenditure. In 2010–11, \$6.6 billion was allocated to mental health services by governments in Australia. State and territory governments contributed \$4.1 billion or 62.5 per cent, and the Australian Government contributed \$2.5 billion or 37.5 per cent.<sup>27</sup>

## **Mental health policy in Australia**

**1.6** Mental health has been an area of national focus since 1992 when the *National Mental Health Strategy* was endorsed by Australian Health Ministers. This committed all governments to a reform process aimed at achieving major improvements in the quality and range of mental health services available to the community. Through various changes in government at the federal, state and territory levels, the *National Mental Health Strategy* has continued as a consistent reform agenda and the National Mental Health Report series has been maintained as the principal vehicle for monitoring reform progress.<sup>28</sup>

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<sup>23</sup> Co-morbidity means the co-occurrence of one or more diseases or disorders in an individual. According to the Department of Health and Ageing, Resource Kit for GP Trainers on Illicit Drug Issues, co-morbid disorders are common, especially in specialist mental health and addiction services. Persons who have co-morbid substance use and mental health disorders have poorer outcomes than those who have a single disorder.

<sup>24</sup> Department of Health and Ageing, *Adult Collaborative Mental Health Care – Final Report*. [http://www.health.gov.au/internet/main/publishing.nsf/content/C23F4021F98C0540CA25792C00790B5D/\\$File/colint.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/C23F4021F98C0540CA25792C00790B5D/$File/colint.pdf) [accessed 13 February 2013].

<sup>25</sup> Coghlan R et al. (2001). *Duty to Care: Physical Illness in People with Mental Illness*. The University of Western Australia: Perth.

<sup>26</sup> COAG National Action Plan for Mental Health 2006–2011, *Third Progress Report covering implementation to 2008–09*, June 2011.

<sup>27</sup> SCRGSP (Steering Committee for the Review of Government Service Provision) 2013, *Report on Government Services 2013*, Productivity Commission, Canberra, Part E.

<sup>28</sup> Department of Health and Ageing, National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993–2008. Commonwealth of Australia, Canberra.

1.7 In 2005, the Mental Health Council of Australia produced a report titled, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia*<sup>29</sup> and in 2006, the Senate Select Committee on Mental Health published, *A National Approach to Mental Health – From Crisis to Community*.<sup>30</sup> Both of these reports highlighted the need for services to assist people with mental illnesses and the need for greater coordination between clinical and community-based services.

1.8 In 2006, the Council of Australian Governments (COAG) agreed on a whole-of-government approach to mental health, to be implemented through a *National Action Plan on Mental Health 2006–2011*<sup>31</sup> (Action Plan). The four key outcomes of the Action Plan were to:

- reduce the prevalence and severity of mental illness in Australia;
- reduce the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
- increase the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
- increase the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.<sup>32</sup>

1.9 Supporting this agreement, in 2006–07 the Australian Government committed a total of \$1.8 billion for 19 initiatives to assist people with mental illness, their families and carers over the five year period 2006–07 to 2010–11. Within this, FaHCSIA was allocated \$554.7 million for the Targeted Community Care (Mental Health) Program (TCC). The program was directed at the Action Plan’s primary aim of improving mental health and the recovery

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<sup>29</sup> *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Mental Health Council of Australia, Canberra, 2005. [http://www.mhca.org.au/index.php/component/rsfiles/download?path=Publications/Not%20For%20Service%20\\_Full%20Report.pdf](http://www.mhca.org.au/index.php/component/rsfiles/download?path=Publications/Not%20For%20Service%20_Full%20Report.pdf) [accessed 21 February 2013].

<sup>30</sup> The Senate, Select Committee on Mental Health, *A National Approach to Mental Health – From Crisis to Community*, April 2006. <http://www.mhfa.com.au/documents/SenateSelectCommitteeFinalReport.pdf> [accessed 21 February 2013].

<sup>31</sup> COAG *National Action Plan on Mental Health 2006–2011*, 14 July 2006.

<sup>32</sup> COAG *National Action Plan for Mental Health 2006–2011*, 14 July 2006. [http://archive.coag.gov.au/coag\\_meeting\\_outcomes/2006-07-14/docs/nap\\_mental\\_health.pdf](http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf) [accessed 15 January 2013].

from illness through a greater focus on promotion, prevention, early intervention and access to mental health services.<sup>33</sup>

**1.10** The Action Plan ceased in 2011, but mental health reform was recognised as requiring continued government commitment and renewal. To this end, the *National Mental Health Strategy* (comprising the *National Mental Health Policy*, endorsed in 2008 by the Health Ministers, and the *Fourth National Mental Health Plan 2009–2014*) builds upon the whole-of-government commitments of the Action Plan and provides the national direction and priorities for mental health reform within Australia's health system. More recently the *Roadmap for National Mental Health Reform 2012–22* was approved and released by COAG on 7 December 2012. The Roadmap provides a pathway towards achieving the vision of an Australian society that values good mental health and wellbeing and confirms the shared intents and goals of Commonwealth, state and territory governments.<sup>34</sup>

**1.11** In the 2011–12 Budget the Australian government announced the release of the *Delivering National Mental Health Reform* package in which the government committed \$2.2 billion over five years for mental health reform, including \$1.5 billion in new measures. The package is a cross-sector reform package that recognises the diverse impact of mental illness throughout a person's lifetime and is intended to build resilient children, support teenagers and families dealing with the challenge of mental illness, improve access to primary care and target more community-based services to people living with severe mental illness and their families.

**1.12** Of this additional funding, FaHCSIA was allocated \$269.3 million to provide further support to community mental health by expanding the TCC Program to include additional services such as employment and family support and additional service locations. These new funds were in addition to ongoing funding over the same period for existing providers under the TCC Program.

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<sup>33</sup> COAG *National Action Plan for Mental Health 2006–2011*, 14 July 2006. [http://archive.coag.gov.au/coag\\_meeting\\_outcomes/2006-07-14/docs/nap\\_mental\\_health.pdf](http://archive.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf) [accessed 15 January 2013].

<sup>34</sup> COAG *The Roadmap for National Mental Health Reform 2012–2022*. <http://www.coag.gov.au/sites/default/files/The%20Roadmap%20for%20National%20Mental%20Health%20Reform%20012-2022.pdf.pdf> [accessed 22 January 2013].

**1.13** Mental health has an extensive committee structure in which FaHCSIA plays a part. Appendix 2 shows the 2012 high level committee structure and the interrelations of committees and councils governing mental health.

## Targeted Community Care (Mental Health) Program

### Development of the Targeted Community Care (Mental Health) Program

**1.14** There are three components to the TCC Program:

- **Personal Helpers and Mentors (PHaMs).** This initiative is designed to assist people whose lives are severely affected by mental illness by providing support: to manage daily activities; gain access to needed services such as accommodation, social support, health, welfare, and employment services; and increase connections with their community;
- **Family Mental Health Support Services<sup>35</sup> (FMHSS).** This initiative provides early intervention support to assist vulnerable families with children and young people who are at risk of, or affected by, mental illness. These services aim to support parents to reduce family stress and enable children and young people to reach their potential; and
- **Mental Health Respite: Carer Support<sup>36</sup> (MHR: CS).** This initiative funds 650 respite care places which provide a range of flexible respite and support options for carers and families of people with severe mental illness and carers of people with an intellectual disability.

**1.15** Appendix 3 provides a detailed description of the TCC Program's three service components.

**1.16** The objective of the TCC Program '...is to implement community mental health initiatives to assist people with mental illness and their families and carers to manage the impact of mental illness.'<sup>37</sup> FaHCSIA's strategy to achieve this is to provide accessible, responsive, high quality and integrated community-based mental health services that improve the capacity of individuals, families and carers to manage the impacts of mental illness on

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<sup>35</sup> Originally known as Mental Health Community Based.

<sup>36</sup> Originally known as Mental Health Respite.

<sup>37</sup> Department of Families, Housing, Community Services and Indigenous Affairs, *Portfolio Budget Statement 2012–2013*, p. 94. [http://resources.fahcsia.gov.au/budget/2012-13/FaHCSIA\\_PBS\\_2012-13.pdf](http://resources.fahcsia.gov.au/budget/2012-13/FaHCSIA_PBS_2012-13.pdf) [accessed 5 February 2013].

their lives and improve their overall wellbeing.<sup>38</sup> The Program complements clinical health services by providing support options that aim to promote social inclusion and recovery. Grant funding is awarded under the TCC Program to community-based not-for-profit organisations and established national charitable organisations to deliver services in sites across Australia.

**1.17** Table 1.1 shows the number of service sites funded in 2011–12, the number of clients FaHCSIA estimates it has assisted and the funding allocation by each service type.

**Table 1.1**

**Targeted Community Care (Mental Health) Program 2011–12<sup>39</sup>**

Mental Health Services	Number of service sites	Number of clients assisted	Funding allocation \$million
Personal Helpers and Mentors	175	13 219	85.6
Mental Health Respite: Carer Support	195	28 745	50.0
Family Mental Health Support Services	54	82 104	20.3
<b>Total</b>	<b>424</b>	<b>124 068</b>	<b>155.9</b>

Source: FaHCSIA.

Note: Number of clients assisted includes remote participants

Number of service sites as at 30 June 2012.

Of the 175 PHaMs sites, 95 were in metropolitan areas, 69 were in non-metropolitan areas and 11 were in remote areas.

## Program delivery model and services

**1.18** The services offered by providers as part of the three service streams have developed over time in step with FaHCSIA's program evaluation and research, and the growth and development of the capacity of service providers operating in the community sector. Following recommendations contained in

<sup>38</sup> Department of Families, Housing, Community Services and Indigenous Affairs, Targeted Community Care Program (Mental Health) Program, *Part A: Program Guidelines*, November 2012.

<sup>39</sup> In the same financial year the Department of Health and Ageing's mental health program (Program 11.1) was allocated \$310.4 million to fund its mental health activities. This program includes National Partnerships paid to state and territory governments as part of the Federal Financial Relations Framework for: *National Health and Hospitals Network – Mental Health – Expansion of the Early Psychosis Prevention and Intervention Centre model initiative*; and *The National Perinatal Depression Initiative*.

the TCC Program evaluation report released in 2011,<sup>40</sup> the three service types were aligned into two funding streams to better associate the funding with the intended target populations.

- **Services for People with Mental Illness**
  - Personal Helpers and Mentors
- **Services and Support for Families and Carers of People with Mental Illness**
  - Mental Health Respite: Carer Support
  - Family Mental Health Support Services

**1.19** Reframing and streamlining the initiatives did not change the outcomes or intent of the overall program.

**1.20** Table 1.2 shows the program funding allocation across jurisdictions and population in 2011–12.

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<sup>40</sup> *Evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives, Final Report*, March 2011. <http://www.fahcsia.gov.au/our-responsibilities/communities-and-vulnerable-people/programs-services/targeted-community-care-mental-health-program/evaluation-of-the-fahcsia-targeted-community-care-mental-health-initiatives> [accessed 23 January 2013].

