MDL
McKinlay Douglas Ltd

Review of Options for Input from the Mental Health Sector for Policy Development and Service Monitoring

A report prepared for the Ministry of Health

McKinlay Douglas Limited

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PART 1: Introduction

1.1 BACKGROUND TO THE REVIEW

The Mental Health Directorate of the Ministry of Health has commissioned McKinlay Douglas Ltd (MDL) to review how the Ministry obtains input from the mental health sector for policy development and service monitoring.

The mental health sector has undergone very significant change over the past decade, as has the Ministry in terms of its roles and responsibilities in health and the state sector in which it operates. It is also ten years since the Ministry first contracted for the provision of input into policy advice and service monitoring. The convergence of these factors makes a review at this point very timely.

We understand that the review does not imply that the Ministry necessarily thinks that the current arrangements are fundamentally unsatisfactory so much as a view that a fresh look at the Ministry's current arrangements for policy and service monitoring input may provide useful insights to guide future developments. We note the Ministry's commitment to seeking input from the mental health sector and that it wishes this to continue. It is a matter of whether the present arrangements are the most effective, or whether there is a more effective way to do it.

In respect of the Ministry's two primary vehicles for obtaining sector input – the contracts with the Mental Health Foundation (through the Mental Health Advocacy Coalition (MHAC)) and the Schizophrenia Fellowship New Zealand (SFNZ) – it is worth acknowledging that 10 years ago the idea of using contracts for such a purpose was innovative. A decade later, the Ministry's wish to tap into the resources of the mental health sector remains as strong. The Ministry is aware however that there may be new ways to access the knowledge and perspectives of the sector, in the light of significant changes in the mental health sector and the changed environment for health policy.

This view seems to be shared in the sector. We note that the review was received positively by those we interviewed. There was a general sense that a review was needed, and a willingness to contribute to it.

1.2 TERMS OF REFERENCE

The Ministry's requirements for the review were that it cover (paragraph numbers as in the contract document):

1.2.1 An analysis of the level of need for stakeholder input into policy advice and monitoring by the Ministry, that takes into account whether changes in the mental health sector in the last ten (10) years may have impacted on the need for such information and the work undertaken by the Ministry.

1.2.2 Consideration of formal structures currently used to deliver policy and service monitoring advice input to the Ministry, including an examination of how the

national advice contracts in place since 1994 (both ongoing and ceased contracts) have performed in terms of delivering the outputs expected by the Ministry.

1.2.3 A description of alternative models of advice and monitoring that will mesh with the Ministry's needs, taking into account the broad range of its outputs from complex reports to visible leadership in the sector, and the range of timeframes within which the outputs are produced.

1.2.4 A comparison of the risks and benefits of changing to any of the proposed models of advice against the advice contracts currently in place.

1.2.5 The integration of national and international evidence and models to support conclusions where relevant.

1.3 STRUCTURE OF REPORT

We begin our report by laying out the approach we have taken to the review and our methodology (Part Two). From there the report covers:

Part Three	The Context
Part Four	The Ministry's Information Needs
Part Five	Current Structures
Part Six	The Two National Contracts
Part Seven	Future Options
Part Eight	Summary/Conclusions.

PART 2: Approach and Methodology

This section sets out how we approached the review, our methodology and the scope of the project.

It is worth highlighting three factors that influenced both the information we gathered for the review and the way we have presented the report:

- First, there are very many people in the mental health sector with knowledge and experience who could have contributed significantly to the review – many more than it was feasible to interview. Instead, and with guidance from the Ministry, we held interviews with a reasonably representative, but by no means exhaustive, range of stakeholders. The report reflects their input.
- Second, in writing up the sections on structures currently used to deliver policy and service monitoring advice input to the Ministry, and the national advice contracts, we were conscious that much of the information would be familiar to the Ministry and perhaps 'old hat'. The value of the historical and descriptive content in these sections lies not in the originality of the information, but in providing the Ministry with, in one place, a source of information to which it can refer.
- Third, for the Ministry a key part of the report is the presentation of alternative models of advice and monitoring options. The purpose was to offer the Ministry some options which it might contemplate for the future. It was not intended that we make recommendations. However, Part Seven, which outlines and evaluates a range of options, does include our views on the usefulness of each option for the Ministry, as well as specific recommendations in respect of the two existing contracts.

2.1 APPROACH

Our approach to the review was defined by:

- The original RFP prepared by the Ministry outlining the scope of the project.
- Discussions with the Mental Health Directorate that highlighted the following:
  - The Ministry's objective that the review fully recognise that the Ministry holds responsibility for problem definition and policy development.
  - That the means for facilitating sector input minimise any incentive for stakeholders to promote special interests/perspectives as opposed to contributing, as objectively as they are able, to the Ministry's policy development process.
  - At the same time, the Ministry needs input that helps ensure proposed policy is relevant to the circumstances the "policy users" are encountering.
  - The Ministry's primary interest is in sector policy, rather than operational policy which is more the responsibility of DHBs, PHOs and other providers,

except that service directorates have a close interest and role in policy that may be operational and national in scope.
- Recognising that the means for sector input to policy must be flexible enough to mesh with the Ministry's ongoing cycle of policy work.

- Discussions with MHAC and SFNZ further defined our approach, and interviews conducted over the course of the review shaped the detail as we proceeded.

2.2 METHODOLOGY

The review was carried out as a two-step process:

Step 1:

Preparation of a preliminary issues paper for the Ministry based on:

- Meetings with Ministry of Health staff involved in managing the contract process.
- Meetings with SFNZ and MHAC.
- A review of documentation provided by the Ministry of Health, including the current contracts with SFNZ and MHAC.

This paper also provided the basis for identifying both the additional parties to interview and the matters to be covered in interviews.

Step Two:

The remainder of the review in the terms agreed with the Ministry involving:

- Stakeholder interviews (listed in Appendix 1).
- A review of relevant national and international evidence (see references on pages 82-85).
- Analysis and report preparation (this included a full draft report for Ministry comment).

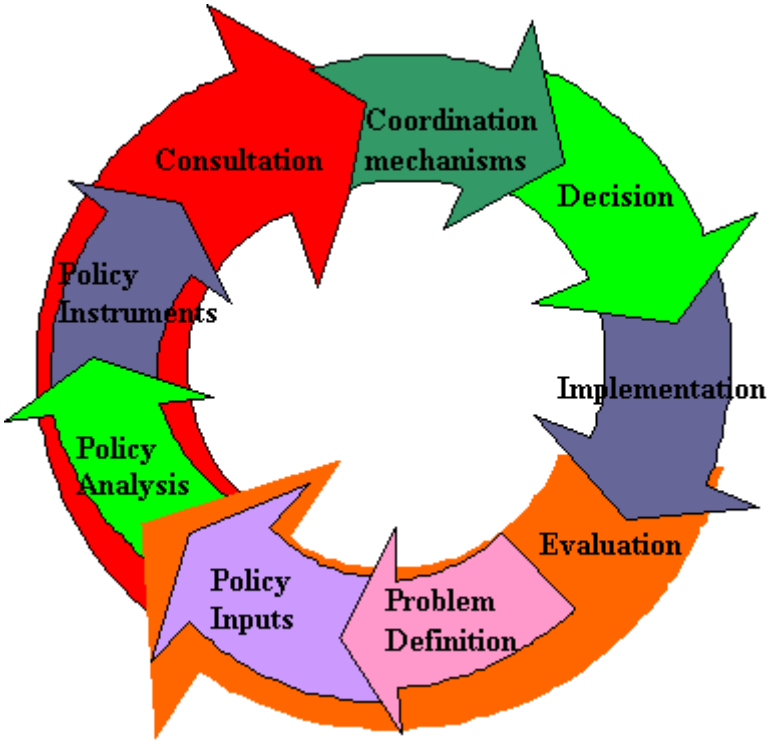
The preliminary issues paper (titled "Report Back on Step One: Preliminary Issues and Contacts") was delivered to the Ministry on 6 December 2004. This current report covers Step 2 of the process.

2.3 SCOPE

Policy Input

A review of this kind has the potential to be quite wide in scope. In setting the boundaries of the project, we have focussed on **input** to policy development and service

monitoring, as opposed to **consultation**. The following diagram from the State Services Commission illustrates the policy development cycle[1]:



The focus of the report is on the "policy inputs" stage, which is earlier in the policy development process than consultation and is where we have focused our attention. This is also where the input comes in from the MHAC and SFNZ contracts. That is, these contracts are not designed for general consultation on draft policy, but rather the discussion of issues that have the potential to shape future policy.

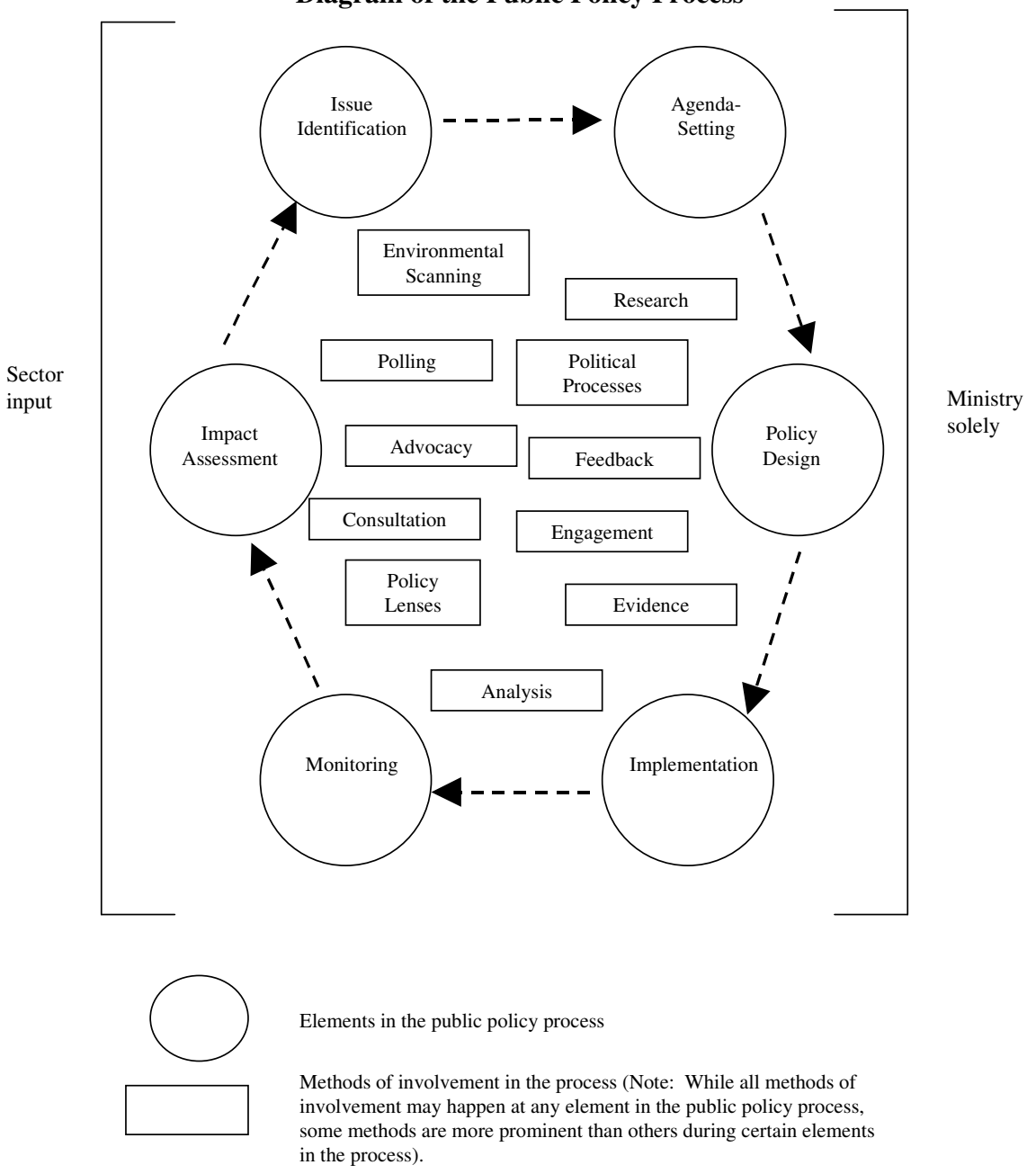
They include input based on service monitoring by the two contractors reflecting the Ministry's interest, from a policy perspective, in the appropriateness of existing services to meet the needs for which they are designed, and any systemic issues standing in the way of effectiveness in service delivery.

The diagram below is adapted from a publication of the Canadian Voluntary Sector Initiative[2] titled *A Code of Good Practice on Policy Dialogue* (see Part Seven below for more information). It also illustrates the public policy process, but focuses on the ways the voluntary sector can influence the process. The opportunities for involvement in the process are true of any stakeholder, not only the voluntary sector. Again the diagram illustrates that involvement or participation in the process is not just about consultation; stakeholder involvement can range from providing evidence-based information through to more complex tasks in policy development.

[1] State Services Commission (1999) p7

[2] Voluntary Sector Initiative (2002) p16

Diagram of the Public Policy Process



Definition of Stakeholder

Apart from our focus on input rather than consultation, we also considered the definition of "stakeholders" in setting the boundaries of the project. The Ministry's definition is:

> "any person/group that has an interest in or may be affected by what's happening in the area concerned".

The Ministry qualified that by saying "not all stakeholders have an equal level of interest or concern in whatever area it is."

The Ministry's approach is consistent with Health Canada's definition in *Public Policy and Public Participation: Engaging Citizens and Community in the Development of Public Policy*:

> "one who will be affected, may be affected or has an interest in an issue, or may have the ability to affect a decision or outcome. A stakeholder may be an individual and organization or a group."[3]

The breadth of this definition carries with it an implication of a need to be selective because of resource constraints the Ministry faces in dealing with input for policy development.

Key Questions

This is not a review that can result in a single agreed and all encompassing approach to policy input from the mental health sector. Rather, as stated in our proposal, we see the review as being focused on three separate but in some respects overlapping concerns for the policy and service monitoring process:

1. Does the Ministry have available to it in a timely and appropriate manner the information it needs for effective policy making and service development?

2. Does the Ministry have in place the means required for effective monitoring of implementation?

3. Do the systems in place for policy development and implementation generally support legitimacy – an acceptance within the mental health sector that government policy development and implementation is well focused, addressing the right issues, open to listening to sector interests, responsive and well coordinated.

These key questions have guided our approach and set the scene for this report.

[3] Smith, Bruce (2003) p5

PART 3: Context

It is useful to consider the historical context for the contracts with SFNZ and MHAC. From the Ministry's documentation, MHAC was set up in 1994 at a conference where the Minister of Health launched the national mental health strategy. It was established "to provide advocacy for the improvement of mental health services, based on the recommendation of representatives from all sectors involved in mental health". The SFNZ contract has been in place since the Ministry inherited responsibility for this relationship from the Department of Social Welfare.

The mental health sector was on the verge of significant change in the period prior to 1994. According to the Mental Health Commission paper by Derek Wright in 1993 "there was no overall strategic direction for mental health and service planning had been locally focussed with no national framework"[4]. Hence the development of the government's first 10 year national strategy in 1994 *Looking Forward: Strategic Directions for Mental Health Services.* Wright states that during 1993, when the new purchasing arrangements came into being, "mental health services were in very different stages of development"[5]. It was also a sector moving away from institutional care, a shift which underpinned the Mental Health (Compulsory Assessment and Treatment) Act 1992. It was a time when there was a recognised need for strategic government direction and improvement to mental health services, which may in part have been behind the establishment of the MHAC contract.

Since 1994, there have been other significant changes to the mental health sector which have impacted the Ministry's policy development. These changes include:

- Structural changes in the health sector.
- Growth in the sector.
- Consumer rights and network growth.
- Recent initiatives such as the PHO strategy and 'whole of government' initiatives, including the shift to "Managing for Outcomes".

3.1 STRUCTURAL CHANGES

The past 10 years have been characterised by significant structural changes in the health sector. Of significance are:

- The Health and Disability Services Act 1993 which divided the responsibility for purchasing and providing services between four Regional Health Authorities and 23 Crown Health Enterprises.

[4] Wright, Derek (1997) p1

[5] Wright, Derek (1997) p1

- The Health and Disability Services Amendment Act 1998 which merged RHAs into the Transitional Health Authority, which then became the HFA.
- The New Zealand Public Health and Disability Act 2000 which replaced CHEs and the HFA by DHBs with responsibility for funding and providing services.

Another significant change was in 1993 when the Department of Health shed its operational functions and became the Ministry of Health. This signalled a new focus on developing policy, monitoring performance, providing Ministerial support and administering legislation while still planning for and purchasing a significant range of health services.

All of these structural changes have meant that control is now far more highly distributed. Mental health services are now delivered through the choices (within the Ministry's parameters) made by the 21 DHBs. DHBs have responsibility for the delivery of health services to their populations, including determining the mental health needs of their communities and planning and organising services to meet those needs. This more devolved model has meant that the Ministry has become more distanced from the operational level than it was prior to 1993. This has increased the distance between the Ministry setting policy, and the entities delivering the services that policy is supposed to shape.

It is worth noting that the contracts with SFNZ and MHAC were both established close to this time of significant sectoral change. That is, they were established at a time when the model was more centralised and the Ministry's information needs were, accordingly, met more directly.

Another significant structural change to note since 1994 was the establishment of the Mental Health Commission in 1996. The Commission's *Blueprint for Mental Health Services in New Zealand* (1998) set out the changes needed to realise the objectives of the government's national mental health strategy. This work has had a significant impact on the sector, and on the Ministry's own policy-making. The Commission has also played a key role in service monitoring since 1996, both of the Ministry itself and the DHBs (originally the Commission monitored the HFA but this changed to monitoring DHBs under the New Zealand Health and Disability Act 2000).

3.2 GROWTH IN THE MENTAL HEALTH SECTOR

There has been substantial growth in mental health services since 1994. In the current draft national plan *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015*, the Ministry stated that earlier plans "were developed at a time when a number of reviews concluded that the funding and nature of mental health services were insufficient. Subsequently, the government has invested a considerable amount in mental health. Since *Moving Forward: The National Mental Health Plan for More and Better Services* was released in 1997, total public sector funding for mental health services has increased from $523.7 million in 1997/98 to $839.2 million in 2002/03.[6]" The Ministry also states that there has been a steady growth in clinical

[6] Ministry of Health (2004b) viii

capacity and that nationally 74% of Blueprint capacity has been achieved (but at varying levels regionally, with Auckland well below the national average). Also access to services has grown.

Strong growth areas include the delivery of services for and by Maori[7] and in the NGO sector following the shift away from institutional care towards a more community-based system of services. The Ministry states that "New Zealand has one of the biggest NGO mental health sectors in the developed world" and that "one-third of total expenditure is spent on non-governmental organisations"[8].

The emergence of the NGO sector over the past 10 years has perhaps further accentuated the impact of a more devolved mental health sector. Growing service delivery at the NGO level means that the Ministry is even further removed from a large proportion of services at the operational level. At a policy level, this means that the Ministry has more of a need for strong communication with and understanding of the sector than it did 10 years ago. There is now a stronger need for policy input from the sector than there was in 1994 when the NGO sector was less developed.

3.3 CONSUMER RIGHTS AND NETWORK GROWTH

The Mental Health Commission also stated in 2002 that since 1994 there had been "a start made in addressing issues of mental health consumers rights and discrimination against people with a mental illness". It added that, during this time, there was also the "development of an explicit recovery approach".[9]

It has been a significant development that the consumer perspective has been seen as a priority throughout the sector. The Ministry reiterates this in *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015* when stating that over the past decade there has been an "increasing recognition that services must be built around the needs of service users/tangata whaiora"[10]. The MHAC structure reflects this in its consumer membership. Consumers also have advisor positions in some NGOs and all DHBs. Overall, the sector is one that has grown a stronger consumer voice over the past 10 years, and the expectation for consumers to be involved in all levels of policy development is high.

The past decade has also seen the establishment and growth of consumer networks, although this has not been without its problems. The collapse of the national consumer network, the Aotearoa Network of Psychiatric Survivors (ANOPS), in 1998 has meant that there has been no "national voice" for consumers. However, the regional consumer networks have become active, providing a channel for consumers to be heard (described in Part Five).

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[7] Mental Health Commission (2002) p23

[8] Ministry of Health (2004b) viii

[9] Mental Health Commission (2002) p23

[10] Ministry of Health (2004b) vii

3.4 RECENT INITIATIVES

There have also been a number of changes over the years that the Ministry has taken into account in developing policy in its latest draft national mental health plan. The establishment of Primary Health Organisations (PHOs) and the implementation of the Primary Health Care Strategy have highlighted the importance of focusing wider than the 3% of New Zealanders requiring specialist mental health services. *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015* states that "the development of the Primary Health Care Strategy and the establishment of PHOs provide a significant opportunity for the further development of mental health care in the primary health sector." It adds that "a focus on improving primary mental health care is at its beginnings"[11].

The implementation of the New Zealand Health Strategy also influenced the development of *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015*. The strategy highlighted severe mental illness as a priority area, and highlighted priority service delivery areas including primary health and improving the responsiveness of mental health services. The New Zealand Disability Strategy was another influential government initiative.

Another change, as outlined in *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015*, is the stronger focus on "whole-of-government initiatives and a recognition that mental health and wellbeing are influenced by a broad range of social and economic determinants that require cross-sectoral approaches and co-operation".[12] The Mental Health Commission states that "recent initiatives by the Ministry of Social Development to support people with mental illness into work and the work by Housing New Zealand to improve access to affordable housing options are evidence of other sectors starting to take responsibility for their contribution to recovery". [13]

These recent government initiatives and whole-of-government approaches are both significant influences on the Ministry's current and future policy development.

There is a further factor that has had a marked impact on the context in which the two contracts operate since they were first established. This is the changing nature of public participation in the public policy process. Public expectations for involvement have increased markedly and, in response, governments are increasingly adopting best practice approaches quite different from those that operated ten years ago. This is discussed in more detail at the beginning of Part Seven below.

All of these changes since 1994 - structural changes, the growth in the sector, a recognition of consumer rights and the growth of consumer networks and the impact of recent initiatives such as PHOs and whole of government approaches – have impacted on policy development and service monitoring for the Ministry of Health. The sector is a

[11] Ministry of Health (2004b) x

[12] Ministry of Health (2004b) vii

[13] Mental Health Commission (2004) p5

very different one than it was in 1994 when the SFNZ and MHAC contracts were established.

The two contracts need to be considered in this historical context. At the time when the contracts were established, the Ministry had only recently changed from its operational, departmental role to a more strategic policy ministry focus. The first mental health strategy had only just been released, and it had been developed in an environment where mental health services were seen as insufficient. It was in this environment that the contracts were established. The sector has seen many changes since. The environment now is one of a larger and more developed sector with an expectation of having input into policy development. And the sector now has an overarching service monitoring body, ie the Commission. It is in the current environment that the Ministry needs to consider what information/input it requires, and the best vehicles for achieving this.

PART 4: The Ministry's Information Needs

In this section of the report we consider the nature of the Ministry's needs for sector input into the development of mental health policy. We do this by considering four factors that, taken together, set the context for the Ministry's information needs.

4.1 THE MINISTRY'S STRATEGIC POLICY ROLE

The first factor is that the Ministry's needs are a function of the nature of its own policy role which is to provide advice to the Minister on priorities and focus for service development and action on mental health. In a sense, the Ministry's concern is with "big P" policy, rather than "little p" policy which is more concerned with the detail of implementation (noting the role of service directorates in policy that may be operational and national in scope).

The distinction is not an exact one but needs to be described in order to put a sensible limit on the Ministry's information needs.

For the purposes of this report, we see the Ministry's policy interest in mental health as being in:

- Service development – essentially policy on what services should be available for whom and under what conditions.
- Service effectiveness – are services meeting the needs they were designed to serve and if not why not. This is a concern which has two separate elements to it:
  - The appropriateness of the service to meet the defined need – here the issue is whether the service, delivered as intended, is in fact appropriate to meet the need.
  - Whether the service is being delivered as intended and, if not, why not. Is it a question of sector development, perhaps requiring a work force development response, is it an issue of resourcing, is it a question of lack of capability in a particular service provider as opposed to the capability in the sector as a whole.

The second point needs to be carefully understood. Under their Crown Funding Agreements, District Health Boards (DHBs) have discretion in terms of service delivery (whether delivered by their own hospital and health services, or by providers whom they fund under contract). It is the DHB itself that has the primary concern with the effectiveness of service delivery in individual cases, but the Minister/Ministry who is concerned if there is systemic failure within a DHB funded service, because public accountability for addressing this type of failure is likely to be sheeted back to the Minister. Systemic failure would indicate a major risk to the Ministry's responsibility for strategic policy. We note also that the Ministry's website (DHB Funding and Performance Directorate page) states that it provides the key accountability interface with the DHBs.

The distinction is an important one in terms of sector input, especially from sector participants who have a strong consumer orientation. As we have found in interviews with sector organisations, there is often a strong focus on individual cases, and how well the needs of particular consumers (individuals; families) are being met. As we understand the Ministry's needs, this is a concern which should be addressed primarily to DHBs and which will be of interest to the Ministry only if it points to either systemic failure, or inappropriateness in the service itself.

4.2 THE MINISTRY'S PRIORITIES

The second factor is where the Ministry's own priorities lie, and therefore where it will require input at any point in the policy cycle. Here the logical starting point appears to be the seven strategic directions set out in *Improving Mental Health*, the draft National Mental Health and Addiction Plan for 2005 – 2015. The strategic directions are:

1 More and better specialist services.
2 More and better services for Maori.
3 Responsiveness of services.
4 Systems development.
5 Mental health and primary health care.
6 Mental health promotion and prevention.
7 Social inclusion – removing social and economic barriers to recover it.[14]

The strategic directions are forward looking; amongst other things, they identify newly emerging concerns, the need to set priorities within individual strategic directions in ways that will benefit from sector input, and ways of working that have not been traditional. Thus, for example:

- Mental health and primary health care is concerned with the newly emerging role of Primary Health Organisations which themselves, in many instances, are still determining the nature of their own strategic role.
- The seventh strategic direction, social inclusion, implies a focus on co-operation and collaboration across different government agencies and beyond. As the executive summary for *Improving Mental Health* notes "social inclusion is about having access to education, to employment, and to affordable sustainable housing; it is about being able to participate fully in society"[15].

Potentially, these raise new information needs, some of which may be satisfied by collaboration with other government or public sector entities but others which could only be met, for example, by NGOs active in areas such as access to affordable housing, or by PHOs.

[14] Ministry of Health (2004b) ix

[15] Ministry of Health (2004b) xi

4.3 A CHANGING ENVIRONMENT

The third factor to consider is that the environment for mental health is highly dynamic, in terms of boundaries between mental health and other areas and in terms of changing needs. Both factors affect who the stakeholders are at any point of time. In the case of mental health needs, for example, *Improving Mental Health* recognises as knowledge, information and the ability to address different conditions change, so do needs change.

Two examples that are undergoing redefinition are:

- Behavioural problems in children. These used to be addressed primarily through disciplinary means; now it is increasingly common to do so through clinical means (use of prescription drugs). The shift is a movement across a boundary into the domain of mental health (as recognised in Strategic Direction One with its concern that there are significant gaps in specialist service development for children and young people).

- Workplace stress. Currently, this is treated as primarily an issue between employer and employee within an occupational health context. Where there is potential for significant cost to be involved, there is a tendency for issues to migrate (or for those affected by them to attempt their migration). Although it might seem speculative, it is nonetheless not outside the bounds of probability that either there will be moves in future to redefine workplace stress as a mental health issue or, alternatively, for a recognition to emerge that the work environment may itself be a trigger which releases what are inherently mental health problems but may not previously have been recognised as such.

The point we are making here is that mental health policy operates in a dynamic environment and, because it does so, it needs processes for information input into policy that themselves are dynamic – capable of coping with or indeed anticipating changing demands and priorities as they emerge.

4.4 DIVERSITY OF THE SECTOR

The fourth factor is the one highlighted by the Health and Disability Commissioner in the quotation included in MDL's proposal:

> "Mental health is noisy – consumer alliances, carer groups, Mental Health Commissioners, academics, other mental health professionals, general practitioners, epidemiologists and policy makers from across the spectrum of health, housing and welfare agencies all crowd upon the stage. All compete for the attention of government and the media.[16]"

For the Ministry, one of the realities of its policy development and monitoring process is that it operates with limited resources – certainly in relation to the number of claims that components of the "noisy sector" would make on the Ministry's time were they permitted

[16] Health and Disability Commissioner (2004) p2

to do so. For the Ministry, this points to means of obtaining information that offer it a good prospect of knowing what it needs to know whilst ensuring that its own resources are not either over-committed, or distracted by dealing with "noise" from participants in the sector who believe that their own concerns or ideas are important, but who, in practice, may add little value to the Ministry's policy development process.

This highlights a crucial difference between information input for policy development, and consultation. It is an accepted principle of consultation that the opportunity to participate must be open to all comers; the Ministry's role in dealing with any consultation is to ensure that submissions are screened and, where relevant, have an appropriate influence on final decisions/recommendations. Typically, though, the process of managing a consultation will be designed primarily to reinforce a sense that people have had an opportunity to participate, rather than with an expectation that they will play a potentially significant role in helping shape the final decision.

Information input for policy development is of a different character. The Ministry's primary interest is in gathering information that it anticipates could have an influence, potentially significant, on policy development, whether of new initiatives, or in fine-tuning or monitoring existing initiatives. There is at least an implicit assumption that it does not have, and cannot by itself generate, all the information needed for effective policy development. It is, accordingly, appropriate that the Ministry's tools for receiving information input should be designed to optimise the potential to gather information (deal with sources) that will be of value for policy development, whilst paying less attention to sources that are likely to be of less or no value.

4.5 SUMMARY COMMENTS

Our report is concerned with the Ministry's need to capture information of value for policy development and service monitoring that may not come to it through other and more formal channels (ie, outside the statutory and contractual mechanisms the Ministry has available to it such as District Health Board reporting, or the information flows that come to the Ministry through its participation in committees, statutory bodies and the like).

This places a particular focus on sector input in areas such as:

- Newly emerging research/analysis that will inform the Ministry about the potential for new treatments, or the changing significance of different mental health conditions.
- Different options, and the potential role of non-traditional providers, for meeting the needs of mental health consumers – especially important for strategic directions such as social inclusion.
- How current treatment regimes, and means for accessing those, are working in practice – with the need for parallel sources of information to the official channels (for example DHB reporting) which also feed information to the Ministry on those issues.

It also highlights the importance of having sector input that can be reasonably easily assimilated into the Ministry's policy development process. This in turn means sources

that give the best assurance that the information meets appropriate standards of quality and relevance, such as:

- Information that is a mix of evidence based, anecdotal, observational and quantitative.
- Information relating to specific and/or priority groups within mental health (Maori, Pacific Island, child/youth, older people).
- Information that reflects specialist knowledge or a ground-up perspective; and information that is cross-cutting; co-ordination.
- Information that is useable (well presented, analysed, relevant, timely and is clear as to, coverage, or representativeness (providers, consumers, carers/families, clinical, NGO etc)).
- Information that fills gaps in the information landscape (and reflects changing priorities).

This points to using channels that give the Ministry the ability to control, or at least influence, the characteristics of the information it receives through, for example, being able to specify the qualitative and other characteristics it requires and/or ensure that the people involved have the mix of skills, experience, networks and capabilities required to deliver what the Ministry needs.

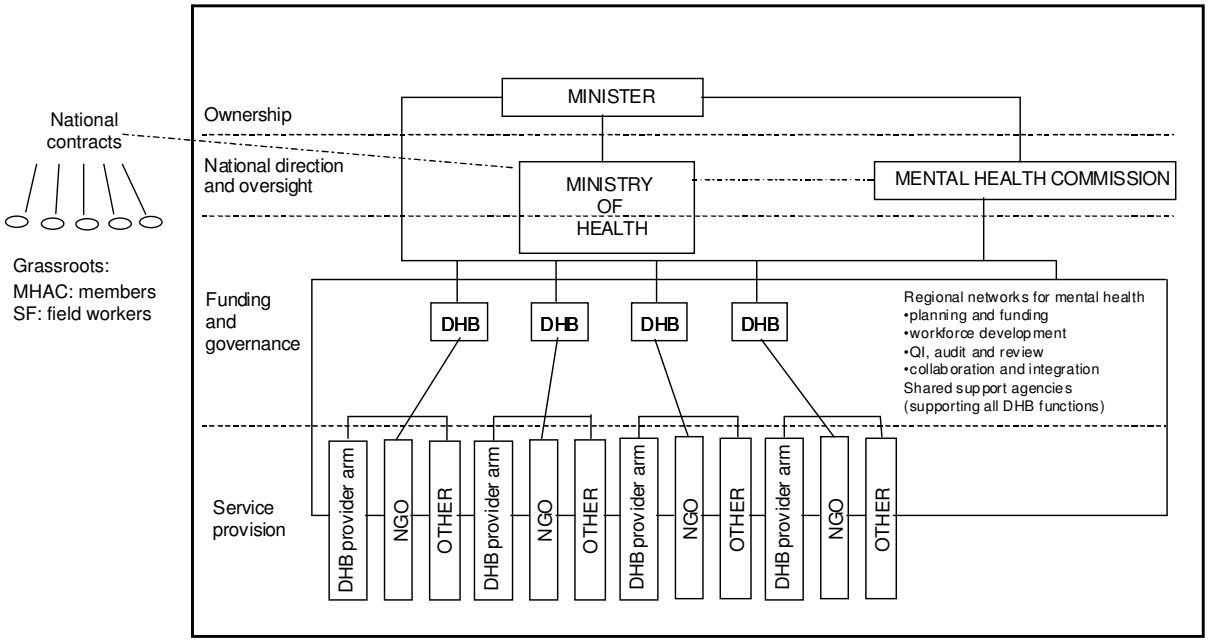
PART 5: Current Structures

This section considers the current structures in the mental health sector that could be an information source for the Ministry. The purpose is to give the Ministry a clear idea of the streams of information that may be available to it for policy development and service monitoring. Although the Ministry will most likely be aware of these, it is useful to consolidate what is already "out there". We can then look at the potential these represent for the Ministry.

Our knowledge of the current structures in the sector is by no means exhaustive. We have based this section on groups/forums/networks we learned about during the interviews. With more extensive interviewing, it is very likely we would have learned of more sources.

Below is a "map" of the sector which shows the main players and their connection to the Ministry[17]. The main streams of information for the Ministry for mental health policy development and service monitoring are:

- MHAC.
- SFNZ.
- DHB networks.
- Mental Health Commission.
- Others.



[17] This diagram has been adapted from the Mental Health Commission's Mental Health Service Accountability Model, in the document "Information about District Health Boards for Mental Health Non-Government Organisations", February 2001

This section includes a description of each of these in turn, a summary of how they operate, their structure and what they produce.

5.1 MHAC

The Mental Health Foundation currently holds a contract with the Ministry of Health to co-ordinate the Mental Health Advocacy Coalition (MHAC). It is unclear from the information we have for this project where the initiative of establishing MHAC came from (although we do know it was set up in 1994 at a conference where the Minister of Health launched the national mental health strategy). In the original terms of reference dated November 1994, MHAC's objectives were listed as being:

1. To focus on meeting the needs of consumers.
2. Through wide consultation, determine issues for advocacy.
3. To develop a national advocacy strategy.
4. To support collective action.
5. To promote clear and accurate information.
6. To develop and implement a media strategy.

This strong advocacy role is reiterated in MHAC's mission statement (also part of the terms of reference) as being "united advocacy for improving mental health services". MDL understands the Ministry had early concerns that MHAC members were initially using the meetings to advocate for certain policies or actions. This advocacy focus changed, as the Ministry was clear it is purchasing advice, not advocacy. The Ministry's view subsequently changed to one that the meetings were now used to exchange information and to develop relationships, accepting that MHAC was the only regular forum for meeting with all key stakeholders together.