**Table 1.2****Targeted Community Care (Mental Health) Program state and territory funding allocations and population size, 2011–12**

State/Territory	Funding allocation \$million	Percentage of program funding allocation	Percentage of Australian population
ACT	2.5	1.6	1.6
NSW	46.2	29.7	32.4
NT	7.2	4.6	1.0
Qld	28.2	18.1	20.2
SA	15.6	10.0	7.3
Tas	4.8	3.1	2.3
Vic	32.4	20.8	24.8
WA	19.1	12.3	10.3
<b>Total</b>	<b>156.0</b>	<b>100.0</b>	<b>100.0</b>

Source: FaHCSIA data. ABS population figures at December 2010 and approved funding as at 30 June 2012.

Note: Because of rounding, the sum of the components do not always add to the total.

## Audit objective, scope, criteria and approach

### Audit objective

**1.21** The objective of the audit was to assess the effectiveness of FaHCSIA's administration and management of the Targeted Community Care (Mental Health) Program.

### Audit scope

**1.22** The audit focused primarily on the program's administration and management since 2010–11. This period included the:

- finalisation of the original program measures; and
- commencement of program expansion measures.



## **Audit criteria**

**1.23** Three high level criteria were used to conclude against the audit objective. These were whether FaHCSIA:

- established and used structured and appropriate planning processes to support the targeting of the program;
- managed the selection of service providers consistently with Australian Government requirements; and
- developed and implemented satisfactory performance reporting arrangements for program effectiveness and accountability.

## **Audit approach**

**1.24** The audit involved the examination of documents and files relevant to the TCC Program. Interviews were conducted with officers in FaHCSIA's national office in Canberra, as well as with officers in the New South Wales, South Australian and Queensland FaHCSIA offices. In addition, the ANAO visited a random sample of 24 PHaMs, FMHSS and MHR: CS service providers in those same states and the Australian Capital Territory.

**1.25** The audit was conducted in accordance with the ANAO Auditing Standards at a cost of \$340 311.

# Report structure

1.26 The structure of the report is outlined in Figure 1.2

Figure 1.2

## Report structure

Chapter	Description
Chapter 2 Program Planning and Management	This chapter describes FaHCSIA's overall approach to planning and managing the expansion of the Targeted Community Care (Mental Health) Program. The chapter also examines the roles and responsibilities of FaHCSIA's national and state and territory offices and the approach taken to risk management.
Chapter 3 Grant Selection and Assessment	This chapter examines the selection approaches taken by FaHCSIA in recent Targeted Community Care (Mental Health) Program and funding rounds.
Chapter 4 Reporting and Monitoring	This chapter examines FaHCSIA's performance monitoring and reporting of the Targeted Community Care (Mental Health) Program and the introduction of a new performance management framework.

Source: ANAO.

## 2. Program Planning and Management

*This chapter describes FaHCSIA's overall approach to planning and managing the expansion of the Targeted Community Care (Mental Health) Program (TCC). The chapter also examines the roles and responsibilities of FaHCSIA's national and state and territory offices and the approach taken to risk management.*

### Introduction

**2.1** High quality planning underpins efficient, effective, economical and ethical grants administration.<sup>41</sup> To implement programs that best support the government's expected outcomes, consideration needs to be given to the planning and targeting of the program, often involving agency staff working with stakeholders to plan, design and undertake the granting activities. Where program delivery is undertaken in a variety of geographical locations using local providers, clearly defined roles and responsibilities are important both within the administering department and with the network of service providers. Risk is an important consideration for agencies, and risk management should be built into an agency's grants administration processes and be an ongoing element of management.

### Program development and implementation

#### Introduction and expansion of program services

**2.2** The original TCC Program measures were implemented progressively over the period 2006–07 to 2010–11. Table 2.1 shows the TCC Program implementation over this time.

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<sup>41</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines, Policies and Principles for Grants Administration*, July 2009 p. 15. [http://www.finance.gov.au/publications/fmq-series/docs/FMG23\\_web.pdf](http://www.finance.gov.au/publications/fmq-series/docs/FMG23_web.pdf) [accessed 19 February 2013].

**Table 2.1****Targeted Community Care (Mental Health) Program implementation 2007–10**

Program service element	Implementation Date*
Personal Helpers and Mentors (PHaMs)	Round 1: May 2007
	Round 2: November 2007
	Round 3: April 2009
	Round 4: March 2010
Family Mental Health Support Services (FMHSS)	Phase 1: June 2007
	Phase 2: December 2007
Mental Health Respite: Carer Support (MHR: CS)	Commonwealth Respite Carelink Centres: April 2007
	National Respite Development Fund (NRDF) Round 1: November 2007
	NRDF Round 2: June 2009.

Source: FaHCSIA program data.

\* Date of Ministerial approval.

**2.3** As part of the 2011–12 mental health budget measures, the expanded TCC Program is being progressively implemented from January 2012. The budget measures provide an additional \$269.3 million for expansion which will be invested in community mental health services over the five year period 2011–12 to 2015–16. FaHCSIA's early draft implementation plans evenly spaced the work over the five year period. However, this approach was subsequently viewed by FaHCSIA as an inefficient approach to large and complicated grant processes and insufficient to meet the expected demands for the services. FaHCSIA accordingly modified its phasing and is now working to a plan that schedules approximately 75 per cent of implementation for completion by June 2013.

**2.4** The expansion of the TCC Program includes:

- Personal Helpers and Mentors: \$154 million to provide additional 425 new personal helpers and mentors to assist around 3400 people with severe mental illness.
  - \$50 million (of the \$154 million) will provide personal helpers and mentors to specifically help people with mental illness on, or

claiming income support or the Disability Support Pension who are also working with employment services.

- Mental Health Respite: Carer Support: \$54.3 million for additional respite services to help approximately 1100 families and carers to maintain their caring role.
- Family Mental Health Support Services: \$61 million to establish 40 additional service sites.

**2.5** In planning the implementation of the expansion, FaHCSIA sought to make sure that:

- the sites with the highest needs were selected for new and expanded services;
- the most capable service providers were selected; and
- program enhancements were measured and tested during implementation before being applied more broadly.

**2.6** To support the expansion, FaHCSIA developed an implementation plan that identified key tasks. These were the development of:

- service delivery models for new service types;
- a list of priority sites for program expansion;
- a consultation strategy with relevant stakeholders;
- provider selection processes;
- new administrative processes to manage implementation and ongoing management; and
- an evaluation strategy for the budget measures.

**2.7** FaHCSIA's implementation plan also incorporated risk identification and associated mitigation strategies along with progress reporting.

## **Site selection**

**2.8** The Commonwealth Grant Guidelines (CGGs) set out the need for agencies to address relevant planning issues before granting activities

commence.<sup>42</sup> To guide the implementation of new community mental health services, FaHCSIA developed principles to support site selection. These principles were that:

- additional service delivery capacity is to be targeted to areas of high need;
- priority is to be given to disadvantaged and vulnerable target groups including, but not limited to, Indigenous Australians, culturally and linguistically diverse (CALD) groups and homeless people;
- consideration is to be given to locations of other Australian Government reform priorities; and
- the equitable distribution of funding across each state and territory and a balance of remote, non-metropolitan and metropolitan services.

**2.9** FaHCSIA used a variety of geographic spatial mapping approaches when analysing gaps in service coverage, identifying high need areas and areas where demand for services exceeds the capacity of current providers. These geographical areas defined by post code, local government area<sup>43</sup> (LGA) boundaries or Housing and Community Care (HACC) regions<sup>44</sup> also delineate client eligibility.

### *Personal Helpers and Mentors*

**2.10** The analysis undertaken by FaHCSIA to identify priority locations of PHaMs used Australian Bureau of Statistics (ABS) 2006 Census Collection Districts<sup>45</sup> (CDs) and LGA population data.

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<sup>42</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines, Second Edition*, Financial Management Guidance No.3 June 2013, p. 32. <http://www.finance.gov.au/publications/fmg-series/docs/FMG-3-Commonwealth-Grant-Guidelines-June-2013.pdf> [accessed 19 February 2013].

<sup>43</sup> A Local Government Area (LGA) is a geographical area under the responsibility of an incorporated local government council, or an incorporated Indigenous government council. The LGAs in Australia collectively cover only a part of Australia. The main areas not covered by LGAs are northern parts of South Australia, a large part of the Northern Territory, the western division of New South Wales, all of the Australian Capital Territory and the Other Territories. <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2901.0Chapter23102011> [accessed 18 February 2013].

<sup>44</sup> The Commonwealth HACC region is the basis of the funding arrangements for Commonwealth HACC service delivery. Commonwealth HACC funding, provided under the Aged Care Funding Agreement, is for services which support frail older people and their carers, who live in the community and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long term residential care. [http://www.health.gov.au/internet/main/publishing.nsf/Content/2F4764279BE70622CA257A2300091BFF/\\$File/HAAC%20Manual\\_web.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/2F4764279BE70622CA257A2300091BFF/$File/HAAC%20Manual_web.pdf) [accessed 18 February 2013].

<sup>45</sup> The Census Collection District (CD) has been designed for use in the Census of Population and Housing as the smallest unit for collection and processing. CDs also serve as the basic building block in the Australian Standard Geographical Classification and are used for the aggregation of statistics to larger Census geographic areas. <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/413876F3BAE9CC70CA25720A000C428B> [accessed 18 February 2013].

**2.11** Relative need was assessed through the use of a number of indicators and calculating an average ranking for each LGA. The indicators used included:

- ABS data on Australia's Indigenous population;
- the Kessler K10 scale<sup>46</sup> by LGA based on synthetic estimates from the ABS 2007–08 National Health Survey;
- the number of people with a Mental Health Care Plan<sup>47</sup> based on data from the Department of Health and Ageing 2009–10;
- Australia's homeless population,<sup>48</sup> and
- people living in Australia's most disadvantaged 5 per cent of CDs based on the 2006 ABS Socio-Economic Index of Disadvantage (SEIFA).<sup>49</sup>

**2.12** FaHCSIA assessed areas where demand for services exceeded the current capacity of providers by identifying the number of current providers operating in each LGA and the number of those providers that were at or near capacity in terms of the number of registered clients. This data was linked to information on estimated demand to identify potential service gaps.

### *Family Mental Health Support Services*

**2.13** For 40 new FMHSS sites, FaHCSIA drew on the same analysis that it had undertaken for PHaMs with an additional focus on:

- the concentration of socio-economic disadvantage;
- areas with high populations of Indigenous and non Indigenous children zero to 14 years; and
- areas with a high CALD population.

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<sup>46</sup> The K10 is a measure of distress based on ten questions about anxiety and depressive symptoms that a person has experienced in the most recent four week period.