MHAC states that its members "bring a range of perspectives but come to MHAC with a particular specialist focus, to reflect the diversity of views and perspectives in the mental health sector." They state that current membership covers perspectives including:

- Consumer.
- Families.
- Pacific Islands.
- College of Nursing.
- Housing.
- DHB provider arms.
- Child and youth.
- Alcohol and drug.
- Maori.
- College of Psychiatry.
- Employment.
- Mental health promotion.
- Older people.
- Specialist mental health services.
- NGO.

There were 16 members as of the list dated November 2004. From our interviews, we understand that membership on MHAC is for 3 year terms. With regard to membership, MHAC states that "where appropriate agencies exist, members are selected by their networks or organisations to represent them on MHAC." It adds that "all members undertake to link to their own networks in a two way process of feeding information in and out on current policy issues."

We discuss how MHAC has worked in terms of its contract with the Ministry in Part Six of this report.

5.2 SFNZ

SFNZ is a current source of information for policy advice and service monitoring through their contract with the Ministry. SFNZ has 22 branches organised through its national office. Its focus is on supporting families of mental health consumers.

SFNZ uses its field workers from the network of branches around the country to report to the Ministry on what is happening with services, and the perceptions of mental health services as a whole. The information is collated into quarterly reports to the Ministry.

A Ministry note on this contract has suggested that the information often has "more local than national relevance" and that "there is not an interplay of views and perspectives as with MHF". The same note also commented that the contract is "essentially a contribution to the rent and salaries for the two national co-ordinators".

From our interviews, SFNZ were said to be able to identify where whanau/family feel there are gaps in services around the country, and that its field workers offered a structure that is able to gather valuable information during the course of daily work.

However, many interviewees were unaware that SFNZ had a contract with the Ministry and what its purpose is. There were many comments about why this organisation was chosen for this purpose, over other organisations. This included why the Ministry received input on families specifically, rather than other key areas such as consumers or Maori.

We discuss how SFNZ has worked in terms of its contract with the Ministry in Part Six of this report.

5.3 DHB REGIONAL NETWORKS

Throughout our interviews there were constant references to the District Health Board (DHB) mental health networks. Several of our interviewees were members of groups that are part of the regional networks. The networks are clearly regarded as a significant and established part of the mental health sector and are utilised by DHBs themselves for obtaining stakeholder input. General feedback was that the networks were working well.

There are four regional mental health networks – the Network North Coalition, and the Central, Midland and South Island Regional Mental Health Networks. Each is funded by the DHBs and report upwards to DHB CEOs.

The Ministry's Mental Health Toolkit states that the establishment of the networks was "driven out of a concern that with the restructuring of the health sector, regional service provision (of tertiary services), regional oversight and economies of scale that were possible under the Health Funding Authority structure would be lost.[18]" We understand from the Ministry that the Commission has been a keen supporter of the network.

There is flexibility around how the networks are structured. The Mental Health Toolkit states that "DHBs have considerable flexibility in how they approach this collaborative work. The structure of a network should reflect the purpose and functions of the network, and will vary from region to region to reflect geographic and social and structural differences between DHB districts and organisations.[19]"

The Mental Health Commission states that regional networks will:

- Develop a regional plan including the provision of regional mental health services and funding direction for the region.
- Foster collaborative approaches amongst DHBs to improve quality and carry out audits and reviews.
- Undertake joint workforce development, recruitment and retention initiatives.
- Promote increased integration and collaboration across the whole range of services[20].

Below is a brief overview of the four regional networks. The information from the Midland Regional Mental Health Network was gathered from a face-to-face interview with the Network Manager. Information about the other three networks was gathered from telephone conversations with the each appropriate network contact. Note that the explanations of the networks are quite complex, reflecting the different structures and layers within each.

Midland Regional Mental Health Network

We received information about the Midland Regional Health Network from meeting with the Manager, Regional Mental Health Network for Midland. The diagram below shows the structure of the network.

[18] Ministry of Health (2003) p17

[19] Ministry of Health (2003) p17

[20] Mental Health Commission (2001) p4

Midland Regional Mental Health & Advisory Network Structure

CEO Forum

The Midland CEOs group takes a proactive strategic leadership approach to matters of interest/concern to the five member DHBs, and ensures well informed decisions are made for the future.

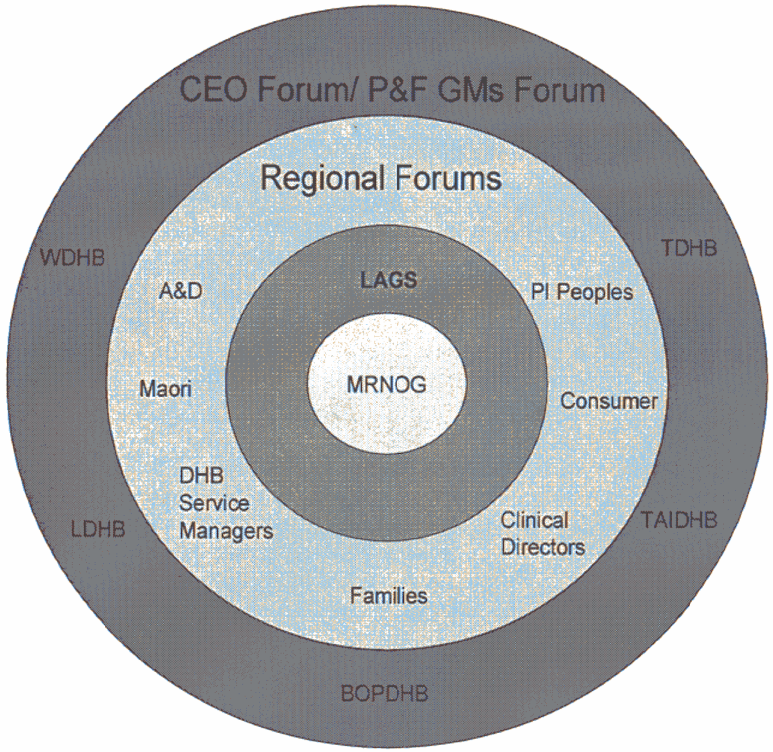
It also provides a mechanism for the coordination of a range of activities and initiatives across the region with the goal of cooperation, collaboration and the efficient use of skills, knowledge, information and resources.

Local Advisory Groups LAGS

Made up of stakeholders from the range of mental health and addiction services

- Consumer
- Maori
- Families
- Pacific People
- AOD
- Child & Adolescent
- Older Persons Mental Health

To provide quality strategic advice to Midland District Health Board Planners and Funders.



Midland Regional Network Operational Group MRNOG

DHB Funding & Planning, LAG Chairs, Clinical Director, RMHN Manager.
Responsible for developing, managing, delivering on and monitoring performance against the objectives of the Regional Mental Health & Addictions Plan.

Regional Forums

- Provide advice to DHB Planning & Funding on regional issues for workforce development, quality improvement and collaboration
- Make recommendations on new services
- Make recommendations that will improve service delivery protocols for sharing resources
- Promote shared development across the region
- Develop a mentorship infrastructure in Midland
- Provide regional leadership and stakeholder perspective

The Midland Network is grounded in the Local Advisory Groups (LAGs). Each of the 5 DHBs has a LAG of stakeholders covering the following range of mental health and addiction services:

- Consumers
- Maori
- Families
- Pacific peoples
- Alcohol and drugs
- Child and Adolescent
- Older people.

Each of the five DHBs nominates four representatives from its LAG into the Regional Forums. There are seven Regional Forums comprising of twenty people and cover a similar range of service perspectives, ie consumers, Maori, families, Pacific peoples, alcohol and drugs, DHB Service Managers and Clinical Directors. The Midland Regional Network Operational Group (MRNOG) manages the information flow, for example ensuring that the regional plan it develops is consulted on by the LAGs and the Regional Forums.

Separate from the network, each of the DHBs also has Consumer Advisory Groups and Maori Advisory Groups.

The Midland model, therefore, has a clear information flow: the LAGs feed into the Regional Forums, and the Regional Forums and LAGs both have the opportunity to feed into the Regional Plan. Both groups act as a mechanism for the DHB itself to get feedback from its stakeholders for decision-making around funding and policy development.

Central Region Mental Health and Addiction Network

Information about the Central Region Mental Health and Addiction Network (CRMHAN) is from the Manager Mental Health for the Central Region's Technical Advisory Services (TAS). She informed us that the structure and functions of CRMHAN are currently under review to ensure that they are as effective as possible. Within the review, a number of benefits of the network have been identified, for example improved relationships, information sharing, networking and communication. There have also been issues such as unclear accountability and decision-making processes, lack of regional clinical leadership and regional and district planning processes that are not integrated. Changes to the network are being proposed to address these concerns.

The network is also supported by six Local Advisory Groups and a regional forum (Central Potential) as well as specific stakeholder groups that are established to discuss particular issues.

The current structure of CRMHAN comprises two groups:

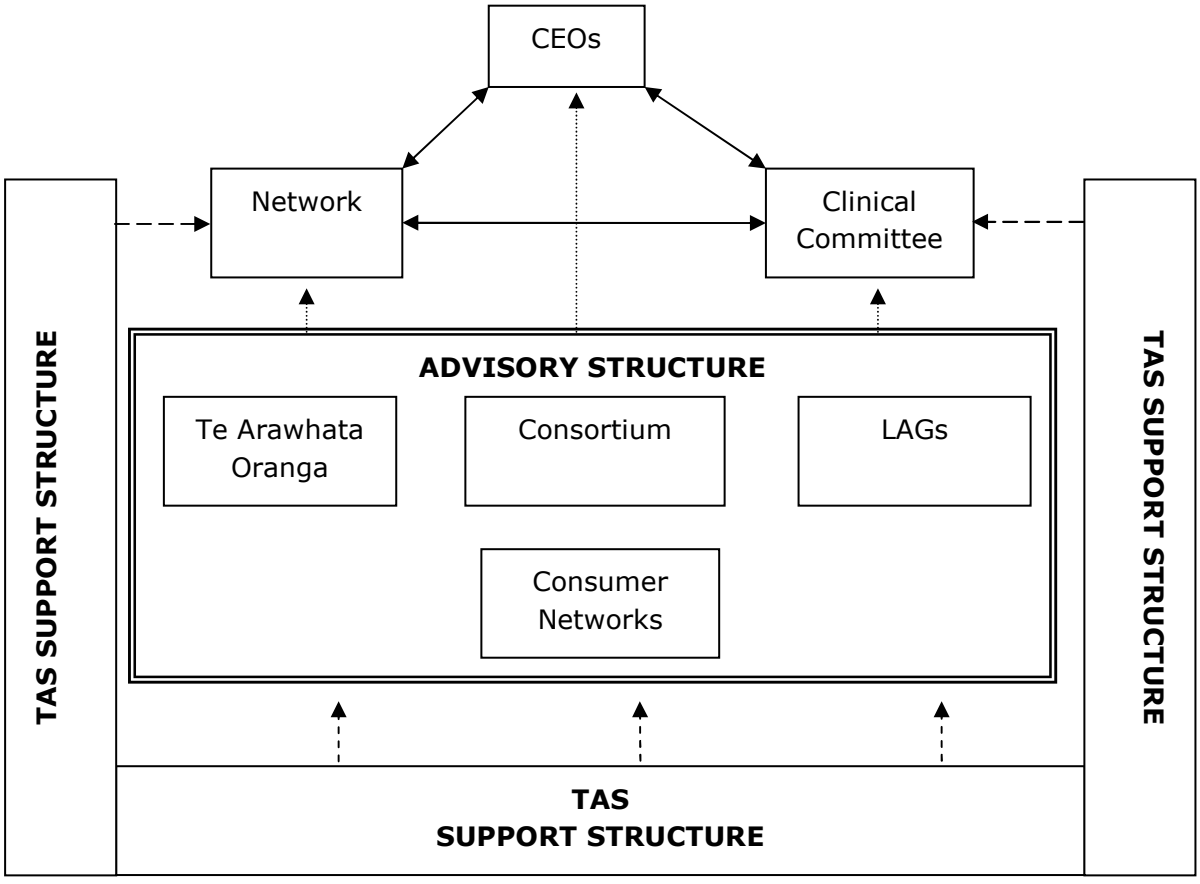
- A broad stakeholder group consisting of 15 or so individuals from a range of organisations including Maori, consumer, family, addiction services and NGOs. At least one representative must be from each Local Advisory Group.
- An Executive consisting of the six mental health portfolio managers and the service leader from TAS. The Executive reports to the GMs Forum which in turn reports to the CEOs.

The Executive Group is responsible for ensuring the regional plan for mental health is written, for decision making, prioritising, identifying and signing off on audit needs, purchasing, quality initiatives in the region, agreement on pricing and costing, ongoing monitoring of contracts and aligning all developments with national strategies. The stakeholder group is responsible for initiating and maintaining consultation with wider stakeholders in the region and networking activities.

Some of the changes to the network following the review are:

- the establishment of a new Clinical Committee to provide clinical leadership within the region
- clear separation of the Executive Group and the Stakeholder Group
- the broader stakeholder group to form part of an advisory structure to both the Network and the Clinical Committee.

The diagram below is a draft plan outlining the new network structure.



South Island Regional Mental Health Network (SIRMHN)

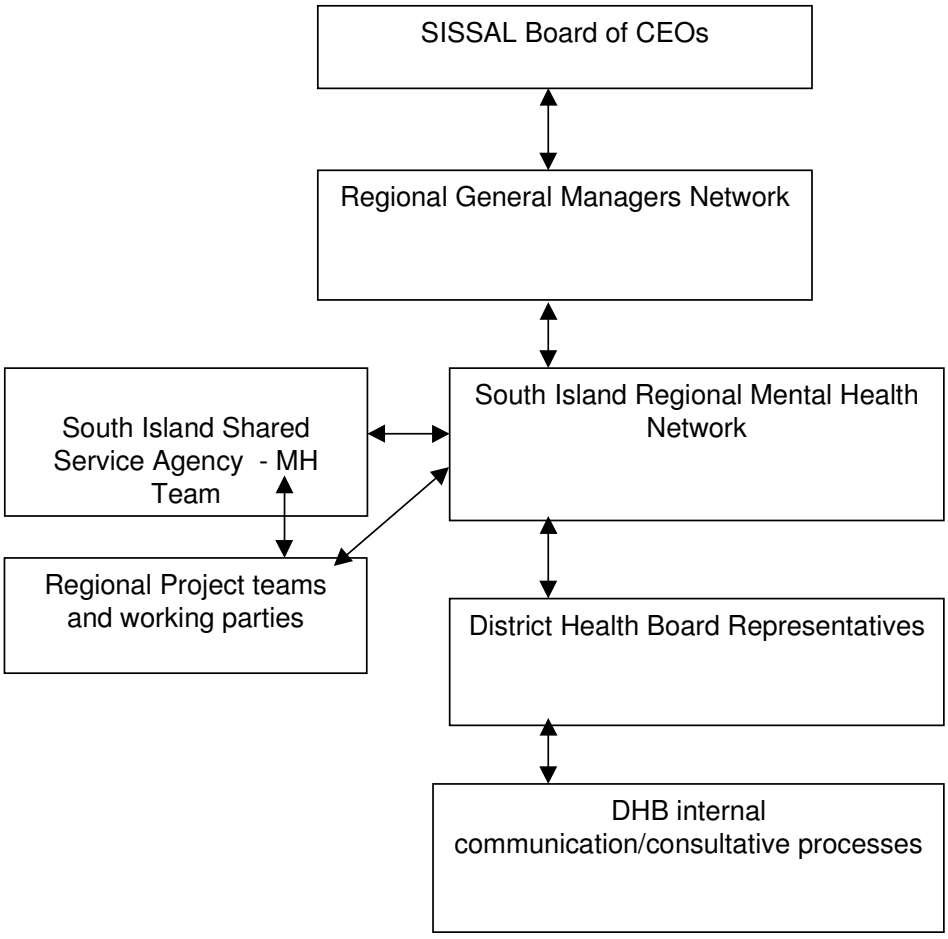
The information about the South Island Regional Mental Health Network (SIRMHN) is from the Manager Mental Health Team, SISSAL (South Island Shared Services Agency Mental Health Team).

The network consists of one representative from each of the six DHBs, a mix of Planning and Funding and Service Managers, plus the Shared Service Agency Mental Health Manager. The network structure of SIRMHN varies from the other three in that there is no regional stakeholder group; it is the responsibility of the DHB representatives to feed back into their stakeholder groups at the local level through their LAGs.

SIRMHN produces a regional newsletter to inform the sector (across districts) on what is happening regionally. The purpose is to provide information for DHB representatives to pass on to their own stakeholders on key issues.

If information is needed on a specific topic, relevant stakeholders from across the region are pulled together to work on it. Projects of this type are usually managed by either a nominated lead DHB or the SISSAL. South Island DHBs have preferred this type of approach over setting up a number of specific advisory groups.

South Island Mental Health Network - accountabilities



Network North Coalition

The information about the Network North Coalition is from the Mental Health Manager, Northern DHB Support Agency (NDSA), and the Counties-Manukau DHB.

The Regional Director Mental Health has led the development of the network, known as the "Network North Coalition" (NNC). This regional leader was appointed to implement the recommendations of the Mental Health Commission review 2002. The role of the director focuses on strengthening regional collaboration through the coordination of sector planning and development.

The NNC is a group of 36 stakeholders from across the mental health services, and consists of the following individuals:

- Regional Director Mental Health Services
- Manager Mental Health, NDSA
- Clinical Directors from the Auckland DHBs plus Forensic Services from Northland District Health Board
- General Manager Mental Health from all four DHBs
- Funding and Planning Managers from all DHBs and the Maori Co-Purchasing Organisation (MAPO)
- NGO sector
- Local Networks (consumers and sector group representatives)
- Family input
- PSA delegates
- Maori input
- Pacific Island input
- Primary care input
- Alcohol and drug input.

Members of the NNC have responsibility to bring to the forum the perspectives of a specific group within the mental health sector, and to engage with the group that they are associated with. They are selected on the basis of their expertise or role in the mental health sector.