<sup>47</sup> Prepared by general practice doctors under the Better Access Program 2009–2010, administered by the Department of Health and Ageing.

<sup>48</sup> Australian Bureau of Statistics, *Australian Census Analytic Program: Counting the Homeless, Australia, 2006*, cat no. 2050.0, Canberra.

<sup>49</sup> The SEIFA is based on National Population Census data. Australian Bureau of Statistics, 2039.0 – *Information Paper: An introduction to Socio-Economic Indexes for areas (SEIFA)* [Internet], ABS, Australia, 2006. <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2039.02006?OpenDocument> [accessed 25 February].

**2.14** Because of the number of high need community sites across Australia was expected to exceed the available funding, FaHCSIA chose to focus on new sites where there were no current FMHSS services.

### *Mental Health Respite: Carer Support*

**2.15** FaHCSIA based the needs analysis for the MHR: CS expansion on LGAs rather than HACC regions to better identify gaps in current service coverage. The methodology identified a number of priority locations with absolute gaps in service coverage or with very poor service coverage.

## **Consultation**

**2.16** The CGGs emphasise the importance of collaboration and partnership between the responsible agency and the program stakeholders when developing or modifying granting activities.<sup>50</sup> FaHCSIA's ongoing consultation with the community and key stakeholders has been a positive initiative that has guided and influenced the design and development of the expanded program. The approach taken by FaHCSIA has also been consistent with the intent of the National Compact between the Australian Government and the not-for-profit sector to genuinely collaborate to achieve shared visions.<sup>51</sup> The ANAO's interviews with a sample of service providers indicated that FaHCSIA has built up working relationships with peak bodies and with the major service providers.

**2.17** Following the announcement of the program's expansion in 2011, a specific communication strategy was developed to set out the need and type of consultation necessary, the appropriate forms of communication and the period over which consultation needed to be undertaken. Discussions were held with FaHCSIA's state and territory offices, state and territory governments, peak organisations and service providers regarding roles and responsibilities, to test proposals and priority areas and to inform them of the intended timetable and program design changes. Following the budget announcement, all TCC Program service providers were sent letters setting out potential changes and were given the opportunity to have input into the proposed program changes.

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<sup>50</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines, Second Edition*, Financial Management Guidance No.3 June 2013, p. 36. <http://www.finance.gov.au/publications/fmg-series/docs/FMG-3-Commonwealth-Grant-Guidelines-June-2013.pdf> [accessed 19 February 2013].

<sup>51</sup> Australian Government, National Compact, *working together*. Part of the social inclusion agenda. <http://www.nationalcompact.gov.au/compact> [accessed 25 February 2013].



## Enhancement to the Targeted Community Care (Mental Health) Program

**2.18** It is important that programs remain well targeted and are appropriately revised as circumstances change, or in the light of implementation experience. As part of the TCC Program's expansions the Australian Government intended that new sites would complement other initiatives such as the National Framework for Protecting Australia's Children<sup>52</sup> and the Building of Australia's Future Workforce<sup>53</sup> pilot sites. FaHCSIA is continuing to refine the delivery models for the mental health employment component of the expanded PHaMs and the FMHSS increased focus on early interventions, with the intention that these models will be further refined through engagement with key stakeholders and service providers.

### PHaMs Employment

**2.19** The PHaMs employment component is designed to assist up to 1200 income support and Disability Support Pension (DSP) recipients/claimants by providing complementary assistance to help people to stabilise those aspects of their lives that are inhibiting their capacity to engage in and maintain employment. Direct employment assistance such as job placements, job skills or job-readiness training is not provided as part of the PHaMs service as this continues to be the role of employment service providers. Services are to be located in areas of high need where there are significant populations of DSP recipients with psychiatric conditions as their primary disability.

**2.20** As part of the planning for the PHaMs employment measure, FaHCSIA undertook broad consultation with a range of stakeholders including Commonwealth agencies; PHaMs service providers; Disability Employment Services and Job Search Australia providers; consumers and carers; and mental health and employment peak organisations. The consultation focused on the implementation of the measures and to confirm that they complement other

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<sup>52</sup> The National Framework for Protecting Australia's Children 2009-2020, endorsed by the Council of Australian Governments in April 2009, is a long-term approach to ensuring the safety and wellbeing of Australia's children and aims to deliver a substantial and sustained reduction in levels of child abuse and neglect over time.

<sup>53</sup> From 1 July 2012 new measures introduced as part of the \$3 billion Building Australia's Future Workforce package announced in the 2011-2012 Federal Budget, are coming into effect. Broadly, these measures relate to: people with disability; the very long term unemployed; job seekers; youth and early school leavers; and tackling entrenched disadvantage. The package involves FaHCSIA, DHS and DEEWR working together and the government has identified ten Local Government Areas where additional assistance is being offered to boost participation and reduce disadvantage.

major initiatives and link with Commonwealth services and programs for people with mental illness. FaHCSIA is expecting the first 12 months of the initiative to be one of consolidation during which the model will be refined and base line measures and performance measurement finalised.

## **Family Mental Health Support Services**

**2.21** In line with the 2011–12 budget, FMHSS services will have a consistent focus on providing early interventions specifically for children and young people. FaHCSIA has planned a progressive introduction of a new model to strengthen the focus on early intervention support for children and young people at risk of developing mental illness, or those displaying early symptoms of mental illness. The model retains and enhances the three elements of the current FMHSS:

- early interventions and casework specifically for children or young people;
- whole-of-family assistance and support where problems within families are impacting negatively on the mental health of children and young people; and
- community outreach, including group work with children and young people, mental health promotion and community development activities.

**2.22** Under the current model, service providers deliver one or more of these elements. However, the new FMHSS model requires service providers to deliver all three elements. FaHCSIA will be working with existing service providers to transition to the new model by mid 2014.

## **Roles and responsibilities for ongoing administration**

**2.23** FaHCSIA's Common Business Model for Grants Management (the Common Business Model), provides a department-wide management structure and approach for grant programs. In general, FaHCSIA's grant program management responsibilities are shared across two main departmental structures: National Office located in Canberra, and the State and Territory Office Network (STO Network).

**2.24** Under the Common Business Model, the National Office staff are generally responsible for developing the overarching documents, tools and processes for program management, while the STO Network staff are

primarily responsible for funding processes and direct service provider management.

**2.25** Responsibilities of STO Network staff, often referred to as Agreement Managers, include:

- entering funding agreements into FaHCSIA's Online Funding Management System (FOFMS) and amending risk profiles as required;
- ongoing performance monitoring including site visits to ensure compliance with the funding agreement and program outcomes are being achieved;
- directly liaising with service providers as required to ensure issues are resolved at a local level;
- undertaking an annual acquittal process against funding agreements; and
- providing feedback to National Office staff regarding gaps, linkages and overlaps with other agencies and programs and other levels of government for inclusion and consideration in national reviews and evaluation.

**2.26** The purpose of the STO Network having these responsibilities is to use local knowledge to manage Funding Agreements and relationships with service providers.

**2.27** The Common Business Model was introduced in 2009 and progressively applied to FaHCSIA's grant programs. In July 2010 the model was introduced to the TCC Program, providing an appropriate basis for the identification of key roles and responsibilities. Similarly, service provider funding agreements set out the service expectations and management relationship between FaHCSIA and the funded organisations.

## Risk management

**2.28** Both the CGGs and the ANAO Better Practice Guide—*Implementing Better Grants Administration*, June 2010, emphasise that programs should include a framework for identifying and treating or minimising risks that may have an adverse impact on the achievement of grant outcomes. FaHCSIA has adopted a department-wide approach to risk management across the program life cycle. The principles of the FaHCSIA business model are underpinned by a risk-based approach to funding processes. To assess and manage TCC

Program risks, FaHCSIA utilises two strategies. The first is a program-wide risk assessment and moderation strategy; and the second is a risk assessment of service providers.

**2.29** Program risk tools provide a standardised approach to the management of risk in relation to: the establishment of programs; selecting service providers; and managing service delivery. The current program risk management tools were developed and released for application in September 2009.

### **Management of program risk**

**2.30** FaHCSIA uses a single, departmental risk assessment tool, the *Program Design Risk Assessment Tool*, to identify risk for all programs. The *Program Design Risk Assessment Tool* generates the risk profile of a program by identifying the risk level in five risk areas of program:

- governance;
- financial management;
- viability;
- performance management; and
- issues management.

**2.31** Responses to the list of questions for each risk area determine the likelihood rating used to calculate the risk level for each risk area. Based on the risk level calculated, control strategies are generated detailing the required documentation and processes to manage risk for each of the five risk areas in the program.

**2.32** The *Program Design Risk Assessment Tool* is a high level analysis which focuses on FaHCSIA's internal program management arrangements. Table 2.2 shows results of the TCC Program Design Risk Assessment which was endorsed on 1 February 2012.

**Table 2.2****Targeted Community Care (Mental Health) Program risk assessment, February 2012**

<b>Risk area</b>	Governance	Financial management	Viability	Performance management	Issues management
<b>Risk level</b>	Low	Low	Low	Low	Low

Source: ANAO adaptation of a table outlining FaHCSIA's risk assessment for TCC Program as at 1 February 2012. The Program Design Risk Assessment is scheduled for review in May 2013.

**Risk assessment of provider organisations**

**2.33** To complement the program level risk assessment, FaHCSIA also undertakes risk assessment of the service provider organisations. Risk assessments of individual service providers are completed using the *Provider Capacity Risk Assessment Tool*<sup>54</sup> and the *Provider Delivery Assessment Tool*.<sup>55</sup> These tools seek to identify and manage risks associated with the service providers' ability to deliver funded activities and to ensure that funded activities are delivered to the agreed standard.

**2.34** Risk assessments are completed by STO Network staff. Similar to the *Program Design Risk Assessment Tool*, the *Provider Capacity Risk and Delivery Assessment Tools* assess risk in the five key program risk areas (governance, financial management, viability, performance management and issues management). Additional supporting comments can be added into the online assessment.

**2.35** Based on the risk level, control strategies are generated by detailing the actions required to manage risks for each of the five risk areas. If a program risk area is identified as low risk, no control strategies are required. Table 2.3 shows a summary of the provider risk assessment for the TCC Program as at November 2012.

<sup>54</sup> Risks associated with the provider organisations' capacity to deliver quality services.

<sup>55</sup> Risks associated with ensuring program requirements and funded activities are delivered to the agreed standard.

**Table 2.3****Targeted Community Care (Mental Health) Program summary of service provider risk assessments, November 2012**

Risk summary	Financial management	Governance	Issues management	Performance management	Viability
Low	172	175	178	176	178
Moderate	18	15	11	10	8
High	0	0	1	4	4
Not allocated <sup>56</sup>	11	11	11	11	11
<b>Total</b>	<b>201</b>	<b>201</b>	<b>201</b>	<b>201</b>	<b>201</b>

Source: Provided by FaHCSIA.