The Regional Director Mental Health Services chairs this forum. The function of the NNC is to improve mental health outcomes across the Northern region by improving services through the following activities:

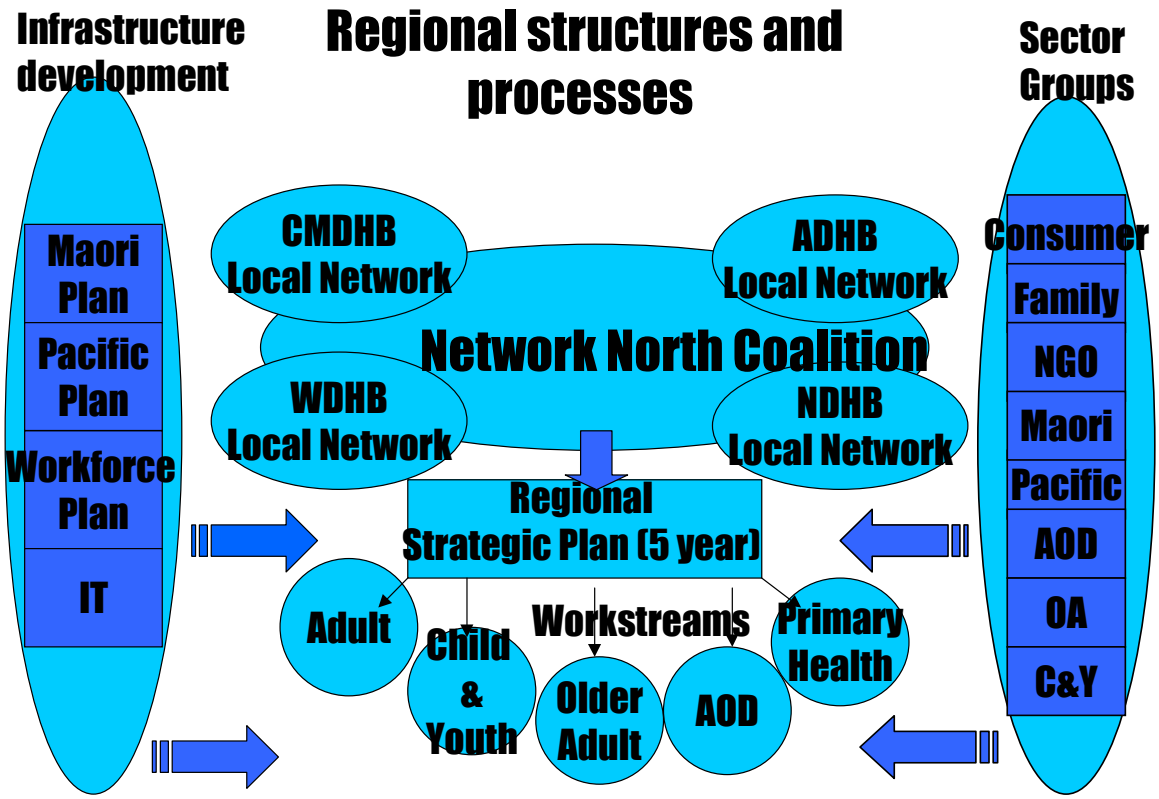
- Advising on planning and funding of mental health and addiction services
- Undertaking projects to develop services across the region
- Communicating with key stakeholder groups
- Advocating on behalf of mental health and addiction services.

The NNC produces the region's mental health plan.

The Regional Director is also supported by another group known as the Northern Regional Mental Health Funding and Planning Team comprised of the NDSA, MAPO and the Planning and Funding General Managers. This group is also part of the network, and their work includes policy development, needs assessment, strategic planning, annual planning and budget expenditure. There are representatives from this group in the NNC stakeholder group (explained above).

A number of key regional sector groups and forums have also been established to assist regional collaboration, including consumers, family, NGO, Maori, Pacific, alcohol and drugs, older adults and child and youth.

The regional structure is replicated at the local DHB level via local DHB networks. The local networks feed into the regional structure via direct representation on the NNC.



Discussion

Our agreed interview coverage gave us insights into two of the four networks – the Midland Regional Mental Health Network and the Network North Coalition (plus we did receive some feedback on one aspect of the Central Regional Mental Health Network – the regional consumer network). The following comments reflect only what emerged from these interviews.

These two networks covered in our interviews are regarded as having developed relatively successfully. We have not investigated how far this parallels the experience of the other two networks.

Although each of the two networks is structured differently, there are many common features. From our interviews, the DHB regional networks appear to:

- Have clear information flows between the local groups and the regional groups, which means that local groups have input into the regional plans and policy.
- Have representatives at the local and regional level from all the main stakeholder groups such as consumers, Maori, families, Pacific peoples, alcohol and drug, child and adolescent, older people and DHBs (including DHB Shared Support Agencies)

(note the South Island Regional Mental Health Network does not have a regional stakeholder group)
- Have formal structures, with clear links between levels and a good two-way information flow.
- Give DHBs a strong link into what is happening "at the grass roots level".
- Address local/regional policy issues and are seen as an effective way to get a wide variety of stakeholder input and create a sense of ownership.

On this last point, regarding using networks for policy input, there was mention of the networks being used as a way for DHBs to get local input on national policy, eg the second national mental health plan. There appears to be limited connection between the DHB networks and the Ministry itself, other than through the regional mental health plans which are a Ministry requirement.

Overall, and on the basis of experience with the Midland and Northern regions, the regional mental health networks appear to be a rich source of knowledge about what is happening in the sector. They also appear to be a good mechanism for establishing partnerships and collaboration. Interviewees suggested they were effective in getting sector input for DHBs themselves, and could be an information source for national policy. One person said that in developing a policy input framework for the Ministry, they would "look at the regional stakeholder network first as a source". The person said it would be easier to manage working with four networks than working with all DHB local networks. They added that the infrastructure was in place, and that it could be useful to fulfil a wider role.

There was also a comment that with the structures in place for stakeholder input, there was a good sense of ownership and that people felt they had contributed to the regional plan. It is possible, therefore, that utilising these structures to inform national policy, may, in turn, create more "ownership" of national initiatives.

Interviewees warned that care would need to be taken if the networks were to be used in a different way. For example:

- DHB protocol would need to be respected.
- There would need to be transparency and clarity over how information was gathered and used.
- It might be necessary for the Ministry itself to gather and collate information it required, rather than ask DHBs to do this, to minimise the impact on DHBs' primary responsibilities.

5.4 MENTAL HEALTH COMMISSION

The Mental Health Commission is obviously a key player in the mental health sector because of its monitoring role, and its role in commenting on progress in the sector. Through these roles, it is a source of information on the effectiveness of Ministry policy. In addition, it has strong links with the sector, and produces significant material that could be (and has been) useful for the Ministry's own policy development.

It is beyond the scope of this report to discuss ways the Ministry could utilise information sources from the Commission. However, it is important to acknowledge the Commission's role as a key information source.

5.5 OTHERS

There are a number of other existing information sources that the Ministry could possibly "tap into" for its policy development and service monitoring. Many interviewees mentioned various groups and forums that could be used for input on specific issues. The following is a list of groups mentioned by interviewees, although is by no means exhaustive:

- Child and youth input: the Ministry's Child and Youth Forum.
- Consumer input: Manuka Steering Group (a newly developed national consumer group); National Association of Consumer Advisors; regional consumer networks.
- Pacific input: Moana Pasifika (a regional mental health DHB NGO forum).
- Maori input: Maori Advisory Groups (part of regional mental health networks).
- Primary health input: there was a suggestion that an ad hoc primary mental health advisory group could be set up (under the Ministry's Primary Health Care Strategy and Primary Health Organisation Development Task Force).
- DHB input: National Mental Health Managers.
- Alcohol and drug input: National Treatment Forum.
- NGO input: Platform.
- Families: Family Forum (part of DHB networks).

There is no doubt there are a number of other sources. In fact, one interviewee suggested that it would be a useful project in itself to look at all possible sources that exist to avoid "reinventing the wheel". There was a sense from the interviews that there was a wealth of information in existing forums that could be utilised by the Ministry, and that these groups would be willing and able to provide it.

All of these current structures, MHAC, SFNZ, DHB networks, Mental Health Commission and other groups, show that there is a rich repository of information with potential for the Ministry to tap into more explicitly. Part Seven of the report will consider how far these structures go towards fulfilling the information needs of the Ministry identified in Part Four.

PART 6: The Two National Contracts

6.1 INTRODUCTION

In this part of the report we examine how the two national advice contracts have performed in terms of delivering the outputs expected by the Ministry and supporting the Ministry's leadership role in the sector, being the contracts with:

- The Mental Health Foundation, delivered through the Mental Health Advocacy Coalition (we will refer to this as the MHAC contract).
- The Schizophrenia Fellowship New Zealand (the SFNZ contract).

We discuss the purposes the contracts are designed to serve, then highlight the main themes that emerge from looking at how they have worked, analysing the pros and cons, strengths and weaknesses of the contracts as an approach to meeting the Ministry's information needs. We end with some conclusions that set the stage for the options explored in Part Seven.

We note the reference to "outputs expected by the Ministry". In a formal sense, these are the outputs specified in both the contracts:

- Input into policy advice (output 1). The contracts specify strategic advice on future directions and future requirements for mental health and disability support services.

- Service monitoring (output 2). The contracts specify feedback on the quality of mental health services and identify areas of particular interest to the Ministry.

Comparing these requirements with the way we have interpreted the Ministry's information needs in Part Four above highlights that the contracts are but one element in the Ministry's overall mental health information "set".

The sources we have drawn on for this section include:

- The contract documents.
- Historical material provided by, and discussions with, the Ministry.
- Interviews and follow up with the two contractors.
- The interviews we held with other people in the mental health sector (listed in Appendix 1).

We have also drawn on our experience and knowledge of contracting principles and practice in the field of contracting/funding between government and the voluntary/community sector.

We would like to acknowledge the insights provided in the material supplied to us by the Ministry relating to the 1998/9 NDOC review which still have relevance (allowing for the advent since of the DHBs and the regional mental health networks), illustrating the

approach the Ministry opted for at that time which was one of allowing the contracts to evolve, rather than significantly changing them.

Part Three above describes the origins of the two contracts. We note that they are annual contracts and re-negotiated each year. We understand they have not been substantially altered over successive contracts.

A point to make is that the two contracts are, on their face, very similar, the only differences being contextual references to MHAC and SFNZ (and an added requirement in the 2004/5 MHAC contract for the provision of strategic advice to be agreed upon by MHAC and the Ministry). This is noteworthy given that the two organisations are quite different in purpose, their coverage of mental health, their structure and composition and their mode of operating:

- SFNZ's focus is on a single part of the mental health sector.[21] MHAC has a sector-wide focus.
- MHAC has a membership structure representing a range of mental health interests, while SFNZ is a national body with a national office structure and 22 area branches.
- MHAC produces its reports for the Ministry by holding quarterly meetings of its members, inviting other parties in for discussion (eg the Ministry, the Mental Health Commission, DHBNZ). SFNZ produces its reports by collating information from its branches, compiled by field workers. In other words, it has a built-in structure for collecting and sending on information. Ministry funding in effect covers MHAC's meeting and administration costs, and, for SFNZ, it covers part-salary and overheads for the on-staff analyst/coordinator.

We return to the fact of these differences in our concluding remarks about the operation of the contracts.

6.2 THE PURPOSES OF THE CONTRACTS

The contracts are an identifiable, structured source of external advice to the Ministry from outside the formal machinery of government. They represent a mechanism through which information and comment is channelled to the Ministry that taps into mental health networks across the country and provides grass roots-informed input on emerging issues, impacts of policy changes and developments/outcomes in access to mental health services.

At a high level, the purpose in having such a source of advice is the Ministry's ability to fulfil its roles and functions satisfactorily. There is a very apt description of this in the 1998/99 NDOC review material (emphasis added):

> "For mental health, the Ministry has a statutory responsibility to provide leadership in the mental health sector and to ensure that the national mental health strategy is implemented (Mental Health Commission Act 1998). … To perform in line with the

[21] We understand that SFNZ is shifting to a wider "brief" based on families rather than schizophrenia.

mental health strategy the Ministry must demonstrate it is in touch with the sector and is responsive to stakeholders, especially consumers, carers and Maori."

This purpose has become more important over time with:

- Restructuring of the health sector, placing the Ministry in a strategic policy role and at greater arm's length from operational/service policy development, where there was previously a more direct source of information.
- Stakeholders being recognised as having a legitimate interest in policy and service delivery and, potentially, themselves an important source of information. This has been a broadly-based trend in New Zealand and other countries, and in both public and private sectors.

It is against this broad purpose that the contracts can ultimately be assessed.

More specific purposes were suggested in the afore-mentioned NDOC review material. These were listed as "benefits" for the Ministry from MHAC and SFNZ reports (reports being the primary output required under the contracts) but we think they serve equally well as purposes. Benefits were divided into two categories:

- First, a "weather vane on the sector":
  - Early warning of a crisis situation.
  - Evidence of poor co-ordination across mental health or intersectorally.
  - Effects of policy changes in other sectors.
  - Funding/purchasing inconsistencies.
  - Knowledge about new initiatives/new learning in mental health.

  This was described as giving the Ministry an insight into "the types of issues that were likely to be taken up with the Minister, MHC and HFA, who's working with whom on what, and what's going on".

- Second, a mechanism for building relationships, both within the sector and between the sector and the Ministry with the suggestion that the benefits of relationships outweighed the benefits of the reports. It added that MHAC had become "part of the Chief Psychiatric Advisor's means of being visible and influential in the sector".

These comments suggest that perhaps the value of the relationships the Ministry has with MHAC and SFNZ had focused less on formal policy input and more on the Ministry knowing what was happening "on the ground" and being seen as engaged with the sector.

The interviews we conducted indicated that these purposes are still seen as valid (which is not to say the contracts, at least in their present form, are always seen as the best way to achieve them, but does say that there is consensus around these purposes).

The interviews did however stress the importance of the pure policy input and monitoring roles under the contracts, and much of the comment we received on how the contracts were working had to do with these expectations.

6.3 THE CONTRACT MECHANISM

Our interviewing drew out a variety of perceptions on the way the contracts work. The six aspects we thought were most useful to highlight are the style of the contracts, the scope of information delivered, alignment of objectives, the reporting process, the idea of the contracts as 'relational' and governance and management.

Contract Style

The material part of the two contracts are the schedules setting out the required outputs and reporting requirements.

The contracts are notable for not being prescriptive. They are relatively open, and unspecific as to the nature of reporting required to meet the Ministry's needs.

This is desirable given the value of the contracts as a "weather vane on the sector" and for building relationships across the mental health sector. Non-prescriptive contracts are also appropriate when the intent is to take a relational approach to the contract relationship.

The relative lack of prescription is less of an advantage for the purpose of policy and service monitoring advice input to the Ministry, to the extent that the input is meant to be part of the process of policy formulation and service development under the Ministry's formal responsibility for these. The Ministry, if it was asked, could find it quite hard to describe how the MHAC and SFNZ input has actually been used in policy formulation and service development. A more precisely worded contract could link the contract requirements more closely to Ministry's responsibilities and make it easier for the Ministry to take the input on board. For example, wording in the contract could require MHAC and SFNZ to consult with the manager when selecting what to focus on (which the MHAC contract already does in respect of strategic policy). This would also be consistent with a relational contracting approach.

Scope of Information

MHAC's information is synthesised from the input brought to the table by its members, and is intended to give a national picture. The scope of information is bounded by the expertise of its members. Many interviewees expressed concern about "gaps" in MHAC's information. These tend to equate, not surprisingly, with the areas felt to be insufficiently represented in MHAC's membership - notably in the areas of Maori, primary health, NGOs, Pacific people, child and youth, alcohol and drugs and DHBs. Insufficient representation is assumed to mean insufficient knowledge within MHAC to provide information/comment.

Asked if there were any areas MHAC could cover that it currently does not, one interviewee suggested more of an emphasis on inter-sectoral policy, for example housing and employment issues. It was felt that MHAC could be a vehicle for assisting with more joined-up policy and service development, although members may need to acquire the skills to do this. This has surfaced more strongly with the emphasis on recovery in mental health strategy. People question how meaningful it is to pursue recovery as a

key mental health objective without making clear links into other areas of social need and social policy.

SFNZ's input is specifically local level and their reports are a collation of local information from field workers. The extent of the information they collect is obviously bounded by their own networks within their area of expertise, ie families. The information SFNZ provides is primarily about families, and within this specific focus, there are perceived gaps. For example, one interviewee stated that SFNZ had no real links to Maori and Pacific Island peoples.

There were also a number of general gaps identified by interviewees in the Ministry's information needs, which suggests a need for more information sources. For example, information on capability of the sector, workforce information (for example how many people are working in the sector, who they are, what qualifications they have, how many NGOs there are etc), and information regarding child and youth.

In respect of primary health care, it would seem that if MHAC and SFNZ are not expected to provide input, the Ministry may need to look elsewhere for a source of "grass roots" mental health sector information and advice.

There is a question around whether some of the perceived information gaps relate more directly to the regional level and would be better generated at the regional level through the DHBs.

We would not suggest more prescription in the contract as the way to resolve the "information gaps". This would risk the possibility that only topics already identified by the Ministry would surface in MHAC and SFNZ reports, limiting the value of MHAC/SFNZ input. A more useful approach would be to introduce a clearer feedback loop between MHAC/SFNZ and the Ministry, as commented on in the next section.

We are aware that there can be a variety of reasons the information produced through mechanisms such as the two contracts may not be inclusive of all that might be desired – besides the reason that it may not be asked for. Other possible factors are that a topic may not have yet emerged with enough clarity to attract attention; there may be no resource or capability to do the work; or the contractors may not have set themselves up to collect and process the information on a topic.

One example of this is the interest both MHAC and SFNZ have in the wider factors in mental health – employment, income, housing and transport – and the interrelationship of these with the mental health strategy objective of recovery. Both organisations believe they need to be connecting with these other sectors, and understanding the wider policy and service issues affecting mental health, in order to be able to fulfil their contracts. Neither has the resources to do this to any depth. We do note that SFNZ's quarterly service monitoring reports quite often identify wider issues impacting on mental health services, such as transport to access services, and that this information could usefully be developed, especially where issues keep recurring.

Alignment of Objectives and Work Programmes

A particular issue raised in our discussions with the Ministry and with MHAC and SFNZ was the degree of alignment between the reports produced under the contracts and the Ministry's expectations and information needs. The issue would seem to be one of how much direction and guidance the Ministry provides MHAC and SFNZ and, consequently, how closely the MHAC and SFNZ reports match the Ministry's priorities for input.

In respect of policy input, the contracts specify only that advice should focus on "one or more of the objectives of the NZ Health Strategy or the NZ Disability Strategy (to be selected at the contractor's discretion)". The contracts leave MHAC and SFNZ with considerable discretion as to what work they undertake and what they report – although in MHAC's case an added clause in the contract requires agreement between MHAC and the Ministry on the scope of strategic advice.

It is a strength of the contracts that they are phrased broadly as it means that what comes through in reports can be a genuine reflection of the groups at the table. This is important if the contracts are to function as a 'weather vane' for the Ministry. What the Ministry gains is sector-driven information rather than 'contracted out' policy projects.

The drawback is the Ministry's need for input not just on emerging or possible future mental health issues, but on issues that have already surfaced as priorities for policy development and where policy is needing to be formulated. This suggests a need for input that is more directed by, and tailored for, the current policy environment.

Both MHAC and SFNZ expressed an interest in more active direction on where they should be focusing their efforts and on how they should present their reports. SFNZ felt it could better meet the Ministry's needs with more guidance on what sort of work programme would give the Ministry the best return on the contract funding.

Relatedly, both MHAC and SFNZ said they do not receive direct Ministry feedback on their reports, and are consequently uncertain as to whether or not their reports are meeting the Ministry's needs. (It should be noted that the attendance by the Director of Mental Health or an alternate at MHAC meetings is intended by the Ministry to be a means of providing feedback). Both said they had developed reporting processes that they felt delivered to their contracts and had not been advised otherwise. (We understand from SFNZ it is itself undertaking a review of the contract and believes it could improve on the nature of its reports in terms of their value to the Ministry.)

Feedback from the Ministry is seen by both MHAC and SFNZ as important for determining what impact their input has had on policy and service development. This is perhaps one reason reports from both organisations keep bringing up some of the "same old" issues. If they cannot be sure their input has been heard and taken into account, they will feel the need to keep repeating it.

Three questions arise from the issue of work programme alignment and the relevance of MHAC and SFNZ reports.

The first is whether there is sufficient communication on the contracts. Perceptions differ on this. From the Ministry's perspective, regular attendance at MHAC meetings, and discussions at the start of the contract year, are ways the Ministry conveys its expectations and priorities to MHAC. MHAC's perspective is that it has recognised the need for much better synergies with the Ministry's priorities by developing a work plan

and a "strategic framework" (used for reporting to the Ministry: see below, "The Reporting Process") to lend some logic to an otherwise huge breadth of mental health issues. In SFNZ's case, our impression is that there is less active communication on expectations under the contract, possibly because SFNZ's field of interest is more defined, meaning that its reports are more easily seen as fulfilling the terms of the contract.

The second question is one of resources, and how much communication can be realistically supported – on both sides. The funding provided to MHAC and SFNZ is generally accepted as being just enough to produce the required reports. For the Ministry's part, the Mental Health Directorate is small and works under heavy day-to-day pressures.

The third, specific to MHAC, is what influence the requirement in the contract that advice "where possible, will represent a consensus view amongst members" has on its work programme and report content. The contract requires, and a very real and important expectation is, that MHAC will base its input on information and advice obtained from its networks of "consumers, care-givers, mental health providers and other mental health groups". Balancing that against the set of issues "given" in the Ministry priorities is quite a challenge.

One means the Ministry does have to enhance the alignment between its priorities and MHAC's and SFNZ's work programmes is the provisions in the contracts allowing the Ministry to seek more in-depth input on specific issues. This has happened from time to time with MHAC. In the case of SFNZ a report sent to the Ministry last year on Family/Whanau Outcomes is regarded by the Ministry as fulfilling the policy component of the contract (although SFNZ sees it as something was undertaken with its own resources). There appears to be a need for more clarity on how the policy component of the contract is met. The Ministry may wish to use these provisions in the contracts more actively (and MHAC and SFNZ should see them as an important means for achieving alignment).

The Reporting Process

The limited guidance in the contract documents has resulted in MHAC and SFNZ taking very different approaches to reporting, in terms of both style and content. We found the relationship between the reports and the contracted outputs a bit confusing and hard to unravel, and have based our comments on the view we arrived at by looking at their actual practice.

- MHAC has adopted a style of reporting that it believes is suited to capturing the strategic issues in mental health. Six "key policy issues" form the framework for their quarterly reports. Reports consistently follow this format. As we understand it, the report structure encompasses both policy input and service monitoring input. It seems to have a reasonable logic for presenting policy input (leaving aside how well the actual content is aligned with Ministry needs). Recent reports follow the terms of the afore-mentioned letter from MHAC to the Ministry confirming the priority areas for MHAC input for the coming year and what form the input will

take.[22] All of these areas are covered in MHAC's September 2004 report, along with other policy issues. It is less obvious how the quarterly reports cover service monitoring. The letter lists the seven areas required for the quarterly service monitoring reports (which are as per the contract).

- SFNZ produces quarterly service monitoring reports that follow exactly the seven areas listed in the contract based on templated information supplied directly by field workers. This information is provided to the Ministry as a "narrative report". SFNZ staff told us they report on output 1 (policy advice input) only when asked to do so by the Ministry.

MHAC itself is satisfied with its reports which it has worked to improve (see further comment below); SFNZ saw scope to improve the way it captures and presents information, believing that the current method of reporting isn't as good as it could be in terms of identifying systemic issues in policy implementation and service delivery, such as could be used to feed into policy and service review. The present process doesn't embody an understanding that information over time, and across reports, is really valuable information for the Ministry.

The differences between the two reporting styles may in fact not be an issue. There is merit in leaving room for both organisations to evolve their own styles of reporting to reflect their particular structures, processes and sources. Letting them do it their way may be best, if it is useful for the Ministry to receive reports that capture flavour rather than following a prescribed style.

A question however is what having two different reporting styles means for the Ministry in terms of its use of the information and its ability to process and internalise it. We were not able to get a clear picture of how MHAC and SFNZ input is processed within the Ministry. Ministry staff advised us that MHAC and SFNZ reports are circulated within the Mental Health Directorate, and the information would infuse staff thinking, but there does not appear to be any specific tracking of the input through the policy and service development process. The Director and Chief Advisor Mental Health said he does not see MHAC and SFNZ reports. Sitting on the outside, MHAC and SFNZ are not able to gauge what actual influence their work is having. (This, according to MHAC, is one reason it communicates directly with the Minister.)

The Contracts as 'Relational'

The Ministry indicated to us that its approach to the two contracts has been in essence 'relational'. We think this is a totally appropriate approach to take to contracting with NGOs and when the value of the outputs being contracted for is as an expression of perspective, rather than when the output is a 'widget'.

The Ministry's intent of relational contracting fits with the non-prescriptive form of the contracts. Non-prescriptive contracts rely to a large extent on trust and goodwill – the defining features of relational contracting.

[22] The letter set out specific outputs: providing detailed advice on the draft second mental health plan (written submission), Primary Mental Healthcare (paper), peer review of the Blueprint Issues Paper, and engaging with the wider social policy environment (Housing and MSD) to support implementation of the second Mental Health Plan (report).

If the Ministry was to take this intent further into practice, it would be looking at introducing a number of other elements into the contracting process designed to achieve greater mutuality. Among other things, a more mutual process would be used to negotiate the contracts, the contract documents would include an expression of shared purposes and objectives, they would express complementary expectations, management of the contract would take into account the reciprocal interests of, and issues for, the parties on both sides of the contract and communication would be more two way, with more active feedback from the Ministry.

We comment further on relational contracting in Part Seven.

Governance and Management

We reviewed how the governance structures of the two contracted organisations work in terms of the contract relationship and contract delivery, and briefly considered the processes they use for managing the contracts.

Governance

We found from our interviews that most of the views expressed about governance around the two contracts related to MHAC. This is not surprising given that MHAC was set up with the express purpose of bringing the mental health sector together around the table, and to speak for the sector, while SFNZ already existed as a service and advocacy organisation with an existing governance and management structure. For this reason, it is not surprising also that the issues raised about MHAC were mainly to do with its composition and particularly its representativity of the mental health sector.

The view expressed by a majority of the people we interviewed from outside MHAC was that MHAC was not sufficiently inclusive of the range of interests in the mental health sector. A number of the people we interviewed were unaware who was actually on MHAC.

The representation of consumers on MHAC, numbering five, is seen as sufficient. While in the past consumer representation has been a bit "fragile", the system for selecting consumer representatives has been clarified and is now considered to be transparent and legitimated. More generally, there is some feeling that MHAC is more a group of "experts" drawing on knowledge from their own experiences, rather than from being connected to a network. One person said that for MHAC to be a truly representative structure, members would need to be selected by the people they represent (it appears this now happens with the consumer representatives, and one consumer representative thought their process was setting a model for the other interests around the MHAC table).

It was felt that the following groups were not well represented:

- Maori: There was a view that MHAC (and SFNZ) do not represent Maori well, either as consumers or NGOs. Maori presence in the two organisations "just doesn't cut it". One comment was that MHAC and SFNZ are "minor players" in terms of in-depth Maori input.

- Pacific Island peoples: There were questions around who represented Pacific Island peoples on MHAC, and a comment that many Pacific Island groups in mental health had no connection to the person on MHAC. There was no sense of a vehicle to feed into MHAC; nothing had been extended to them.
- Primary health: It was felt that primary health was not adequately represented, and probably not sufficient to cover mainstream primary care. It was felt that MHAC did not appear to have strong links to the provider side, needing stronger representation of clinicians, professional body representatives and PHOs. The general theme was a need for MHAC to have people who understand more than how to address "the 3%" (acute mental health).
- NGOs: While MHAC's membership includes NGOs, some see this as too "light" and not representative, especially given the growing presence of NGOs in the mental health sector.
- Alcohol and drugs: There was no voice for this group on MHAC. The National Treatment Forum was described as the alcohol and drug voice of the sector.
- DHBs: Although there is a provider representative on the board, there is a view that this doesn't do the DHBs justice. One DHB is not representative of all DHBs. There is however another vehicle for representation from DHBs, the National Mental Health Managers group.
- Age groups: Children and youth and older people are not represented.
- Other: Suggestions for a more "complete" membership included Police, Courts and forensic.

What this illustrates is that MHAC currently is not a truly representative organisation for the mental health sector. The breadth and complexity of the interests involved also raises the question as to whether it would be possible for a single organisation to play that role. MHAC itself says that the range of viewpoints it encompasses can never be comprehensive. Simply the fact of contracting for the group to provide a sector-wide view, however, raises this expectation.

From the Ministry's perspective, the main point is to have a means for allowing alignment of the wider sector view, and the interests of the various mental health sector groups, with the strategies, plans and specific policy focus of the Ministry.

It is relevant to note that at the time MHAC was established it was the only regular forum for sector stakeholders to meet together. Since then the regional mental health networks have emerged and become established. Arguably they are more representative than is MHAC, and perhaps than MHAC can feasibly be. It may not be necessary to expect MHAC to have that representative role, although there is no reason not to aim for breadth of perspective and knowledge.

The other governance issue that emerged from our review of the MHAC contract was MHAC's practice of informing the Minister on issues. MHAC's quarterly reports to the Ministry say that as well as providing advice to the Ministry it "provides advice and feedback to the Minister of Health, the Mental Health Commission and to national funders". The contract document refers only to providing advice to the Ministry's Manager, Mental Health.

As MHAC's original terms of reference make clear (see Page 19 above) it was established with an advocacy role – the mission statement in its terms of reference including "united

advocacy for improving mental health services". It is entirely consistent with such a role that MHAC does cultivate a direct relationship with the Minister and other key influencers.

At the same time the Ministry is clear that through its contract with MHAC it is purchasing advice for policy input, not advocacy.

A question for the Ministry (and MHAC) to consider is whether the one entity should be undertaking the two separate roles of acting as an advocate for the sector, and providing input to the Ministry for policy development. There is an arguable case that there is a conflict between the two roles so that MHAC should decide which role it wishes to undertake, and the Ministry should consider whether it is appropriate to contract for input for policy development – which almost by definition should be as objective as possible – with an organisation which separately sees itself as having a role to act as an advocate.

Management

An examination of MHAC's and SFNZ's management performance in respect of the contracts is outside the scope of this review.

We think it is worth acknowledging however that both organisations have invested effort in improving their processes in order to fulfil their contracts better. Both organisations have developed reporting templates that provide consistency between one report and the next. This should make it easier for the Ministry to assimilate the information. SFNZ has developed a version of the service monitoring topics listed in the contract that is more user-friendly for the field workers, and then re-formats the field worker information into the contract version. MHAC's quarterly two day meetings now follow a structured process that ensures an orderly identification of issues for the quarterly report which is agreed by the close of the meeting.

If the Ministry was to change the contracting process in any significant way MHAC and SFNZ would need time and perhaps guidance on any new contract management requirements.

6.4 SUMMARY OBSERVATIONS

The MHAC and SFNZ contracts, as a means for sector-advice input to the Ministry for policy development and service monitoring, have the potential to offer considerable strengths, for example:

- Underpinning the Ministry's leadership role in the sector by providing means for it to be well informed and connected with the different interests the sector comprises.
- Contributing to the Ministry's "early warning systems" regarding changing needs, new initiatives, problems with service delivery and other mental health developments.

Most of the questions that arise relate to the following four issues:

- The composition of the two organisations and the structure that sits behind them, in terms of the information they are capable of producing, how well the information

reflects and captures the knowledge, experience and perspectives of the stakeholder groups and how effectively the information is conveyed to the Ministry. This affects the nature and quality of information able to be provided by MHAC and SFNZ and how far it meets the Ministry's purpose of a "weather vane on the sector" and the purpose of specific policy and service monitoring advice input.

- The Ministry's provision of direction and guidance to MHAC and SFNZ on the advice input most needed by the Ministry, especially as this changes (which it will do). This is a matter of communication and feedback, and affects what alignment is achieved between the Ministry's priorities and MHAC's and SFNZ's work programmes and reports.
- How well the Ministry is placed to assimilate the advice input from MHAC and SFNZ. This concerns what happens to the reports within the Ministry, and how the information is brought to bear on policy and service development.
- The appropriateness of MHAC acting in the three separate roles of a contractor providing input for policy development, an advocate for the mental health sector and an advisor to Minister of Health.

The question of where the contracts might go in the future might require the two contracts to be considered separately, in the light of the different nature of the two organisations and the different results they produce, under almost identical contracts.

On a concluding note, it is fair to say that the Ministry can not realistically itself tap into the numerous sources of potentially valuable input from the sector, and needs some means by which information can be effectively and efficiently collected, digested and channelled into the central policy and service monitoring process. Part Seven explores some of the options.

PART 7: Future Options

7.1 INTRODUCTION

This section addresses the required outputs:

- Suggestions for alternative models of advice and monitoring that mesh with the Ministry's work, taking into account the broad range of its outputs from complex reports to visible leadership in the sector, and the range of timeframes within which the outputs are produced.
- A comparison of risks and benefits of changing to any of the proposed models of advice against the advice contracts currently in place.

We start by recognising that, since the current advice contracts were entered into, there have been major changes in accepted understandings of best practice for public input into the policy making process. The changes reflect a number of factors including:

- A greater demand, on the part of the public, to play a role in determining policy that will have an impact on them.
- An increasing recognition, on the part of governments, that much relevant knowledge and information is held outside the public sector and is best accessed through processes for engagement with those who hold that knowledge and information.

The rationale for increasing citizen involvement in the policy making process is well expressed in an OECD Public Management Policy Brief, *Engaging Citizens in Policy Making: Information, Consultation and Public Participation (Policy Brief No. 10 2001)* as follows:

> "Strengthening relations with citizens is a sound investment in better policy making and a core element of good governance. It allows government to tap new sources of policy-relevant ideas, information and resources when making decisions. Equally important, it contributes to building public trust in government, raising the quality of democracy and strengthening civic capacity. Such efforts help strengthen representative democracy, in which parliaments play a central role.[23]"

That same Policy Brief notes that progress on different levels of citizen engagement differs, both between the three levels the OECD identifies, and between different countries. The Brief comments trends show that:

[23] Organisation for Economic Co-operation and Development (2001b) p1

- **Information** for citizens is now an objective shared by all OECD countries. The scope, quantity and quality of government information provided to the public has increased greatly over the past decade.
- **Consultation** and opportunities for citizens to provide feedback on policy proposals is also on the rise, but at a slower rate. Large differences remain between OECD countries.
- **Active participation** and efforts to engage citizens in policy-making on a partnership basis are rare, undertaken on a pilot basis only and confined to a very few OECD countries[24].

One issue, in considering what represents current best practice, is that terminology is not yet precise; specifically, the term "consultation" is often used to cover both:

- The type of situation with which the Ministry is concerned, seeking input from groups and/or individuals selected by the Ministry, in the expectation that they will have particular expertise, knowledge, networks and/or capabilities that will be of value in providing information for policy development and service monitoring; and
- Consultation in the sense of providing an open opportunity for the public to comment on policy proposals.

State Services Commission Occasional Paper No. 9 *Essential Ingredients – Improving the Quality of Policy Advice* provides an example of the broad meaning attached to consultation. In a section entitled "Encouraging Significantly Better Consultation as an Input to Policy Advice" the paper observes:

> "The term 'consultation' covers two distinct aspects in the policy development process in New Zealand:
>
> - *Consultation* among agencies with interests and responsibilities in the development of a particular policy or set of policies, in order to work through to agreement as to the best possible advice to be presented to Ministers.
> - *Consultation* with people and institutions in the community by agencies with interests and responsibilities in the development of a particular policy or set of policies, as an input to the formulation of their advice.[25]"

The occasional paper speaks of consultation partly in terms of the broad-based, open opportunity sense and partly in terms of dealing with people who have particular knowledge, stating that "policy development processes that do not take account of first hand knowledge of problems and of the implications and practicality of those solutions clearly carry risks of failure. Consultation – communicating directly with people and institutions with such first hand knowledge – is the logical way to bring this information into policy development. There is, in fact, little in the way of practical alternatives"[26].