**2.36** While FaHCSIA assesses and monitors risks for service providers, FaHCSIA also expects service providers to identify and manage their own risks as stated in the TCC Program Guidelines Part A.

## Conclusion

**2.37** Over the period 2006–11 FaHCSIA made a number of adjustments to the TCC Program to reflect implementation experience and increased understanding of different needs for mental health services. The expansion of the program announced in 2011 sought to build on this base by expanding sites and the capacity of services. It further sought to refine the service delivery models and introduce program enhancements. In developing these enhancements, FaHCSIA has actively drawn on its own experience and that of service providers in the sector.

**2.38** To support the expansion of the TCC Program, FaHCSIA has given appropriate consideration to key aspects of planning and administration. A detailed implementation plan was developed and covered essential elements such as: stakeholder consultation and communication; the development and refocusing of services models; the identification of risks; staged provider

<sup>56</sup> For 11 organisations funded under the TCC, an assessment of capacity risk has not been completed. The service delivery risk has been assessed for 10 of these organisations. For the one organisation where neither the capacity risk nor service delivery risk has not been completed, the organisation was funded for a sum of \$70 000 for development of training modules for use by community-based carers. FAHCSIA advised the deliverables under the arrangement were delivered on time, to the satisfaction of the department, and without issue.

Of the 11 organisations where the capacity risk has not been completed, 9 organisations have continued funding and FaHCSIA has indicated that organisational capacity risk assessments will be completed.

selection processes and the identification of high priority areas in which the expansion should be focused.

**2.39** FaHCSIA has given appropriate attention to identifying areas with the greatest need for community-based mental health services as areas of poorer socioeconomic conditions tend to have a greater incidence of mental illness than other areas. Accordingly, to support the program's initial implementation and subsequent expansion, FaHCSIA has used data from the Australian Bureau of Statistics to identify areas of relative disadvantage<sup>57</sup> and to target groups such as Indigenous Australians, CALD groups and homeless people.

**2.40** In June 2012 FaHCSIA was funding 201 service providers in 424 locations across Australia. The program's widely dispersed and community-based service delivery model requires a clear understanding of the respective roles and responsibilities of FaHCSIA's national, state and territory offices and of the service providers. FaHCSIA's Common Business Model for Grants Management allocates the day to day management of service providers to FaHCSIA's state and territory offices while the overall administration and development of the program is the responsibility of FaHCSIA's national office. Funding agreements are in place with service providers which clearly set out their roles and accountabilities. Overall, the department's management arrangements provide a sound framework to support the administration of the program. The service providers interviewed as part of the audit considered the program was generally well managed from their perspective.

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<sup>57</sup> Socio-Economic Indexes for Areas (SEIFA) Index of Disadvantage. The SEIFA is based on National Population Census data. Australian Bureau of Statistics, 2039.0 – *Information Paper: An introduction to Socio-Economic Indexes for areas (SEIFA)* [Internet], ABS, Australia, 2006. <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2039.02006?OpenDocument> [accessed 25 February]. SEIFAs based on 2011 Census data had not been released at the time of the audit.

## 3. Grant Assessment and Selection

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*This chapter examines the selection approaches taken by FaHCSIA in recent Targeted Community Care (Mental Health) (TCC) Program and funding rounds.*

### Introduction

**3.1** The original Commonwealth Grant Guidelines<sup>58</sup> (CGGs) were issued in July 2009 by the Minister for Finance and Deregulation under *Financial Management and Accountability Regulations 1997*, 7A.<sup>59</sup> The CGGs establish the grants policy framework and outline the Australian Government's expectations of agencies in respect to grants administration practices. Officials performing duties in relation to the administration of grants must act in accordance with the CGGs.<sup>60</sup>

### Program guidelines

**3.2** The CGGs require Australian Government agencies to develop and maintain guidelines for the operation of grant programs. Agencies must develop grant guidelines for new grant programs and make them publicly available (including on agency websites) where eligible persons and/or entities are able to apply for a grant under a program.<sup>61</sup>

**3.3** The TCC Program guidelines provide a single reference source for policy guidance, administrative procedures, appraisal criteria, monitoring requirements, and evaluation strategies.<sup>62</sup> The guidelines are written in plain English and provide clear information for applicants. The guidelines also provide the framework for the implementation and administration of the program and comprise the following documents:

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<sup>58</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines, Policies and Principles for Grants Administration*, July 2009. [http://www.finance.gov.au/publications/fmg-series/docs/FMG23\\_web.pdf](http://www.finance.gov.au/publications/fmg-series/docs/FMG23_web.pdf) [accessed 19 February 2013].

<sup>59</sup> The CGGs apply to agencies subject to the FMA Act. Agencies will be required to comply with the Commonwealth Grant Guidelines Second Edition from 1 June 2013, however, agencies may adopt some or all of the requirements in the CGGs from the date of their registration. The July 2009 CGGs will remain in force until that time.

<sup>60</sup> ANAO, *Better Practice Guide—Implementing Better Practice Grants Administration*, June 2010, Canberra

<sup>61</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines, Policies and Principles for Grants Administration*, July 2009, 3.24, p. 11.

<sup>62</sup> *ibid.*, p. 22.



- **Part A: Targeted Community Care (Mental Health) Program Guidelines** - an overview of the Targeted Community Care (Mental Health) Program and the Activities relating to the program.
- **Part B: Information for Applicants** - information on the Application, Assessment, Eligibility, Selection and Complaints Processes; and Financial and Funding Agreement arrangements.
- **Part C 1, 2 and 3: Application Information for the Personal Helpers and Mentors Activity, the Mental Health Respite: Carer Support Activity and the Family Mental Health Support Services** - specific information on the Activity, Selection Processes, Performance Management and Reporting for each service stream.

**3.4** The TCC Program guidelines and standard funding agreement are both publicly accessible on FaHCSIA's website. The program guidelines are up to date and generally appropriate for the program. However, as discussed in paragraph 3.7 the guidelines do not give the same emphasis to the preference for open competitive merit-based selection process as is given in the CCGs.

## **Selection processes used in the Targeted Community Care (Mental Health) Program**

**3.5** FaHCSIA has used a combination of competitive merit-based selections, restricted competitive selection and direct selection over the course of the original TCC Program implementation period to select service providers.

**3.6** To support the subsequent expansion, FaHCSIA completed four selection processes in 2012 and finalised two further tender rounds in April 2013. FaHCSIA has used open competitive merit-based selection processes in two of these rounds where new service locations were required. The other selection processes were undertaken with the objective of expanding existing services and made use of direct and restricted selection processes depending on the circumstances.

**3.7** A key consideration in grant selection is whether decision-makers have equitably and transparently selected for funding the application that represents best value for public money in the context of the objectives and outcomes of the granting activity, as set out in program guidelines.<sup>63</sup> Integral to

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<sup>63</sup> ANAO, *Better Practice Guide—Implementing Better Practice Grants Administration*, June 2010, Canberra

this consideration is the CGG requirement that agency staff should choose selection methods that will “.....promote open, transparent and equitable access to grants”.<sup>64</sup> To this end, the CGGs consider the use of open competitive merit-based grant selection to be better practice, but not mandatory. However, specific agreement should be obtained to use a selection process other than a competitive process.<sup>65</sup> Although a preference for an open competitive merit-based selection process is not mentioned in the TCC Program guidelines, FaHCSIA advised the ANAO that this approach is the department’s starting position for TCC Program grant rounds.

**3.8** FaHCSIA sought and gained the approval from the Minister to a direct selection processes in regard to PHaMs expansion stages 1 and 2 and a restricted selection process for the 2012 expansion of FMHSS. The ANAO examined the justification provided by FaHCSIA to the Minister for the approval of the grants selection processes for these rounds in 2012.

**3.9** The rationale provided to the Minister for the direct selection of providers for the PHaMs expansion Stage 1 was that this expansion was focused on priority sites in which there was a single at-capacity, high performing provider. Likewise for the PHaMs expansion stage 2, a direct selection approach was approved by the Minister in 19 Local Government Areas (LGAs) where a single suitable provider was identified. A restricted selection approach was agreed in a further 12 LGAs where there was more than one suitable provider. In the later instance, FaHCSIA noted that the restricted selection approach would promote equity between providers within the LGAs. The rationale provided to the Minister for the restricted selection of providers in the 11 sites identified for FMHSS expansion (which was limited to providers currently providing Family Support Program, Reconnect or Community Care services), was that this would enable FaHCSIA to engage with providers with expertise and good local linkages and which were positioned to establish new services quickly.

**3.10** The ANAO observed that FaHCSIA’s briefs did not routinely advise the Minister on the requirements of the CGGs. The Minister’s attention was not drawn to the CGGs preference for competitive merit-based selection processes and other policy and obligation requirements of the CGGs. Agency staff are

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<sup>64</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, July 2009, p. 21.

<sup>65</sup> *ibid.*, pp. 21 and 29.

responsible for advising the Minister in a timely manner<sup>66</sup> and for following the explicit requirements of the CGGs when seeking Ministerial approval to grant issues.

Agencies are responsible for advising Ministers on the requirements of the CGGs, and *must* take appropriate and timely steps to do so where a Minister exercises the role of a financial approver in grants administration.<sup>67</sup> [Emphasis as per CGGs]

**3.11** As is noted in the ANAO Better Practice Guide—*Implementing Better Practice Grants Administration* it would ordinarily be prudent for agencies to provide this advice each time a grant proposal is put forward for Ministerial consideration, given there are steps for the Minister to follow should he or she choose not to follow departmental advice.<sup>68</sup>

**3.12** FaHCSIA has advised the ANAO that the department fully considers all selection methods with a preference for open competitive merit-based processes. In advising the Minister, the department considers factors such as continuity of services for highly vulnerable groups, reducing lag time for service establishment, and efficient use of government funds such as utilising existing infrastructure. However, until recently, FaHCSIA's advice to the Minister has not consistently outlined the requirements of the CGGs.

**3.13** Under broader reforms, the Australian Government has committed to strengthening the contribution of the not-for-profit sector to the government's social inclusion agenda<sup>69</sup>. Streamlining contracting and funding arrangements are part of the overall reform approach but the government is also seeking to improve the sector's accessibility to grant funding opportunities. Open competitive selection processes would be expected to help in this regard and it is important that agencies give appropriate consideration to ways of increasing access to grant opportunities, and that decision makers are advised accordingly.

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<sup>66</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, July 2009, paragraph 1.4.

<sup>67</sup> *ibid.*, paragraph 3.23, p. 11.

<sup>68</sup> ANAO, *Better Practice Guide—Implementing Better Practice Grants Administration*, June 2010, Canberra, p. 28.

<sup>69</sup> Australian Government Initiative, National Compact, *working together*, part of the social inclusion agenda. <http://www.nationalcompact.gov.au/> [accessed 10 January 2013].