In terms of best practice, certain common themes emerge whether the techniques being discussed are public consultation in the open sense, the use of advisory groups, or

[24] Organisation for Economic Co-operation and Development (2001b) p2

[25] State Services Commission (1999) p38

[26] State Services Commission (1999) p44

partnership relationships between (say) a government agency and the voluntary sector. They include:

- Clarity of objectives – the agency specifies what it is that it seeks from the process it is establishing and how it expects to make use of the input it receives from that process.
- Clearly stated roles and responsibilities – of greatest importance when the agency is tasking a particular group.
- Shared expectations – both parties are clear with each other on what they expect to gain from the process.
- Open and transparent communication – there is a free flow of information with at least an implicit agenda of building trust between the parties.
- The agency is not only clear about the purpose for which it seeks input; it also provides feedback on what happened to the input and why.[27]

Against that background we consider a number of option sets. We note that they are not intended to be seen as alternatives, but rather options each of which has its own particular value, and two or more of which might be adopted by the Ministry depending on its assessment of their potential value, and the resources available to fund and service the activity. The option sets are:

- Retain existing contracts with changes to reflect current practice and the needs of the parties.
- Advisory groups.
- Use of existing sector mechanisms currently servicing the needs of other sector participants eg DHB regional mental health networks.
- International innovations.

We also consider, as a separate issue, the implications of the community outcomes process under the Local Government Act 2002, including central government's decisions regarding departmental response to those provisions.

7.2 EXISTING CONTRACTS

In assessing the continuing utility of the existing contracts (either as they are currently worded and managed, or in some alternative form), a useful starting point is the Ministry's expectations of what it expects the contracts to achieve. Literature reviewing the nature of public participation in the public policy process identifies a number of different reasons for which a government or a government agency may seek public

[27] Different variations on these themes can be seen in materials such as *A Code of Good Practice on Policy Dialogue*, a publication of the Canadian Voluntary Sector Initiative; in *Stakeholder Relations in the Public Sector: Innovation in Management*, a collaborative study, prepared by the Allen Consulting Group with participation from 20 Australian commonwealth and state government agencies, *Health Canada Policy Tool Kit for Public Involvement in Decision Making*, published by Health Canada in 2000 and *Chartermark Standard*, a publication of the UK Cabinet Office Chartermark Group. A similar theme can also be seen in the New Zealand Treasury publication Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown although that publication deals with a much wider range of matters than simply input for policy making.

involvement. We quote from two pieces of work, one an Australian study examining existing practice across twenty commonwealth and state government agencies and the other a Canadian publication developed as a workbook for officials engaged in public participation.[28]

Australia

The Australian study included a discussion of the use of advisory groups.

The Australian Report notes that:

> "The functions that advisory groups are reported to serve are the following:
>
> - *Informing the government* – on both technical issues and the community's (or industry's) attitude on particular matters;
> - *Disseminating information* – they often have well structured networks for disseminating information quickly and accurately back to stakeholders;
> - *Political safety valve* – they may be used as a 'safety valve' which may arise because politicians feel obliged to give people the opportunity to express their views and concerns; and
> - *For leveraging or obtaining outcomes* – non-mandated advisory groups can be a strategic or tactical tool for leveraging/obtaining an outcome quickly.[29]"

Canada

The Canadian workbook identifies a number of reasons why government agencies may want to seek public participation. In this respect it has this to say:

> "While it may seem easier to simply forge ahead and make decisions on their own, there are many reasons why government and other sponsors are making increased use of direct techniques for public participation. Public participation can help to:
>
> - Enhance effectiveness:
> - get it right
> - decisions are complex (we need to understand and include all relevant information, views, needs, and interests)
> - implementation is improved with public consent and commitment
> - participation yields higher quality decisions
> - Meet a growing demand for public participation:
> - public desire to be involved in making decisions that will affect them.
> - need for greater openness of decision processes
> - mistrust of expert advice

[28] *Stakeholder Relations in the Public Sector: Innovation and Management, A Collaborative Study* prepared by the Allen Consulting Group, Australia in 1999, with input from twenty Commonwealth and state agencies, and a workbook, *Public Policy and Public Participation: Engaging Citizens and the Community in the Development of Public Policy*, prepared for the Population and Public Health Branch of the Atlantic Region of Health Canada in 2003.

[29] The Allen Consulting Group (1999) p30

- Resolve conflicts:
  - set priorities
  - negotiate trade-offs
  - seek consensus
- Increase fiscal responsibility:
  - establish priorities
  - find partners
- Enhance public knowledge, understanding, and awareness:
  - share information
  - opportunities for stakeholders to hear each other and better understand the range of views on an issue
- Meet legal and policy requirements:
  - international and national agreements
  - federal and provincial legislation and regulation
  - special rights of Aboriginal people
- Establish/solidify legitimacy:
  - participation is fundamental to democracy
  - counter public mistrust of the system.
- Allocate scarce resources.[30]"

7.3 THE PLACE OF THE CONTRACTS

The output requirements in the two contracts are expressed in broadly similar terms. Notwithstanding this, they can be seen as serving somewhat different purposes using the Australian and Canadian material just cited.

First, using the Australian classification, both contracts are clearly intended to inform the government. Neither contract, currently, involves disseminating information and neither is used for leveraging or obtaining outcomes.

On the fourth aspect, political safety valve, it seems likely that the SFNZ contract qualifies – so long as it is in place, there is at least the possibility that the Schizophrenia Fellowship, and people associated with it, will believe that they do have a channel of communication to the Minister/Ministry and utilise that rather than overtly more political means of making their views known.

The same does not seem to be the case for the MHAC contract. This is partly a function of the way MHAC members are selected – from feedback we received from different interviewees, it seems clear that MHAC is not widely recognised as representative of the sector or as being a means of effectively channelling sector views to the Minister. That perception reflects, as much as anything, both the wide range of differing views, interests and conditions covered by the mental health sector and MHAC's structure and coverage. Indeed, it may be impossible to structure a group in such a way that it is seen as sufficiently representative, by a sufficient number of stakeholders, that it can effectively act as a political safety valve for the sector as a whole.

[30] Smith, Bruce (2003) p35

Applying the Canadian criteria gives a somewhat different perspective. They come from a workbook which was completed in September 2003 and is thus based on current best practice. Assessing the SFNZ and MHAC contracts against the Canadian criteria draws attention to the change in practice regarding participation (contracting for public input) since the terms of those contracts were agreed. Thus, although both contribute to enhancing effectiveness, it would be difficult to claim for either that they represented public consent and commitment or that the mental health sector would see them as sufficient to establish/solidify legitimacy.

MDL, in its proposal to the Ministry, saw the review as focused on three separate but in some respects overlapping concerns for the policy process. Cited earlier in our report, we quote them again here as they are useful criteria for assessing the ongoing utility of the two contracts:

- Does the Ministry have available to it in a timely and appropriate manner the information it needs for effective policy making and service monitoring?
- Does the Ministry have in place the means required for effective monitoring of implementation?
- Do the systems in place for policy development and implementation generally support legitimacy – an acceptance within the mental health sector that government policy development and implementation is well focused, addressing the right issues, open to listening to sector interests, responsive and well coordinated.

Common themes came through from both contracting parties in considering how they could better meet these criteria. They included:

- Alignment with the Ministry's work programme – setting their own work programmes to meet current Ministry needs/priorities.
- Associated with this, clarifying the role and purpose of the contract.
- Inclusion of a feedback loop – with the Ministry giving SFNZ/MHAC information on how their reports had been used (perhaps including an assessment of their usefulness).

Other themes which emerged included:

MHAC

- Improved representation, eg Maori, primary health, NGOs, Pasifika peoples, alcohol and drug, DHBs, child and youth.
- Improved processes for nominating/selecting people on MHAC – including a clear representative structure.
- Expansion of the contract – for example intersectoral policy covering issues such as housing and employment (the social inclusion strategic direction).
- Creation of "mini-MHACs" tied into a regional structure.

SFNZ

- Expansion of the contract, eg, using reports/information to the Ministry under the contract to make submissions on behalf of families.
- Improve reports to the Ministry, for example looking at information across various reports to identify broad issues/trends.

7.4 COMMENT

The Ministry has put in place an appropriate means for addressing the question of alignment between the work undertaken under the MHAC contract and its own work programme. It has included in the MHAC contract a requirement that "the provision of strategic advice … is to be agreed upon by the Contractor and the Manager." The fact that it is now within the contract means that alignment can be achieved without the need for further amendment.

We understand that the Ministry considers there is a similar opportunity under the SFNZ contract as currently worded.

The common themes identified by both MHAC and SFNZ simply reflect current "best practice" as discussed above. They could be addressed by more explicitly adopting a relational contracting approach. This is an approach building on the way the Ministry currently regards the contracts, which places a strong emphasis on managing contracts – or rather the relationship they establish – in order to optimise the value for both parties. It represents a shift beyond the contract being treated as simply a means for receiving clearly defined components – specific advisory outputs; payment for services – to treating the contract as the basis for a relationship under which each party seeks to understand and act in the context of the needs of the other party (obviously within resource based limits) in order that each gains maximum benefit from the relationship. (See Appendix 2 for a discussion of relationship contracting adapted from an MDL report on contracting practices.)

A separate issue for the Ministry is whether it considers that it is in fact obtaining best value from the contracts with SFNZ and MHAC. The fact that the Ministry does not (at least as far as MDL has been able to establish) specify a work programme for either contracting party (although this is changing for MHAC with the new contractual provision), or have formal mechanisms to provide feedback on the material which each party produces under its contract, makes it difficult to judge whether the contracts contribute adequately to the three criteria set out above.

Each should certainly have the potential to do so. Specifically:

SFNZ

- The SFNZ contract should be able to provide the Ministry with input on the impact of schizophrenia[31] on individuals, their families and whanau, as well as on specific barriers they face – for example access to employment, education and affordable housing. It should also be able to provide information to support effective monitoring of implementation, especially given the regional coverage – but that requires a common understanding of what information the Ministry needs and how it will utilise that information.
- It should certainly contribute to the third criterion, that of legitimation but again, to do this, there needs to be an understanding within SFNZ itself of how its input affects policy – there is otherwise a risk that the contract will contribute to de-legitimation,

[31] Changes currently within the organisation could broaden the range of input.

if a sense develops that, despite the ability to provide input, nothing appears to happen.

MHAC
In contrast to the SFNZ contract, which is focused on a particular segment of the mental health sector, the MHAC contract is intended to provide a means for sector wide input – not that every project it undertakes should relate to the entire sector but rather that MHAC should have the capability to deal with any part of the sector.

Here, there are obvious gaps which are a function of at least two factors:

- The fact that MHAC develops its work programme independently of the Ministry and, apparently, without any strong understanding of the Ministry's current needs and priorities. (This should change with the application of the new provision regarding strategic advice).
- As MHAC itself notes, it has significant gaps in coverage.

One issue with MHAC is whether it sees itself (and is seen) primarily as an advisor to the Ministry, or as an advocate for the sector, underpinning its current relationship with the Minister. So far as the contract is concerned, that issue should be easily resolved by more active management of the relationship between the Ministry and MHAC through the contract, most specifically by developing an agreed work programme and feedback mechanism.

The larger question for the Ministry is whether MHAC, by itself, is able to meet the Ministry's sector wide needs for input to policy development, especially given the nature of the seven strategic directions. Factors this involves include:

- Resourcing – providing reasonable coverage of the mental health sector as a whole would involve greater resources than MHAC currently has.
- Capability. Does MHAC currently have the capability, given that it has itself identified a number of gaps in its coverage? Is that capability best addressed by enhancing the membership of MHAC, by establishing issues/direction specific entities (perhaps groups focused specifically on Maori and on Pasifika mental health needs) or by establishing a separate body.

7.5 SUGGESTED MODIFICATIONS TO EXISTING CONTRACTS

SFNZ

Given that the Ministry believes its provisions are adequate to provide for discussion of SFNZ's work programme, MDL does not consider that there is any need for amendment to the existing SFNZ contract. Instead, we suggest that the Ministry work with SFNZ to ensure, within the Ministry's own resource constraints, that SFNZ has a sufficient understanding of the Ministry's own work programme and priorities so that SFNZ can design its work programme under the contract with a better awareness of what the Ministry requires. It would be useful, also, if the Ministry were to provide SFNZ with feedback on how its reports are used and what happens to any recommendations they contain.

With better alignment between SFNZ's work under the contract, and the Ministry's own work programme (including feedback from the Ministry to SFNZ) we consider the contract should deliver reasonable value both in terms of providing information, maintaining relationships with a component of the mental health sector which does have issues of real concern, and helping build legitimacy for the policy development and service monitoring process (because of its role in relation to families, SFNZ could be particularly well placed to provide input for the social inclusion strategic direction).

Finally, we comment on one point that has been made to us; why should SFNZ be singled out to have such a contract with the Ministry whilst other NGOs do not. If there were no contract with SFNZ, we doubt that a case would be made for putting one in place. The fact that one does exist, and has been in place for more than 10 years, creates a different dynamic. It has become a valued part of the Ministry's support for this part of the sector. Its withdrawal would have a significant and potentially negative impact both on SFNZ and on the perceived legitimacy of the Ministry's policy process.

If there were no contract, then the onus of proof for establishing one would rest with those arguing to put it in place. With an existing contract, we suggest that the onus rests with those arguing that it should cease – that is, that the contract fails to deliver value. As will be clear from this report, our assessment is that the contract probably does deliver value but that it would benefit from the recommendations for better alignment and feedback.

MHAC

Three options are considered for the future of the MHAC contract. Two are based on a standard contracting model – where the focus is on the purchase of defined outputs. The third has a stronger focus on outcomes for the contracting parties, whilst still recognising the importance of the outputs the Ministry receives. This is a relational contracting model.

In more detail, the focus of a standard contracting approach is on defining outputs, the terms and conditions under which they will be delivered, measures of delivery (KPIs) and the consequences of non delivery. In current practice, it is an approach which is seen as most appropriate for one-off purchases of standard items.

A relational contract recognises that, whilst the defined outputs are still central to the contract, it is appropriate to recognise that the contracting parties are engaged with one another because each has outcomes which it wishes to achieve and the relationship between the two of them, through the process of delivering the outputs, will contribute to this. It recognises that, over and above the delivery of particular outputs at a particular time, the parties are establishing a long-term relationship and will gain value in ways other than just the delivery of and payment for outputs. Typically a relational contract includes provisions reciting how the parties will deal with each other and will use tools such as consultation and mediation, rather than sanctions such as termination or non-renewal, to deal with any failures in performance.

The comments on the MHAC contract recognise that MHAC, as an entity, sees itself as undertaking three separate roles; provision to the Ministry of input for policy advice

pursuant to the contract between MHAC and the Ministry, advocacy activity on behalf of the mental health sector, and advice to the Minister of Health.

The Ministry's mandate, in dealing with MHAC, is restricted to purchasing input for policy advice. It is expressly prohibited from contracting for the provision of advocacy services. Any contractual relationship between MHAC and the Minister for advisory services is a matter for the Minister, not for the Ministry (MDL understands that, in fact, there is no contractual relationship between the Minister and MHAC; simply an intent on the part of MHAC carried through in the way in which it seeks to work with the Minister, that it should be seen as an advisor on mental health issues).

The discussion which follows deals with three options the Ministry might consider in order to ensure that purchasing input for policy advice from an entity that sees itself as having other roles as well is managed so that the integrity of its policy advice process is not put at risk.

The following table describes the three options and how each would deal with the three separate roles of MHAC as a contracted provider of input for policy advice, an advocate for the mental health sector, and an advisor to the Minister of Health.

MHAC: Contracting Options

Option	Roles	Pros and Cons for the Ministry
1. The current contract. The focus is solely on the two specific outputs required from MHAC. The contract does not address the second and third roles. It does provide for the contractor and the Manager (the Ministry) to agree on the strategic advice to be provided and for the contractor to use its best endeavours to accommodate specific requests for service monitoring and attendance at meetings with officials.	• Policy advice – mechanisms exist for adequate definition of the Ministry's requirements. Quality standards are spelt out. • Advocacy and ministerial advisory. Neither role is addressed within the contract.	The contract provides the Ministry with a significant window into the sector and the means, if it chooses to use it, to get a focus on particular issues (whether for policy or service monitoring). Feedback confirms that the existence of the contract, and the regular contact between people represented on MHAC, and the Ministry, both support the Ministry's leadership role within the sector and provide the potential to add to the legitimacy of the Ministry's policy role. Principal drawbacks (cons) are: • Coverage is not total as MHAC members themselves do not cover all components of the mental health sector. This is a drawback only to the extent that the Ministry has no other channels of input available to it (it applies equally to each of the other two options discussed and so is not dealt with in relation to them). • The contract does not deal with MHAC's advocacy and ministerial advisory roles and thus exposes the Ministry to the risk that MHAC's discharge of those roles may conflict with or create difficulties for the Ministry's objectives. Specifically, MHAC may be both providing advice for policy input and using that same material to advocate publicly or to ministers for change in ways that may conflict with or pre-empt Ministry advice.