## Recommendation No 1

**3.14** In order to better support the Minister in relation to grant funding decisions, the ANAO recommends that FaHCSIA provides more explicit advice to the Minister on key aspects of the Commonwealth Grants Guidelines, and that agency staff are better supported in providing this advice.

FaHCSIA's response: *Agreed.*

### Rollover of funding agreements

**3.15** A related aspect of grant selection is the rollover of existing funding agreements. Appendix 4 provides a time line of the implementation events and the program of contract renewal over the life of the TCC Program. In all three service streams; PHaMs, FMHSS and MHR: CS, providers have been offered extensions on occasions through non-competitive processes.

**3.16** On each occasion FaHCSIA has sought and obtained approval from the Minister to renew funding agreements through direct selection. The primary justification for taking this approach has been to maintain continuity and stability in the provision of the services in the chosen sites. In regard to recent PHaMs renewals FaHCSIA advised the Minister that the rationale for the rollover of funding to 30 June 2014 was that:

- it would allow time for new reforms to be developed and incorporated in funding agreements in 2014 thereby bringing all 175 PHaMs services under one approach;
- it would relieve uncertainty post the 2011–12 budget announcement of new mental health measures; and
- there was an advantage of limiting the need for services to bid for continued funding during the same time they might be seeking new funding under the 2011–12 budget measures.

**3.17** Renewals have ranged from a year up to three years and have assisted in streamlining administrative arrangements so that the majority of current agreements now expire on 30 June 2014 rather than expiring on different dates. To support the decision to renew agreements FaHCSIA has provided the Minister with information in regard to the estimated cost and impact on the program budget; the number of service providers and sites involved;

verification of *FMA Regulation 10* approval if required, and the outcome of the performance assessment<sup>70</sup> of providers recommended for renewal.

**3.18** FaHCSIA has not recommended all funding agreements be renewed nor has the Minister agreed to the recommendations without additional information on aspects of provider performance. Where providers recommended for rollover have been located in the Minister's electorate a letter has been forwarded to the Minister for Finance and Deregulation as is required by the CGGs.

**3.19** In the case of grant extensions, the CGGs acknowledge that granting activity can, in some cases, '... support the ongoing delivery of services, with grants provided to the same or similar organisations over a period of years'.<sup>71</sup> However, using an open competitive merit-based grant selection process, where all applications are assessed as a means of a common appraisal process is considered better practice,<sup>72</sup> rather than one where providers have been assessed on their performance and not in relation to other providers. Similar to the briefings provided for grant selection process, discussed in paragraph 3.7 to 3.13, FaHCSIA's briefings in support of extensions did not make reference to the CGGs preference for open competitive merit-based selections.

**3.20** Many of the existing funding agreements expire in June 2014 and FaHCSIA will need to decide on a selection process as part of its planning for future grants round renewals. In this respect, FaHCSIA's program guidelines note that the choice of selection processes are at FaHCSIA's discretion and indicate no preference. This approach does not fully accord with the emphasis given in the CGGs to the use of open competitive merit-based processes as the preferred selection process. A further consideration is that the Australian Government's reform directions to strengthen the contribution of the not-for-profit sector encourage improving the sector's accessibility to grant funding opportunities. An open competitive merit-based process would be expected to assist in this regard.

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<sup>70</sup> FaHCSIA reviewed the service quality and performance of providers to determine if they meet funding agreement requirements and are performing adequately.

<sup>71</sup> Department of Finance and Deregulation, *Commonwealth Grant Guidelines: Second Edition*, Financial Management Guidance No.3 June 2013, p. 40. <http://www.finance.gov.au/publications/fmg-series/docs/FMG-3-Commonwealth-Grant-Guidelines-June-2013.pdf> [accessed 19 February 2013].

<sup>72</sup> *ibid.*, p. 62.

## Distribution of service providers

**3.21** Australians who live in areas with poorer socio-economic conditions tend to have worse health than people who live in other areas. Although the relationship between health and socioeconomic disadvantage is not straightforward, Australian Bureau of Statistics analysis shows that 16 per cent of Australians living in the most disadvantaged areas have mental or behavioural problems compared with 11 per cent of those living in the least disadvantaged areas.<sup>73</sup>

**3.22** Access and equity are important elements of the administration of grant programs. ANAO's analysis of the 2012–13 estimated total TCC Program funding distribution across the 150 Federal electoral divisions<sup>74</sup> ranked by the Socio-Economic Indexes for Areas (SEIFA) Index of Disadvantage,<sup>75</sup> shows that the most disadvantaged 20 per cent of electoral divisions account for 24.9 per cent of the program's funding while the least disadvantaged 20 per cent of electoral divisions account for 14.9 per cent of program funding.

**3.23** ANAO assessed the pattern of funding distribution across Federal electorates and the results are shown in the Figure 3.1. Of the estimated \$158.9 million provided during 2012–13,<sup>76</sup> Australian Labor Party (ALP) electorates received \$70.1 million, Liberal Party of Australia<sup>77</sup> (Liberal) electorates received \$57.5 million, National Party of Australia electorates received \$20.0 million and other<sup>78</sup> party electorates received \$11.2 million.

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<sup>73</sup> Australian Bureau of Statistics, *Measures of Australia's Progress*, 2010, cat no. 1370.0, Canberra.

<sup>74</sup> Department of Families, Housing, Community Services and Indigenous Affairs, *Electoral Location Report*. <http://www.fahcsia.gov.au/grants-funding/fahcsia-grants/grant-funding-reports-by-location/electorate-locations-report> [accessed 19 March 2013].

<sup>75</sup> The SEIFA is based on National Population Census data. Australian Bureau of Statistics, 2039.0 – *Information Paper: An introduction to Socio-Economic Indexes for areas (SEIFA)*, ABS, Australia, 2006. <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2039.02006?OpenDocument> [accessed 25 February]. SEIFAs based on 2011 Census data had not been released at the time of the audit.

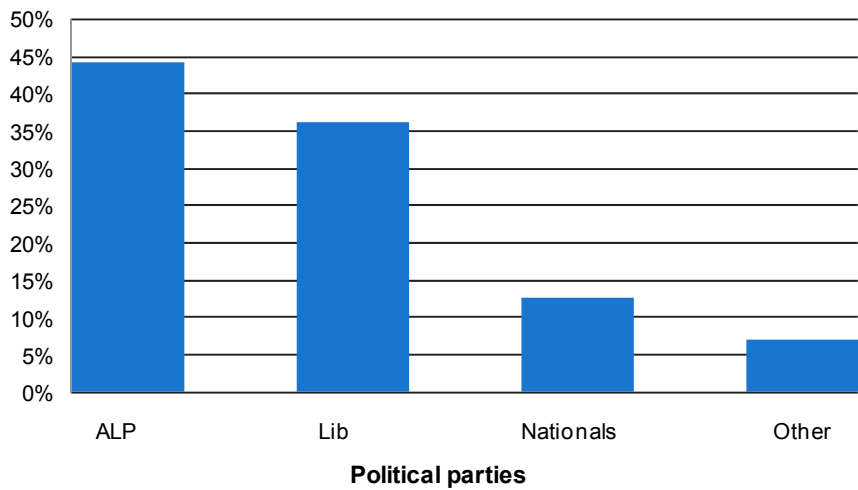
<sup>76</sup> Department of Families, Housing, Community Services and Indigenous Affairs, *Electoral Location Report*. <http://www.fahcsia.gov.au/grants-funding/fahcsia-grants/grant-funding-reports-by-location/electorate-locations-report> [accessed 19 March 2013].

<sup>77</sup> For the purposes of the audit analysis, the Liberal Party of Australia also includes the Liberal National Party of Queensland and the Country Liberal Party.

<sup>78</sup> For the purposes of the audit analysis other parties includes the Independents, the Australian Greens and the Katter's Australian Party.

**Figure 3.1**

**Targeted Community Care (Mental Health) Program, proportion of program expenditure in electorates held by political parties**



Source: FaHCSIA, *Electoral Location Report*

**3.24** Further analysis indicates that the median expenditure allocated to ALP electorates and those held by the Liberals are very similar at \$216 000 and \$218 000 respectively.

## Conclusion

**3.25** The CCGs, while noting that several selection methods are open to Australian Government agencies, indicate the Australian Government’s preference for using open competitive merit-based selection processes when selecting grant recipients. Where an alternative method is chosen as the most appropriate to the circumstances, the CCGs emphasise that the selection methods need to promote transparent and equitable access to grants and that agreement on the process needs to be given by the Minister, chief executive or appropriate delegate. FaHCSIA informed the ANAO that a competitive merit-based grant process was the department’s starting position for TCC Program grant rounds.

**3.26** FaHCSIA has primarily undertaken open competitive merit-based selection processes to initially select service providers but has also made use of direct and restricted competitive processes in situations where the objective of the selection process was to support an expansion of existing services. Direct selection processes have also been used to extend a large number of existing

funding agreements to align their expiry dates with the result that most current providers have had their funding agreements renewed without a competitive process. The use of various selection processes is provided for in the FaHCSIA TCC Program guidelines and Ministerial approval has been obtained in all cases in relation to the proposed selection methods.

**3.27** Under the CGGs, agencies are required to advise Ministers of the requirements of the guidelines. This will necessarily involve advising on the policy aspects and obligations set out in the *Financial Management and Accountability Regulations*.<sup>79</sup> Briefs provided by FaHCSIA to the Minister seeking approval did not routinely include reference to the CGGs, and in this context the preference for competitive merit-based selection processes. FaHCSIA's TCC Program guidelines also do not reflect the emphasis given in the CGGs to competitive merit-based selection processes. The TCC Program guidelines<sup>80</sup> list three possible selection methods but indicate that the choice of method is at the discretion of the department.

**3.28** Under broader reforms, the Australian Government has committed to strengthening the contribution of the not-for-profit sector to the Government's social inclusion agenda.<sup>81</sup> Streamlining contracting and funding arrangements are part of the overall reform approach but the Government is also seeking to improve the sector's accessibility to grant funding opportunities. Open competitive selection processes would be expected to help in this regard, and it is important that agencies give appropriate consideration to ways of increasing access to grant opportunities, and that decision makers are advised accordingly.

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<sup>79</sup> ANAO, Audit Report No. 21 2011–2012, *Administration of Grant Reporting Obligations*, p. 47.

<sup>80</sup> Department of Families, Housing, Community Services and Indigenous Affairs, Targeted Community Care (Mental Health) Program, *Part B: Information for Applicants*, November 2012.

<sup>81</sup> Australian Government Initiative, National Compact, *working together*, part of the social inclusion agenda. <http://www.nationalcompact.gov.au/> [accessed 10 January 2013].



## 4. Reporting and Monitoring

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*This chapter examines FaHCSIA's performance monitoring and reporting of the Targeted Community Care (Mental Health) Program and the introduction of a new performance management framework.*

### Performance management framework

**4.1** Good governance requires an agency to have a structured and regular system for monitoring and reporting its performance. This includes the collection and analysis of a balanced set of performance indicators to demonstrate agency effectiveness against set outcomes, and efficiency in managing outputs, key tasks and services.<sup>82</sup> Adequate performance information, particularly in relation to program effectiveness, allows entities to assess the impact of policy measures, adjust management approaches as required, and provide advice to government on the success, shortcomings and/or future directions of programs. This information also allows for informed decisions to be made on the allocation and use of program resources. In addition, performance information and reporting enables the Parliament and the public to consider a program's performance, in relation to both the impact of the program in achieving the policy objectives of the government and its cost effectiveness.<sup>83</sup>

### Agency level performance reporting

**4.2** The Australian Government Outcomes and Programs framework requires entities to firstly identify, and secondly report against, the programs that contribute to government outcomes over the Budget and forward years. A central aspect of this approach is the development of clearly specified outcomes, program objectives and appropriate key performance indicators (KPIs).<sup>84</sup> To support this reporting, agencies need to have sound approaches to the collection, analysis and reporting of relevant performance information, including a combination of quantitative and qualitative data.

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<sup>82</sup> ANAO and Department of Finance and Administration, Better Practice Guide—Better Practice in Annual Performance Reporting, 2004, p. 1.

<sup>83</sup> ANAO, *The Australian Government Performance Measurement and Reporting Framework*, No. 28 2012–13, p. 14.

<sup>84</sup> *ibid.*, p. 15.

**4.3** The TCC Program is one of the programs that contributes to the Department's Outcome 5: Disability and Carers. The outcome as stated in the Portfolio Budget Statement (PBS), is:

An adequate standard of living, improved capacity to participate economically and socially and manage life-transitions for people with disability and/or mental illness and carers through payments, concessions, support and care services.<sup>85</sup>

**4.4** Within Outcome 5, the TCC Program is program 5.1: Targeted Community Care, the objective of which '....is to implement community mental health initiatives to assist people with mental illness and their families and carers to manage the impact of mental illness.'<sup>86</sup>

**4.5** The program's deliverables and KPIs are presented in Tables 4.1 and 4.2. Changes were made to the deliverables and KPI's from the 2010–11 financial year. Information for 2009–10 is provided for comparison.

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<sup>85</sup> Department of Families, Housing, Community Services and Indigenous Affairs, *Portfolio Budget Statement 2012–2013*, p. 89. [http://resources.fahcsia.gov.au/budget/2012-13/FaHCSIA\\_PBS\\_2012-13.pdf](http://resources.fahcsia.gov.au/budget/2012-13/FaHCSIA_PBS_2012-13.pdf) [accessed 5 February 2013].

<sup>86</sup> *ibid.*, p. 94.

**Table 4.1****Targeted Community Care (Mental Health) Program deliverables 2009–12**

Deliverables	2009-10		2010-11		2011-12	
	Target	Actual	Target	Actual	Target	Actual
Number of families and carers assisted through respite, brokerage and community-based support	19 500	48 696	..	..	..	..
Number of people with severe functional limitations arising from mental illness assisted through recovery support services (PHaMs)	6000	9871	..	..	..	..
Percentage and number of clients, families and carers whose lives are affected by mental illness accessing support services	..	..	NTI	95% (107 052) <sup>a</sup>	49 000 <sup>b</sup>	124 068 <sup>b</sup>

Source: Targets were obtained from the Minister's Portfolio Budget Statements for FaHCSIA and actuals from FaHCSIA's annual reports.

Note: NTI: no target indicated.

- a. Based on the number of registered clients as a proportion of all eligible people who have applied for assistance.
- b. Percentages were not provided in 2011–12.

**4.6** In 2011–12 FaHCSIA reported that it had significantly exceeded the target for access to the program. FaHCSIA subsequently advised the Australian Senate that it had taken a conservative approach to setting the targets for deliverables and that it included various mental health community education activities undertaken by a small number of service providers as part of its calculation for access.<sup>87</sup> The target for 2012–13 has been increased to 63 000 and FaHCSIA informed the ANAO that it was reviewing the way it calculates access numbers to provide for a more realistic assessment.

<sup>87</sup> Australian Senate, Community Affairs Legislation Committee, Estimates, Thursday, 18 October 2012, p. 95. [http://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/b0848147-7603-4f15-8aa2-988570715be0/toc\\_pdf/Community%20Affairs%20Legislation%20Committee\\_2012\\_10\\_18\\_1473\\_Official.pdf;fileType=application%2Fpdf#search=%22committees/estimate/b0848147-7603-4f15-8aa2-988570715be0/0000%22](http://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/b0848147-7603-4f15-8aa2-988570715be0/toc_pdf/Community%20Affairs%20Legislation%20Committee_2012_10_18_1473_Official.pdf;fileType=application%2Fpdf#search=%22committees/estimate/b0848147-7603-4f15-8aa2-988570715be0/0000%22) [accessed 14 May 2013].

**Table 4.2****Targeted Community Care (Mental Health) Program key performance indicators 2009–12**

Key performance Indicators	2009-10		2010-11		2011-12	
	Target	Actual	Target	Actual	Target	Actual
Percentage and number of people accessing recovery support services whose lives are severely affected by mental illness	NTI	97% (9871) <sup>a</sup>	..	..	..	..
Percentage and number of clients who report that they are satisfied that the service they received was appropriate to their needs	NTI	93% (10 298) <sup>a</sup>	NTI	99% (1387) <sup>c</sup>	NTI	98% (7873) <sup>c</sup>
Percentage and number of families and carers assisted through respite, brokerage and community-based support	NTI	98% (48 696) <sup>b</sup>	..	..	..	..
Percentage and number of registered participants maintaining progress against individual/relevant goals	..	..	NTI	98% (1314) <sup>c</sup>	NTI	91% (7152) <sup>c</sup>
Percentage and number of clients from Indigenous backgrounds	..	..	NTI	9% (9496)	5% (2400)	8% (9921)
Percentage and number of clients from culturally and linguistically diverse backgrounds	..	..	NTI	21% (22 642)	14% (6800)	20% (25 032)

Source: Targets were obtained from the Minister's Portfolio Budget Statements for FaHCSIA and actuals from FaHCSIA's annual reports.

Note: NTI: no target indicated.

a Data is comprised of client satisfaction survey responses from Mental Health Respite Brokerage and the Community Based Services.

b Data is comprised of the number of families assisted through Community Based Services plus the number of carers assisted through the Mental Health Respite Brokerage and National Respite Development Fund.

c Based on client surveys from a sample of participants.

**4.7** The existing performance information does not sufficiently demonstrate how the TCC Program is contributing to the achievement of the Program 5.1 objectives. Some of the indicators assess access to the program while others seek to measure some impact on individuals. However, they do not measure the program's broader impacts or services and quality. The only two outcome focused indicators adopted by FaHCSIA are:

- Percentage and number of clients who report that they are satisfied that the service they received was appropriate to their needs; and
- Percentage and number of registered participants maintaining progress against individual/relevant goals

### **Revised performance framework**

**4.8** As part of FaHCSIA's Common Business Model for Grants Management, a Standard Performance Framework was introduced in 2009 for program management to provide a more consistent, logical and streamlined basis for monitoring and reporting FaHCSIA's performance in achieving outcomes through its grants funding activities. The standard performance framework seeks to identify the impact of services delivered by collecting information that addresses four overarching key performance indicators:

- service outputs - how much was done
- service delivery, quality and intent – how well was it done
- immediate outcomes – did it make an immediate difference; and
- lasting outcomes – did it make a lasting difference.

**4.9** FaHCSIA recognises that the performance indicators reported in its Annual Reports and the Minister's Portfolio Budget Statements, do not fully measure the effectiveness of the program. Internally, to supplement these, FaHCSIA gauges the TCC Program's effectiveness through a combination of performance indicators, evaluation, and the annual survey completed by participants. FaHCSIA determined that to better report on the TCC Program against the Standard Performance Framework and to address key weaknesses in the existing performance mechanisms it needed to review and revise its performance framework. A review of the existing data collected from TCC Program service providers for program evaluation, ongoing program management and performance monitoring purposes was commenced in September 2010 and was completed in 2011. This led to the development of a revised TCC Program performance management framework.

**4.10** The revised performance framework has been piloted with generally positive results. There is, however, still a substantial amount of development work to complete. FaHCSIA has planned to work with TCC Program service providers to progressively implement the revised framework to all service streams and all measurement and reporting activities by mid 2014. Support will be provided in the form of targeted capacity building activities such as workshops, forums and direct liaison by FaHCSIA's STO Network.

**4.11** The framework incorporates performance information for the above four indicators (paragraph 4.8) coupled with the aim that it will:

- have the capacity to report on mental health reforms and the non-government organisations national minimum data set;<sup>88</sup>
- streamline the reporting process and reduce the reporting burden on service providers;
- link the performance reporting of specific activities to the overall program performance and achievement of outcomes;
- provide a logical and consistent approach for measuring outcomes across the TCC Program; and
- have the capability to collect client-level information over time.

**4.12** Appendix 5 sets out the draft TCC Program performance framework.

**4.13** The information proposed for collection, using standard data definitions, will assist management of the program by providing a richer source of activity data, individual client information and service quality levels. The resulting data sets will provide FaHCSIA with a large amount of information for analysis. Of further importance, FaHCSIA intends to conduct periodic program evaluations as an important element of the new program performance framework.

## **Reporting requirements for individual grants**

**4.14** To assess provider performance, FaHCSIA has compliance processes which primarily rely on self-reporting by service providers. FaHCSIA uses

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<sup>88</sup> The Australian Institute of Health and Welfare was contracted by the Department of Health Ageing (DoHA) to develop a National Minimum Data Set (NMDS) to collect establishment level data for specialised mental health services provided by non-government-organisations. It is expected that this national data collection will be mandated for all funding bodies, including the Mental Health Commission, in 2013–14.

providers' reports to monitor their adherence to the terms and conditions of funding agreements and to obtain information on performance indicators. Providers are also required to provide an audited financial acquittal to provide assurance that program funding is spent appropriately. These accounts are to be submitted by the end of October and are reviewed by the STO Network via central acquittal teams.

**4.15** Through structured arrangements FaHCSIA receives information about levels of client activity and the types of services used as well as assessments by service providers about their performance. Funding agreements provide details of the quality and performance reporting standards against which service providers must report for the relevant service types. Under current arrangements service providers are required to provide six monthly performance reports to FaHCSIA using reporting templates provided by the department. Reporting periods are 1 July–31 December and 1 January–30 June. Each reporting period requires the collection and collation of qualitative and quantitative data.