2. Amended current contract. The current contract could be amended to deal specifically with the relationship between MHAC's role of providing input under contract with the Ministry, and its advocacy and ministerial advisory roles. Any amendment should be explicit that the Ministry does not fund either the purchase of advocacy services or the purchase of ministerial advisory services (at least through the current contract or any amendment of it).	• Each of the three roles would be dealt with within the contract.	The advantage of this approach is that the potential for conflict is specifically dealt with and means of resolution clearly understood by both parties.
A "soft" amendment would be a "no surprises" clause under which MHAC agreed with the Ministry that it would not either undertake advocacy activity, or advise the Minister, in respect of any matter on which it had provided input to the Ministry for policy development or service monitoring purposes without first advising the Ministry – and this could include a timing provision so that MHAC could not act until the expiry of a defined period after advising the Ministry.		There is a potential disadvantage, which is lesser for the "soft" than for the "hard" option. MHAC's mission statement identifies it as an advocacy organisation. This role has been stated in each of its reports to the Ministry. Attempting to constrain that and the related ministerial advisory role could have a negative impact. With the "soft" approach, that impact should be manageable – because the Ministry would not be saying to MHAC you can't do it, it would simply be saying we need to know when you are doing it and on what aspect of policy. It is possible that MHAC would see this as an attempt by the Ministry to pre-empt what it sought to do by getting in first, but working through with MHAC the requirements for effective policy advice should manage this – as MHAC itself will know that its interests lie not in winning the occasional point ahead of the Ministry but rather in the long term integrity and output of the policy process year on year.
A "hard" option would make it a condition of the contract that MHAC not undertake advocacy or ministerial advisory activity on any matter on which it had provided, or was expected to provide, input for policy advice or service monitoring.		The "hard" option is a more difficult one. It would effectively exclude MHAC from an advocacy or ministerial advisory role as the contract contemplates that MHAC will provide policy input and service monitoring across the spectrum of the sector.
3. A relational contract. Under this approach, the required outputs could still be specified as they are in the current contract. Changes would come in the way that the contract gave specific recognition to the outcomes important to each contracting party: • For the Ministry, to be able to provide free frank and informed advice to the Minister with a minimal risk of disruption to its process. • For MHAC, to be an effective voice on behalf of the mental health sector in the development of mental health policy, something that would include being able to demonstrate to the	• Each role is appropriately dealt with.	The Ministry gets a clear recognition by MHAC of the outcomes it seeks from the contract – not just the outputs. A basis is set for a mutual understanding of (a) the context in which the Ministry provides policy advice to the Minister and (b) how each party can assist the other achieve the outcomes it seeks. A possible con is that a relational contract, of its very nature, requires more intensive management which would require commitment by the Ministry of staff resources who would see their function as building and maintaining an effective and trust based relationship within MHAC. A further possible drawback (con) is the fit with the Ministry's organisational culture and accountability arrangements. It is a different style of contracting, and may not

sector that it is an effective voice. This would include a recognition in the contract that MHAC, as well as providing input for policy advice and service monitoring to the Ministry, also acted as an advocate for the sector and provided advice to the Minister. The contract should include protocols regarding how these two roles would be managed by MHAC so as to avoid (minimise?) any detriment to the Ministry's policy advice role. The contract would include explicit "good faith" commitments by each party to the other including a provision that, if either party had any concerns regarding the other's conduct, that concern would be raised directly and the parties would seek to resolve it through discussion (and perhaps mediation if that level of formality were seen as desirable).		fit well if the Ministry's preferred approach is one of compliance/sanction against detailed provisions of a contract.

One issue, of clear concern both to the Ministry and to MHAC, is the extent to which MHAC is representative of the mental health sector. A possible option for dealing with this is to structure MHAC so that it is seen as genuinely representative of the entire mental health sector. The Mental Health Council of Australia (MHCA) has been suggested as a possible precedent.

MHCA is a very different entity from MHAC. Not only is it structured to be representative of the mental health sector; it operates with a significant full time staff and a budget (for the year ending 30 June 2004) in excess of $A1.2 million.

The MHCA structure implicitly makes a significant point about representativeness in a sector which is policy intensive. Representativeness is not just about coverage in the formal sense of a membership which reflects, or has direct linkages back to, all of the significant interests within the sector; it is also a function of effectiveness – does the body have the resources (both financial and non-financial) to be an effective representative?

Again, this comes back to the Ministry's objectives. Is it looking for a body or bodies which primarily acts as something that can be used as a channel of communication (but inevitably resource constrained), or is it looking for a body that is capable of providing the Ministry with an independent and well researched perspective?

We are aware that the Ministry has had concerns about MHAC's performance in terms of deliverables. The Ministry requires but considers that it is not getting coordinated advice. MHAC was late in providing feedback on the Second National Mental Health and Addiction Plan. Both of these concerns can be seen in a context in which MHAC receives very little funding – a level that may have been appropriate in the circumstances of the mid 1990s

when the movement for increased public participation was just starting to gain momentum but which may not be appropriate now if the Ministry requires comprehensive and coordinated advice from the sector.

7.6 ADVISORY GROUPS

Advisory groups provide an apparently attractive alternative means of obtaining input into the policy process.

They offer the opportunity to determine the terms of reference, decide the qualifications required for membership, and select members accordingly. Well used, they can be a very effective means of providing a government agency with a well informed and well networked group capable of significantly enhancing the agency's awareness of current developments both in research, in public perceptions, in changing needs, and in the effectiveness of current policy initiatives.

However, their very flexibility can create difficulties. Their effective use requires the establishment of clear ground rules. As an example, the Allen Consulting Group report cited above (footnote Page 45) reports the following critical success factors for the use of advisory groups, as derived from its discussions with the twenty commonwealth and state agencies that participated.

CRITICAL SUCCESS FACTORS FOR ADVISORY GROUPS[32]

Critical Success Factors:	Explanation
Clear objectives and agenda	Clearly identified objectives and agendas provide: • Focus and direction. Ideally, both broad and detailed objectives are specified. For example, a broad objective would specify whether the group is required to take a national/state/regional focus. • A synchronised approach between the department, the Minister and the advisory group. This is important if all parties are to own the final product/decision.
Clearly stated roles and responsibilities	Roles and responsibilities need to be clearly articulated. Roles such as policy adviser, policy developer, or policy manager/implementer will clearly influence the relationship between the advisory group, department and Minister. Clearly specified departmental roles and responsibilities are a prerequisite for functions and responsibilities to be delegated to advisory bodies.
Clearly identify the constraints/ boundaries of the group	Placing constraints and boundaries on the issues that the advisory group is to deal with provides and reduces potential work program

[32] The Allen Consulting Group (1999) p31

	conflicts with the department and the Minister(s). Specifying a timeframe can be important for maintaining focus and momentum.
Select/appoint the right people for the right job	Selecting the right people for the advisory group is crucial for achieving the groups purpose and objectives. Factors that need to be considered include: • Representativeness: what stakeholders do you want representing what issues? For example, do you want representatives from peak associations and lobby groups or is it more appropriate to have direct business people rather than association executives, grass root stakeholders or academics. • Knowledge and skills: the skills and knowledge of the advisory group need to be considered in relation to the objectives, roles and responsibilities. For example, one department noticed that CEO's were not the best people for 'ground level' knowledge, but had sound knowledge of private and public sector interactions and could see the 'big picture'. The chairperson can make or break the effectiveness of an advisory group. Selecting a person for this position should consider their personality in relation to the approach required (ie the 'Hawke approach': building a consensus; or the 'Keating approach': crash through or crash).
Be prepared to listen and learn	Advisory group recommendations must not only be considered but implemented where possible (and the link to advice should be acknowledged); where not, feedback on the reason is important to maintain advisory group 'buy-in'. If the group perceives that its advice is not relevant, it will lose respect and interest in the process.

Note: The reference to "direct business people" in the select/appoint critical success factor reflects the fact that a number of the agencies contributing to the Allen report were dealing with the business sector. The equivalent, for the mental health sector, would be people directly engaged in service delivery.

As an example of the concerns that the use of advisory groups can create, *Citizens as Partners: Information, Consultation and Public Participation in Policy Making*, a report published by the OECD in 2001, records an American legislative response to the growing use of advisory committees in the following terms:

> "The Federal Advisory Committee Act (FACA). Growth of government also caused a proliferation of boards and commissions with substantial authority and the growing use of informal advisory groups. These advisory committees often wielded substantial influence over policy by virtue of their secret, direct access to decision-makers up to and including the President. FACA gives the public access to the deliberative processes of so-called multi-member agencies (eg regulatory boards, commissions, and advisory committees). It requires that agencies declare the existence of any advisory bodies that they create, and that those committees be "representative" of the affected constituencies. It further requires

> that meetings of boards, commissions, and advisory committees be announced and open to the public. Agencies may close meetings only if they fit within one of the series of exemptions similar to those in the Federal Official Information Act. But even then, agencies must announce that such a meeting is planned and the reason for not allowing it to be open to the public.[33]"

Here, the concern was that the lack of transparency in the operation of advisory groups was giving rise to significant distortions in the policy process. Other sources have noted the potential, for example, for the membership of advisory groups to be manipulated – for example by appointing people who are in favour with the government of the day and/or by appointing people who are thought to be "safe" rather than people who may be quite trenchant critics of current policy settings.

The advisory group option offers considerable potential for input into policy process, especially in terms of filling the gaps in the current MHAC coverage – for example the relative lack of Maori and Pasifika input. It is an option which should be implemented only after the adoption of clear protocols regarding the selection and operation of advisory groups.

An Example

The Pharmac Consumer Advisory Committee provides an example from within New Zealand's public health sector of the use of an advisory group.

Pharmac is required by the Public Health and Disability Act to establish a Consumer Advisory Committee "to provide input from a consumer or patient point of view". Members are appointed by the Pharmac board. When first set up indications of interest and names were sought widely, from Pharmac's database of consumer groups and also by advertising.

The Committee has a proactive role in identifying issues to work on, albeit that agendas are set with Pharmac staff input. It is able to open up issues on its own initiative.

A key element in the value of the Committee is that it reports to the Pharmac board, and the terms of reference place a reciprocal obligation on the board to take the Committee's reports into account.

The Committee has come to have a tangible impact on the board's decision-making, on matters ranging from access to, pricing of and use of medicines, prescribing, patient information and Maori responsiveness. The Committee also seeks and receives information from Pharmac on matters of consumer interest which goes into the Committee's deliberations and on which members can seek feedback through their own networks.

The Committee is intended to represent the interests of health consumers, but nevertheless is small. The current committee of seven reflects Maori, Pasifika, women's health, older persons, mental health and parent interests. This has been one factor in its ability to provide effective input. Another is that it is well resourced and supported, with

[33] Organisation for Economic Co-operation and Development (2001a) p165-166

a mandate to engage and consult with the community and consumer groups and work with special focus or interest groups.

Importantly, there is a very good relationship between the Committee and the board, and particularly with the board chair. Communication between the committee and the board is active and includes each providing the other with feedback. The prescriptive terms of reference (which, for example, include specifying when the Committee is to meet) have not hindered the development of a high level of goodwill on both sides. The practice is for the Committee's chair to join Pharmac board meetings to discuss the Committee's reports.

As well as reporting to the Pharmac board, the Committee communicates directly with the Minister of Health and the Ministry, and may make recommendations or urge action on issues affecting consumers.

7.7 UTILISE ESTABLISHED NETWORKS/FORUMS/GROUPS

DHB Networks

One prominent feature of the mental health sector is the existence of strong local and regional networks. Earlier in the report we have described the four regional mental health networks (Part Five).

They draw their strength from the local DHB networks, which feed into them. The Counties-Manukau DHB provides an example of the working of a network at the local level. Its stakeholder network brings together twenty people covering age groups, primary, secondary and tertiary population groups and also consumers (including substance issues and families). They have a strong structure, good exchanges of information and are supported by an executive officer.

They meet six weekly to discuss priorities. Meetings are attended by two DHB board members.

Critical success factors for the network include strong chairing, investment in an executive officer, being consistent (eg no substitutes at meetings), DHB attendance and stakeholders clearly expected to disseminate information (it is explicit that this is a role and responsibility for stakeholder group members. NGOs on the group are expected to do this not just within their own organisation but to other NGOs not on the group).

Counties-Manukau's local stakeholder network contributes to a regional stakeholder group which is part of the Network North Coalition. It focuses on the regional plan and looks at strategies for the region, for example workforce development strategies.

Local stakeholder networks differ considerably one from another but have common objectives of providing comprehensive coverage and are typically well supported by their DHB.

Regional networks, rather than local stakeholder networks, were suggested as a possible alternative means for the Ministry to obtain input for policy development. One reason for

preferring regional networks is that there are only four, as compared with the 21 local stakeholder networks (one for each DHB).

The suggestion has merit, especially in the context of developing additional advisory groups. It would need to be managed with some care. Among the issues that would need consideration are:

- Ensuring that there was a clear distinction between the regional role – which is essentially input into DHB planning, service delivery and monitoring – and a national role, providing input for the Ministry for policy development.
- Ensuring that giving regional networks a role in providing input to the Ministry did not compromise their effectiveness at a regional level. For example, would some DHBs, on at least some issues, feel less able to be frank in their discussions with regional networks if they felt that the information concerned might feed back directly to the Ministry?

It should be possible to manage these concerns, if the Ministry is attracted to this option, by agreeing with DHBs the basis on which networks could be a source of input for the Ministry, especially as the DHBs themselves have a vested interest in the Ministry having good input on many aspects of mental health policy and service delivery. There would probably need to be an understanding on how networks provided any input in respect of DHBs themselves to avoid undermining the basis of their relationship with DHBs.

Other Forums/Groups

As the Ministry will be aware, there are a range of other groups within the mental health sector that are seeking to establish themselves as having a sector wide perspective rather than simply a perspective on behalf of a single region or a single issue. A number of these have indicated their interest in being recognised by the Ministry as potential sources of input. In MDL's view doing this would form part of a strategy to develop a broader advisory group network, and would be subject to developing appropriate protocols and terms of reference as well as being satisfied that acting as a source of input for the Ministry would not compromise a group's other activities.

7.8 SOME INNOVATIVE EXAMPLES

In this part of the report we outline three innovative examples, all of which may have some relevance for the Ministry's needs. All examples, interestingly, are Canadian. They are:

- The Voluntary Sector Initiative.
- The Public Policy Forum.
- Voluntary Planning.

Each initiative is targeted at a "whole of government" approach – in other words, the focus is on cross-sector policy input - in two cases (the Public Policy Forum and Voluntary Planning) across the full spectrum of government policy; and in the other case, the voluntary sector initiative, across the spectrum of relationships between the voluntary sector and the federal government.

The Public Policy Forum (www.ppforum.ca)

The Public Policy Forum was founded in 1987 to provide a neutral venue where the private sector and the public sector could meet to learn from one another.

From an original base of eight the forum now has over 150 participating organisations that cut across all sectors of society – business, labour, academia, government, the voluntary sector and the media.

Its mission is to strive for excellence in government – to serve as a neutral independent forum for open dialogue on public policy and to encourage reform in public sector management.

The forum's website identifies four key factors which it considers make it a unique organisation within Canada. They are:

- A resolute belief that high quality government is critical to Canada's quality of life as well as to its prospects as a competitive nation in the global economy.
- Its reputation as a neutral, trusted facilitator. It provides a meeting place where diverse and often opposing opinions and interests can be aired openly and debated, and opportunities can be sought for mutual understanding and collaboration.
- It does not sit in judgement on what government does but instead looks at how public policy is developed and how the public service is managed.
- Finally, it bases its mandate on seeking membership that represents all sectors in Canada.

The model is distinctly different from any of the participants in public policy debates within New Zealand. In contrast, for example, to the New Zealand Business Round Table, it scrupulously avoids any appearance that it represents a specific sector interest. Its publication record suggests that it does indeed play a significant role in the development of public policy within Canada.

A New Zealand equivalent could certainly play a useful and innovative role in the development of health policy. However, given its scale and scope and the nature of the interests incorporated within it, it is almost certainly beyond the scope or role of the Ministry of Health, let alone the Mental Health Directorate, to seek to act as the catalyst for establishing a New Zealand equivalent. It is, though, worth being aware of as an example of how to get broad based input on public policy.

The Voluntary Sector Initiative (www.vsi-isbc.ca)

The Voluntary Sector Initiative grew out of a group established in 1995 by 13 national umbrella voluntary sector organisations as the Voluntary Sector Roundtable. In 1997 the VSR convened the Panel on Accountability and Governance in the Voluntary Sector. That Panel reported in 1999 with a number of recommendations for the voluntary sector and for governments with the goal of enhancing the effectiveness and credibility of the sector.

Following the release of that report, the VSR encouraged the creation of a joint Government of Canada/Voluntary Sector Process to work on three areas of common

concern; building a new sector/government relationship, strengthening the voluntary sector's capacity, and improving the regulatory environment in which the voluntary sector operates.

The response by the government was to provide funding for what is now known as the Voluntary Sector Initiative.

One of the outputs from the Voluntary Sector Initiative is the Code of Good Practice on Policy Dialogue which was promulgated in October 2002. The code is based on the following shared principles:

> **"PRINCIPLES UNDERPINNING THE CODE**
> Building on the Accord, this Code is based on the following shared principles:
>
> **The Voluntary Sector's Value**
> A healthy and active voluntary sector plays an important role in helping the federal government identify issues and achieve its public policy objectives. By its very nature and particularly because of its connection to communities, the voluntary sector brings a special perspective and considerable value to its activities, including those it undertakes with the Government of Canada.
>
> **Mutual Respect**
> Both sectors will listen to and consider the views of all participants and respect their legitimacy and input.
>
> **Inclusiveness**
> Both sectors will involve the broadest possible range of groups or individuals who may be affected by a policy or who can make a meaningful contribution to the debate. Increasingly, policy development must take account of the specific needs, interests and experiences of the diversity of the voluntary sector including, for example, groups representing women, visible minorities, persons with disabilities, Aboriginal people, linguistic minorities, sexual orientation, remote, rural and northern communities and other hard-to-reach subsectors. Policies must also respect the *Canadian Charter of Rights and Freedoms*, the *Canadian Human Rights Act*, the *Employment Equity Act*, the *Official Languages Act*, the *Multiculturalism Act* and the *United Nations Universal Declaration of Human Rights*, as well as Canada's obligations as a signatory of relevant international treaties and conventions, for example, on the rights of children, women and indigenous peoples. Policies must also respect all amendments, extensions or replacements to these laws and policies.
>
> **Accessibility**
> Both sectors will take the appropriate measures to ensure that all those invited to participate in a dialogue have access to the process. This will take account of factors such as language, region, distance, ethno-culture, religion, socio-economic background, age, knowledge or capabilities.

Clarity
Recognising that a clear mutual understanding of the objectives, purpose and process of participation and feedback is vital, both sectors will establish the terms of the policy dialogue in advance and communicate them to participants.

Transparency
To build trust, both sectors will establish open lines of communication, provide information readily and invest in working relationships. Participants must clearly understand the context within which each decision will be made, including the scope of and limitations on dialogue.

Responsibility
Both sectors will participate in good faith and recognise that adequate resources and time are required for an effective process.