**4.16** In addition to the above information requirements, PHaMs and FMHSS service providers are required to submit monthly data reports and incident reports. All reports are lodged electronically, via FaHCSIA's Corporate Reporting Portal for PHaMs and FMHSS providers and the TCC SmartForm<sup>89</sup>, for MHR: CS providers and reviewed by the STO's. Discussions with a sample of service providers interviewed as part of the audit indicated an understanding of their obligations in regard to reporting, but revealed that many:

- did not understand the usefulness and value of information provided and how FaHCSIA used it;
- felt there were data quality issues with some of the information provided;
- felt the information provided did not provide a measure of the quality of the service they were providing; and
- received little or no feedback on the information provided to FaHCSIA.

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<sup>89</sup> SmartForms are intelligent PDFs that allow users to complete their reports using the Adobe Reader application in an online or offline mode and to submit it to FaHCSIA via email. SmartForms are automatically generated from FaHCSIA's Online Funding Management System (FOFMS).

**4.17** FaHCSIA's National Office is responsible for monitoring the program nationally, and identifying trends in services providers' performance and capacity issues. Periodic feedback on the performance of the program can assist individual service providers understand their contribution. Of the three FaHCSIA state offices visited as part of the audit, only one provided consolidated state feedback to service providers on common issues contained in service provider reports and other matters of generic interest. STO Network staff have limited opportunity to undertake detailed analysis of the information provided. However, staff had a good general knowledge of their service providers and the operation of their services and had, in most cases, conducted site visits.

**4.18** The periodic reinforcement of the importance of the performance information and how it is used by FaHCSIA would assure service providers of the continued need for the information and how it contributes to program improvement.

## Program evaluation

**4.19** The evaluation of program performance provides accountability and transparency, and assists to improve program design. An evaluation of the TCC Program was commissioned by FaHCSIA in June 2009 and concluded in March 2010. The evaluation was designed to:<sup>90</sup>

- assess the performance of the TCC Program to date and to determine changes that would enhance service policy and program design, so the initiatives can achieve optimal results; and
- consider the role of TCC Program within the broader mental health sector and how the suite of programs integrate and complement other services—focusing on policy direction.

**4.20** The final report to FaHCSIA was made publicly available in May 2011 on the FaHCSIA website.<sup>91</sup> In summary, the outcomes of the evaluation reported were that:

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<sup>90</sup> The Department of Families, Housing, Community Services and Indigenous Affairs, *Working with Australians to promote mental health, prevent mental illness and support recovery. Evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives, Final Report*, March 2011, p. vii. <http://www.fahcsia.gov.au/our-responsibilities/communities-and-vulnerable-people/programs-services/targeted-community-care-mental-health-program/evaluation-of-the-fahcsia-targeted-community-care-mental-health-initiatives> [accessed 8 February 2013].

<sup>91</sup> *ibid.*



- clients who have accessed services under all three initiatives are achieving significant outcomes in line with the objectives of the program and client personal plans;
- access by clients of Indigenous and culturally and linguistically diverse target groups are much lower than hoped. Many systemic and cultural barriers remain, which are largely outside the control of services;
- despite only being recently established, each of the TCC Program initiatives are demonstrating quality service and making a substantial contribution to the service system by increasing access to services, improving service pathways and ensuring social inclusion; and
- management of the mental health initiatives is regarded positively compared to programs funded by other agencies. The flexibility to meet needs is valued highly and there is a strong sense that FaHCSIA understands the business of mental health service delivery.

**4.21** Assessing of the overall impact of the TCC Program is challenging. However, FaHCSIA has implemented an evaluation approach to: understand the performance of the program by service types and service provider; potential areas of program improvement both in terms of service models and administration; and the interaction and integration of the program with the broader mental health service system. The March 2011 evaluation has given valuable insights into the performance of the TCC Program and helped FaHCSIA understand the need to re-design the Mental Health Respite measures into a streamlined model of two service types providing services to both carers and families.

## Conclusion

**4.22** There is limited information available on the specific contributions made by PHaMs, FMHSS and MHR: CS to improvements in community level mental health. Assessing the overall impact of the TCC Program is challenging and FaHCSIA recognises the limitations of its current performance management framework. As part of ongoing program management and continuous improvement, in September 2010, the department reviewed the program's existing performance management information collections and its needs for future planning and monitoring. As a result of that review, the department identified the following priority activities to improve its performance framework. These are to:

- improve the capacity to report on Mental Health Reforms;
- streamline and reduce reporting demands on providers;
- prepare for the non-government-organisations' National Minimum Data Set;
- focus on outcome reporting; and
- move to client-level data over time.

**4.23** FaHCSIA is taking important steps in the review of its current performance management framework. A draft framework was completed in 2011 and FaHCSIA undertook a trial of its use with service providers. The department will need to maintain momentum to ensure its implementation by mid 2014. Once it is in place the new framework will assist FaHCSIA to better monitor the ongoing service performance of providers and to access higher level information required to report against outcomes and program objectives.

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Ian McPhee  
Auditor-General

Canberra ACT  
19 June 2013

# Appendices

## Appendix 1: Agency Response



Australian Government

Department of Families, Housing,  
Community Services and Indigenous Affairs

Finn Pratt PSM  
Secretary

Dr Andrew Pope  
Group Executive Director  
Performance Audit Services Group  
Australian National Audit office  
GPO Box 707  
CANBERRA ACT 2601

Dear Dr Pope

I refer to the recent performance audit by the Australian National Audit Office of the Targeted Community Care (Mental Health) Program.

The Department received a copy of the Section 19 draft report on 14 May 2013 and I am pleased to provide a formal response to this report.

- FaHCSIA welcomes the Australian National Audit Office report on FaHCSIA's effective management of the Targeted Community Care (Mental Health) Program.
- It was beneficial for the Department to be involved in the audit during its peak phase of implementing new community mental health services nationally.
- The Department provides comprehensive advice to the Minister in relation to grants selections and approvals. The Department's current Delivery Reform Agenda will provide opportunities to further strengthen advice to systematically provide explicit reference to the Commonwealth Grant Guidelines.
- The Department's approach to continuous improvement through implementing a strengthened performance framework will assist in ensuring greater information is available on the impacts of the Targeted Community Care (Mental Health) Program.

A summary of the Department's formal response to the audit recommendation, for inclusion in the final report, is provided at **Attachment A**.

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National Relay Service: TTY – 133 677, Speak and listen – 1300 555 727, Internet relay – [www.relayservice.com.au](http://www.relayservice.com.au)  
[www.fahcsia.gov.au](http://www.fahcsia.gov.au)

I thank you for the opportunity to provide a formal response to the audit report on FaHCSIA's effective management of Targeted Community Care (Mental Health) Program.

Yours sincerely



Finn Pratt

5 June 2013

**Attachment A:** FaHCSIA's formal response to the ANAO Section 19 Report – Targeted Community Care (Mental Health) Program

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[www.fahcsia.gov.au](http://www.fahcsia.gov.au)

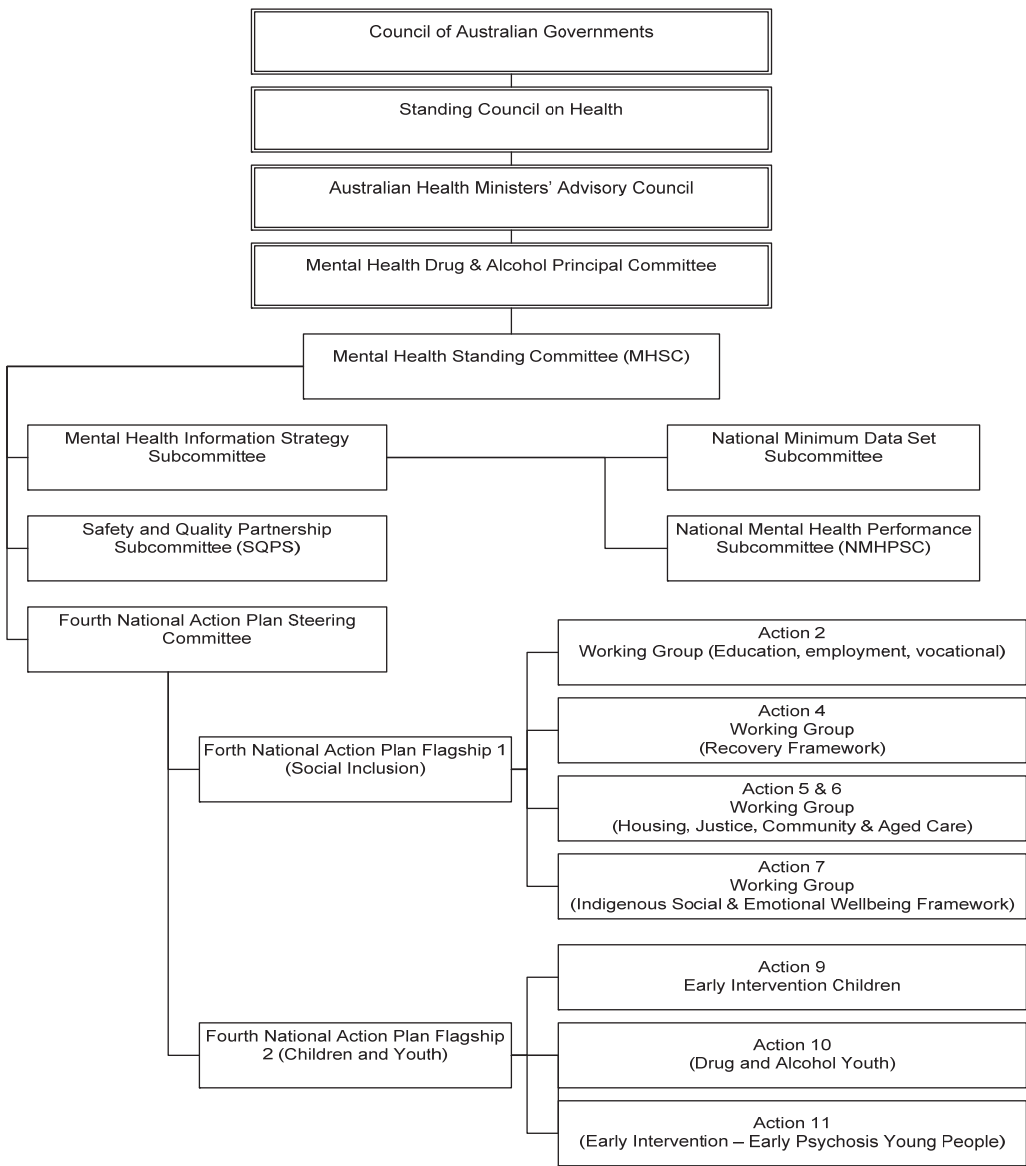
**FaHCSIA's formal response to ANAO Section 19 Report – Targeted Community Care (Mental Health) Program**

***Recommendation No 1 Paragraph 3.14:***

*In order to better support the Minister in relation to grant funding decisions, the ANAO recommends that FaHCSIA provides more explicit advice to the Minister on key aspects of the Commonwealth Grants Guidelines, and that agency staff are better supported in providing this advice.*

**FaHCSIA Response:** FaHCSIA Agrees

Appendix 2: Mental health key committee structure as at 2012



Source: FaHCSIA information

## Appendix 3: Targeted Community Care (Mental Health) Program Activities<sup>92</sup>

### Services and Support for People with Mental Illness

#### Personal Helpers and Mentors (PHaMs)

PHaMs services provide increased opportunities for recovery for people whose lives are impacted by severe mental illness by helping them to overcome social isolation and by increasing their connections to the community. The service type aims to foster each individual's sense of dignity and capacity for resilience through stages of recovery that seek to underpin three key outcomes:

- increased access to appropriate support services at the right time;
- increased personal capacity and self-reliance; and
- increased community participation (both social and economic)

PHaMs assists people aged 16 and over whose ability to manage their daily activities and to live independently in the community is severely impacted as a result of a severe mental illness. The PHaMs Remote Service Delivery model (additional funding to develop community capacity and initiate alternate supports in Indigenous communities) does not have an age restriction in these sites.

While a person does not need to have a formalised clinical diagnosis of a severe mental illness to access PHaMs, participation in the program requires a functional assessment to determine the severity or impact of mental illness on an individual's level of functioning.

#### Services and Support for Families and Carers

This funding stream adopts a flexible model of service delivery that meets the needs of families, carers, children and young people impacted by mental illness or at risk of developing mental illness and takes into account the needs of special needs groups including Indigenous Australians and Culturally and Linguistically Diverse groups.

There are two service types funded under Services for Families and Carers of People with Mental Illness.

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<sup>92</sup> Department of Families, Housing, Community Services and Indigenous Affairs, Targeted Community Care (Mental Health) Program Guidelines, *Part A – June 2011*



### **Mental Health Respite: Carer Support**

This service type provides respite and support services to assist carers of people with mental illness (including autism) to sustain their caring role.

The key outcome is that carers make progress towards addressing those things that prevent them sustaining their care role, including not being able to coordinate access to services and support for the person they are caring for.

Services recognise the divergent carer groups and their individual needs such as young carers and older carers. Services recognise the importance of readily accessible and comprehensive information and support that facilitates the family and carer's ability to make informed choices about their caring role and provide assistance that is appropriate to their needs and the needs of the care recipient.

Up to 25% of services can be aimed at providing respite support to families and carers of people with an intellectual disability where such an intervention is assessed as providing a preventative response to mental health needs of families and carers.

### **Family Mental Health Support Services**

This service type is designed to assist families, children and young people impacted by mental illness or at risk of developing mental illness through early and preventative interventions.

The key outcome is that families, children and young people are more confident, resilient and better supported to manage the impact of mental illness by:

- empowering and strengthening families through information, education and skills development;
- developing more effective parenting, relationships and communication strategies within families affected by mental illness;
- improving the emotional health and wellbeing of family members and carers;

- increasing community awareness and understanding of mental health issues and the impact of mental illness on families; and
- improving family functioning and social support for families, carers, children and young people affected by mental illness.

# Appendix 4: Targeted Community Care (Mental Health) implementation timelines

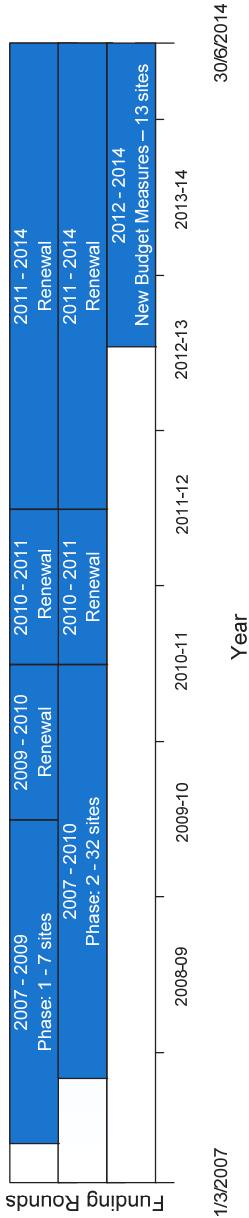
## Personal Helpers and Mentors

2007 - 2010 Round: 1 – 21 sites		2010 - 2013 Renewal		2013 - 2014 Renewal			
		2010 - 2012 Round:1 Expansion – 6 sites		2012 - 2014 Renewal			
2007 - 2010 Round: 2 – 37 sites		2010 - 2013 Renewal		2013 - 2014 Renewal			
		2010 - 2012 Round: 2 – Expansion - 11 sites		2012 - 2014 Renewal			
		2009 - 2011 Round: 3 – 79 sites	2011 - 2014 Renewal				
		2009 - 2011 Round: 3 – Remote – 2 sites	2011 - 2014 Renewal				
		2009 - 2011 Round: 3 - Remote 1 site	2011 - 2013 Renewal		2013 - 2014 Review in progress		
		2010 - 2012 Round: 4 – 10 sites		2012 - 2014 Renewal			
		2010 - 2012 Round: 4 – Remote – 6 sites		2012 - 2013 Renewal – 6 sites			
		2011 - 2012 Round: 4 – Remote - 1 site		2012 - 2013 Renewal			
		2011 - 2013 Round: 4 – Remote – 1 site		2013 - 2014 Renewal			
		2011 - 2013 Round: 4 – Remote – 1 site		2013 - 2014 Review in progress			
				1/4/2012 - 30/6/2014 Stage 1 - Expansion – 17 sites			
				2012 - 2014 Stage 2 - Expansion – 48 sites			
1/5/2007	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	30/6/2014
Year							

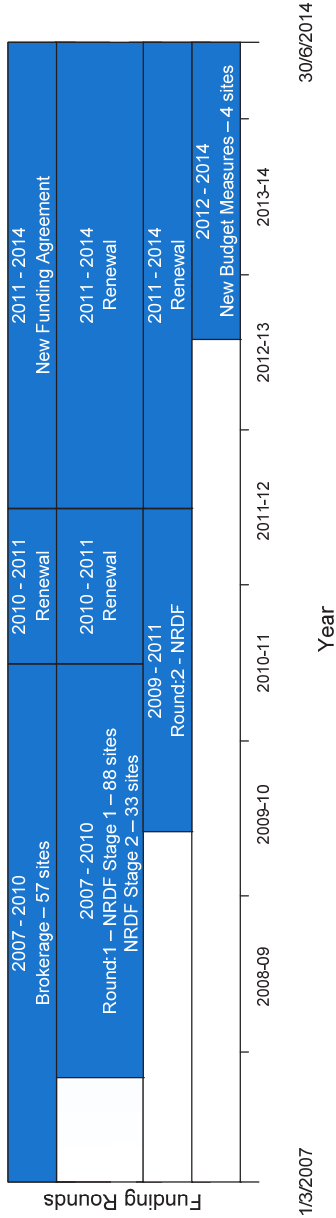
Source: Information provided by FaHCSIA.

\* Four sites - renewed until June 2014; two sites - review in progress as of March 2013.

**Family Mental Health Support Services**



**Mental Health Respite: Community Support**



Source: Information provided by FaHCSIA.

## Appendix 5: Draft Revised Targeted Community Care (Mental Health) Program performance framework

TCC Program Performance Framework				
			Portfolio Budget Statement Pls	Mental Health NGO National Min. Data Set data items
<b>Did it make a lasting difference?</b>				
Did service recipients have increased confidence, capacity and choice to sustainably manage the impacts of mental illness?				
<b>TCC Program Service Stream performance information</b>	<b>PHaMs</b>	Client confidence, capacity and choices to independently managing their living arrangements		Use of outcome measurement tool Type of outcome measurement tool
	<b>MHRCS</b>	Client confidence, capacity and choice to sustain their care role		Type of outcome measurement tool
	<b>FMHSS</b>	Client confidence, capacity and choice to manage the impacts of mental health on their family		
<b>Did TCC Program service recipients have improvements in their life situation?</b>				
<b>TCC Program Service Stream performance information</b>	<b>PHaMs</b>	Changes in well-being of people with mental illness across key life domains		
	<b>MHRCS</b>	Changes in well-being for families and carers of people with mental illness		
	<b>FMHSS</b>	Changes in well-being for families of people with mental illness (and children and young people at risk of mental illness)		

TCC Program Performance Framework				
			Portfolio Budget Statement Pls	Mental Health NGO National Min. Data Set data items
Did TCC Program build capacity to respond to mental illness?				
TCC Program Service Stream performance information	PHaMs	Changes in capacity of organisation and individuals to respond to mental illness (where TCC Program providers apply significant resources to capacity building activities)		
	MHRCS			
	FMHSS			
Did it make an immediate difference?				
Did service recipients make progress in those areas that have a significant impact on their well-being?				
TCC Program Service Stream performance information	PHaMs	Progress against goals in individual recovery plan (e.g. finding a job; securing a house)	Percentage of clients reporting progress against relevant goals (better able to deal with the issues that they received help with)	
	MHRCS	Progress against respite/carer support goals (e.g. capacity to deal with future crisis)		
	FMHSS	Progress against family support goals (e.g. family functioning; school attendance for children & young people)		
Did the service address the client's needs?				
TCC Program Service Stream performance information	PHaMs	Percentage of clients reporting that the service they received was appropriate to their needs	Percentage of clients reporting that the service they received was appropriate to their needs	
	MHRCS			
	FMHSS			

TCC Program Performance Framework				
			Portfolio Budget Statement Pls	Mental Health NGO National Min. Data Set data items
How well did we do it?				
Was service delivery in line with agreed service standards and requirements?				
TCC Program Service Stream performance information	PHaMs	Independent validation/self-assessment of delivery in line with PHaMS standards	Rating of delivery against relevant service standards and requirements	
	MHRCS	Independent validation/self-assessment of delivery in line with FMHSS standards		
	FMHSS	Independent validation/self-assessment of delivery in line with FMHSS standards		
Was service delivery accessible to clients?				
TCC Program Service Stream performance information	PHaMs	Coverage of clients from Indigenous and culturally and linguistically diverse backgrounds	Percentage of clients from Indigenous and CALD backgrounds	
	MHRCS	Geographical coverage of services		
	FMHSS			
How much did we do?				
How many service recipients were assisted?				
TCC Program Service Stream performance information	PHaMs	Profile of service recipients & pattern of service activities for people with a mental illness	Number of people with mental illness, families and carers accessing TCC Program services—by type of assistance	Service provider /outlet characteristics Number of clients Number of service contacts
	MHRCS	Profile of service recipients & pattern of respite and support services for carers of people with mental illness (including autism or people with an intellectual disability)		
	FMHSS	Profile of service recipients & pattern of services to assist families, children and young people impacted by mental illness or at risk of developing mental illness		

Source: Information provided by FaHCSIA.

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