Accountability
Both sectors will provide feedback to their respective constituencies on the full range of views expressed, and clearly communicate how this input has been considered in the public policy process.[34]"

New Zealand has an approximate equivalent to the Voluntary Sector Initiative with the Office for the Voluntary and Community Sector which provides advice to government agencies on how to manage relationships with the voluntary and community sector. It does not, however, appear to encompass an ongoing relationship which falls short of partnership and so does not cover the territory encompassed by the Canadian Code on Policy Dialogue.

Theoretically, the equivalent of the Canadian code could be adopted by the Mental Health Directorate, or the Ministry as a whole, to govern its relationship with those sectors with which it deals (the fact that the Canadian code deals solely with the voluntary sector would need to be addressed as, presumably, the Ministry would be seeking input not just from the voluntary sector but also from academics, researchers, practitioners and consumers).

We identify two principal barriers to adopting the code model. They are:

- Of its very nature it represents a commitment to deal with anyone who identifies themselves as a stakeholder. It has the potential, therefore, to become quite resource intensive – but this could be dealt with by drafting the code so it applied only to those situations where the Ministry and another party – an NGO, a consumer representative, a practitioners' grouping or an academic institution – had indicated a wish to become involved in providing policy input.
- It may raise "whole of government" issues suggesting that this type of approach would be best adopted not by a single Ministry, but on behalf of government as a whole.

[34] Voluntary Sector Initiative (2002) p6-7

Voluntary Planning (www.gov.ns.ca/vp/)

Voluntary Planning is a Nova Scotia (Canada) based entity which describes itself as a citizens' policy forum. It is constituted as a government agency under its own legislation.

It occupies a unique place in public policy debate. Voluntary Planning's mission is "to measurably improve the social, economic and environmental well-being of all Nova Scotians by providing the Premier and Cabinet with valuable volunteer and citizen-based advice on relevant policy issues for today and for the future."

Voluntary Planning began in the 1960s as an economic planning agency but over time has evolved to encompass the full spectrum of public policy. It operates through a small professional staff and a network of volunteers, contributing through 6 broadly defined societal sectors: economic growth and competitiveness, education and lifelong learning, environmental quality and stewardship, fiscal management policy, health and social well-being and natural resources.

Its strength is its unique combination of perceived independence (operating under a board of directors all but one of whom come from outside the government sector) and mandate to manage, on behalf of the provincial government, citizen participation in debate over public policy issues – with the work programme itself being set in conjunction with the Treasury and Policy Board. It is funded by the Nova Scotia government through the Treasury and Policy Board.

What it is able to offer both the provincial government and the citizens of Nova Scotia is a combination of:

- Expertise: Voluntary Planning has built up considerable experience in facilitating citizen participation and providing informed input, based on that, to the provincial government's policy development process.
- Independence: it is sufficiently distant from the provincial government (by virtue both of the independence of its board and its established track record), that its involvement can be seen as basically free from political interference. It supports this by publishing and adhering to a set of guiding principles for citizen engagement. Those are:

  "Guiding Principles for Citizen Engagement
  In carrying out its work, Voluntary Planning (VP) will observe the following guiding principles:

  1) Recognition of the interests of Stakeholders, Citizens and Communities:
     a) Communities, citizens and stakeholders are categories having a direct concern or interest in the decision or policy under discussion.
     b) Stakeholders are persons or groups who are likely to be impacted in a specific manner or (conversely) may be able to impact the decision or policy under discussion.
     c) "Community" may exist as geographic entities, or communities of interest(s).

d) The VP process will strive to ensure fair, comprehensive and equitable representation of stakeholders, citizens and communities in its consultation and engagement programs.

2) Inclusive:
Voluntary Planning will strive to ensure the opportunity for diverse citizen participation by including variation in social class, gender, race, ethnicity, religion and age. Particular attention will be given to inclusion of First nations people, women, persons with disabilities, African Canadians and members of racially visible groups.

3) Respectful:
   a) VP will ensure the purpose and objectives of its consultation and engagement activities are clear to participants.
   b) VP will foster a respectful atmosphere in its public consultation and engagement processes. A respectful atmosphere is one that enables participants to: have open dialogue; freely express ideas; achieve clear understanding, and; avoid premature judgement.
   c) VP will adopt ground rules appropriate for the issues and for the needs of participants.
   d) VP will design engagement activities to avoid or remove barriers, as much as possible, which may inappropriately limit stakeholder or citizen participation.

4) Objective:
   a) Besides citizen engagement, the VP process includes a commitment to independent research and the solicitation of non-stakeholder expert opinion. In blending research, expert opinion and consultation, the VP process will always strive to be objective and fair in considering the input of all parties.
   b) The VP process is an enabler and advocate for citizens as a vehicle through which relevant and important information can be gathered, clarified and distilled, leading to the formation of particular recommendations.

5) Responsive:
The VP process will always undertake a response to participants such as through reports and/or set of recommendations reflecting the public input.[35]"

Voluntary Planning operates at a "whole of government" level, managing citizen participation processes across the full spectrum of public policy. The model, though, is one that could readily be adapted to meet the needs of a particular sector or sub-sector of public policy – for example social policy, as embracing health, education, housing, social development etc, a sub-set of social policy, such as health, or a sub-set of health such as mental health.

The essence of the model is the existence of an entity which is seen as independent of government – in the sense that its governing body is appointed from outside government

[35] Voluntary Planning (2005) p2

with an expectation that it will adopt an apolitical approach – but with a mandate to manage citizen participation for a defined area of public policy.

It is a model which has the potential to offer a number of benefits, both to government or a government agency, and to the interested public for reasons including:

- With a measure of permanency, it has the ability to build up expertise in managing citizen participation and engaging with the policy process.
- With a structure designed to underpin its independence it is, to a degree, insulated from concerns over political influence.
- It can be designed to ensure that different aspects of citizen concern can be adequately accommodated without undermining the focus of the organisation as a whole – within Voluntary Planning, this is achieved by the existence of a number of sector groups (defined by policy area). A similar approach could be taken in a New Zealand context – that is defining by policy area. Alternatively, sector groups could represent particular interests, eg, Maori and Pasifika peoples.

In terms of innovation in means for obtaining (enabling) public input into the policy development process, this is the most interesting and potentially most useful model of which we are aware.

Its main downside is that it would represent a significant investment as compared with (say) establishing one or more advisory groups as it would represent a commitment to putting something in place for the long term and ensuring that it was adequately resourced at a professional level – even although the overarching objective would be to facilitate voluntary engagement.

7.9 LOCAL GOVERNMENT ACT 2002

The Local Government Act 2002 introduced a new role for local government, and a new set of processes, intended to facilitate agreement on outcomes at a community level (regional and local) and on the means for realising those. Government's intention in introducing the legislation included establishing a means for closer co-operation and collaboration between different government agencies at the regional and local level, and between regional and local communities and government agencies.

Under the outcomes process both regional and territorial local authorities are required to put in place a process for identifying community outcomes and, as part of that process, to engage other groups and organisations capable of influencing the identification or implementation of those outcomes.

The legislation makes it clear that what is at issue is the outcomes the community seeks, not just outcomes within the area of responsibility of the local authority.

Accordingly, it includes outcomes across the full spectrum of community interests ranging from economic and social development, to health, community safety and so on.

The process is of relevance to the question of sector input into mental health policy in at least two ways:

- It can provide a very useful complementary process to that of district and regional planning within the health sector.
- It can support the cross-cutting elements of the strategic directions in the new mental health strategy, such as social inclusion.

In terms of setting regional or local outcomes the primary participants from the government component of the health sector should clearly be District Health Boards. Some DHBs are already seeking to engage with the community outcomes process within their own districts.

The outcomes process also offers an opportunity for central government agencies, even those which are not widely represented "on the ground", to become engaged, both as a means of gaining a better understanding of needs and opportunities within any given region or district, and as a means of making it clear what government may be able or prepared to offer in the policy area for which the agency is responsible.

The rationale for central government agency engagement was set out in a paper to cabinet government policy committee in the following terms:

> "If departments do not engage in COPs there is a risk that communities will not have adequate information to appropriately identify their future well-being outcomes, and they might build up unrealistic expectations about what government can and should do to help achieve these outcomes. COPs provide opportunities for central government to collaborate and benefit from the process. All central government agencies will have the opportunity to communicate Government's goals and priorities from their relevant sector, provide information they may have about communities and their agency's activities, and raise awareness of particular issues. Those that participate directly in COPs can listen to community concerns, help clarify local issues, explain what agencies are doing in the community, and manage expectations about what central government can and cannot do.[36]"

In MDL's assessment, it would be difficult for the Mental Health Directorate, on its own, to become actively engaged in the community outcomes process. There would be an expectation for other participants that, if the Directorate was becoming engaged, so should the rest of the Ministry.

Instead, we recommend that the Ministry maintains a watching brief on developments with the community outcomes process, including emerging practice of central government and DHB engagement. We note that, as far as central government engagement is concerned, the lead agency with responsibility for monitoring evolving practice is the Department of Internal Affairs.

[36] Office of the Minister of Local Government (2004) p3

7.10 USING THE DIFFERENT OPTIONS

The different options discussed in this section are not mutually exclusive. Each (with the suggested exception of the public policy forum) could well have its place in the Ministry's future strategy for obtaining input for policy advice and service monitoring.

We discuss each in turn.

Existing Contracts

MDL sees no case for terminating either of the existing contracts. They provide useful connections with the sector and should be seen as part of the Ministry's legitimation process.

The Ministry should continue to use, in respect of the MHAC contract, the requirement for the provision of strategic advice to be agreed upon by the contractor and the manager and the equivalent provisions within the SFNZ contract. As part of this, there would be merit in moving toward a more relational approach in the management of the contracts, including feedback to each contractor (which is at least partly provided, in respect of the MHAC contract, by the attendance of the Director of Mental Health or other senior official at MHAC meetings).

Finally, the Ministry should decide how it wishes to manage the MHAC contract to minimise the risk of any conflict between MHAC's role under the contract, and its advocacy and ministerial advisory activities.

Representativeness

This is an issue specific to MHAC; should it be restructured so that it is more genuinely representative of the mental health sector as a whole? A decision on this would require a sufficient understanding of the different components of the mental health sector to determine how they would respond to the proposition that MHAC should, in essence, be seen as a peak organisation representing their views to the Ministry. Would this be acceptable to Maori? To Pasifika peoples? To interest groups such as those concerned with alcohol and drugs?

A related issue is the potential for the local and regional networks taking shape under DHBs to provide that representativeness (subject to avoiding any conflict with the role they have in relation to DHBs).

On balance, MDL's view, based on the information available to is, is that there would be sense in considering two possible options:

- The extension of MHAC's coverage seeking to position it as the representative body for the mental health sector.

- The creation of a separate peak body to undertake this role.

Either option would require much more careful consideration of matters such as the reaction of different interests within the sector, the resource requirements (including the

Ministry's capacity to deal with a much better resourced peak organisation), and the implications for other existing bodies (eg, the Mental Health Foundation) and emerging structures (eg DHB networks).

A further factor to consider is whether representativeness is best achieved through a single peak structure or through drawing on a range of different options. The single peak structure can look much tidier but has about it elements of "putting all the eggs in one basket." An alternative is to use a variety of sources – MHAC itself, advisory groups, DHB networks, depending on what the Ministry's specific need is. The deciding factor is likely to be the extent to which, and how often, the Ministry believes it needs the support of a genuinely pan-sector view as opposed to exercising its leadership role to formulate from different sources what it considers is a fair representation of sector views.

Advisory Groups

These are most appropriate when the Ministry is seeking an ongoing source of advice based on particular skills rather than on representativeness (although by their nature, skills may carry with them an element of representativeness). It is a good means of providing the Ministry with an alternative perspective in any area where it considers that the channels of information otherwise available to it may not result in it being as fully informed as it needs to be.

As material cited earlier in this report emphasises, any decision to establish advisory groups should be preceded by the development of clear principles for their operation, and their relationship with the Ministry.

Normally, they should be seen as issue specific and non-representative – the essence of this latter point being that the members of an advisory group, themselves, would not carry any obligation to report back to other organisations; rather their role is one of assisting the Ministry improve its understanding.

DHB Networks

From the information available to MDL, DHB networks in mental health are still evolving with each of the four regions developing somewhat different approaches and those approaches themselves under review.

Although arrangements differ from region to region there is a common intent of providing DHBs locally and regionally with comprehensive coverage both of policy relevant issues and of service monitoring. Currently, the focus of what the networks do is on the DHBs themselves. At this relatively early stage in their development, the networks will still be going through the process of establishing their own culture and understandings, and the levels of trust which different people/organisations within the networks have of each other, something which suggests that seeking to use them for a purpose different from that for which they were established would need to be done with care. This is particularly the case as it is likely that, in at least some instances, network members and/or the DHBs with whom they work may not share the Ministry's view.

For this reason, among others, it would not be appropriate for the Ministry to seek to join the networks – that could create the potential for conflict of interest.

Rather than seeking to become a member of local or regional networks, a better approach for the Ministry could be to seek agreement with the networks on the range and type of input it would like to receive from the networks and under what conditions. Given the role that DHBs have in the establishment and support of networks, the best channel for exploring this possibility may be DHBNZ.

The cost should be relatively minimal; if the Ministry sees merit in this approach, MDL would suggest that it take it up sooner rather than later.

We suggest that the proposed relationship with DHB networks be seen as complementary to the relationship with MHAC. The former should provide a reasonably comprehensive coverage of matters that are arising in the day to day management and delivery of mental health services. The latter provides opportunity, especially using the provision in the contract to agree on the provision of strategic advice, to receive more focused input on matters of particular concern to the Ministry.

In MDL's view, a judicious use of a combination of improved management of existing contracts, advisory groups, and the DHB networks should provide the Ministry with quite comprehensive coverage of mental health sector issues at a relatively low cost (certainly as compared with the cost of operation of the Mental Health Council of Australia).

For the longer term, we recommend consideration of one of the innovative arrangements used internationally, Voluntary Planning, as a possible model for addressing more deep seated and policy intensive issues of significance for the sector. Any decision to adopt that option should be preceded by careful investigation including:

- Indepth assessment of the "on the ground" experience of Voluntary Planning.
- Discussion with other central government agencies that may have similar needs to consider whether an initiative of the Voluntary Planning kind should be mental health specific, health specific, designed to cover the wider social services sector, or a "whole of government" initiative.

7.11 RISKS AND BENEFITS

The starting point for assessing risks and benefits of any new means of obtaining policy input should be the risks and benefits associated with current practice.

Because we are unclear about how the reports from SFNZ and MHAC are used within the Ministry, it is difficult to determine what if any benefit the Ministry receives for its policy development process. We assume, as a minimum, that any report signalling a potential crisis with significant risk to the Minister/Ministry would be acted on. However, neither SFNZ nor MHAC gave us any indication that any of their reports had ever identified an issue of this type.

On the other hand, we consider that the management of the current contracts does carry with it a significant risk to the legitimacy of the policy development process. Particularly in the current climate for public participation, an invitation to provide input for a policy development process carries with it an expectation that the input will be used or, if not,

at least the providers will be told why. In this respect, we note the critical success factor for advisory groups "be prepared to listen and learn" taken from the Allen Consulting Group report.

Note also the following comment in the OECD Policy Brief cited above (Page 42):

> "Governments may seek to inform, consult and engage citizens in order to enhance the quality, credibility and legitimacy of their policy decisions … only to produce the opposite effect if citizens discover that their efforts to stay informed, provide feedback and actively participate are ignored, have no impact at all on the decisions reached or remain unaccounted for.[37]"

Each of the alternative models outlined in this Part carries with it its own risks and benefits; there is a positive correlation between the level, and the novelty of the option.

Use of existing forums, such as DHB regional networks, should offer the best mix of low risk/high benefit, with two provisos:

- The risk to their primary role is minimised.
- Clear protocols are agreed between the Ministry and the networks (and the DHBs).

Between them, these networks appear to have a relatively comprehensive coverage of the mental health sector and the capability to provide good input. The potential benefits are high in significantly extending the Ministry's outreach/input and, subject to complying with the two provisos above, the risks are low.

Greater use of advisory groups is also a relatively low risk/high benefit approach, but again with provisos:

- Clear protocols would be required, with shared expectations on the part of the Ministry and advisory group members.
- The process of selection would need to be designed to minimise the potential for appointment because someone was in favour with the government of the day or seen to be "safe" – here the risk is undermining the legitimacy of the policy development process.

The potential benefits are high provided that membership of advisory groups is seen as an effective means of contributing to policy development. It is an approach which should allow the Ministry to tap into a wide range of expertise, knowledge and networks in a very targeted way.

Creating, for the mental health sector, the equivalent of Nova Scotia's Voluntary Planning is somewhat riskier than the two options just discussed but might also bring greater benefits.

The risks lie in the novelty of the approach, whether it could be established, and accepted, as an independent enabler of public participation and in whether the

[37] Organisation for Economic Co-operation and Development (2001b) p1

Ministry/Minister would be prepared to work closely with a body of that kind without wanting to limit its independence.

The benefits, if it were successfully established, could be considerable. Quite apart from providing a source of expertise in managing public participation – and thus, ideally, ensuring that the Ministry was able to get the information it needed when it needed it – it could also play a very significant legitimation role. The fact of an independent body managing public participation in what is a very sensitive area should give added legitimacy to government policy decisions (assuming that, generally, there was seen to be a positive co-relation between the input resulting from citizen participation, and the decisions taken by government).

The last of the structural innovations reviewed, the Public Policy Forum, MDL considers too risky for implementation in a New Zealand context, at least by a single Ministry. Leaving aside the fact that it would probably be difficult to establish an entity of that type as a government initiative, it would be operating in an environment where public expectations (and political ones) have been strongly influenced by the performance of apparently similar bodies such as the New Zealand Business Round Table.

PART 8: Summary/Conclusions

This report has considered the operation of the two existing contracts under which the Mental Health Directorate receives input from the mental health sector for policy development, and other channels of communication which are available to it. It has also examined possible alternatives that the Ministry may wish to consider.

In this section we briefly summarise key findings and present conclusions.

Key findings relate to:

- The operation of the existing contracts.
- Other structures within the sector that hold information of potential value for policy development.
- Possible alternative means of enabling sector input for policy development.

8.1 SUMMARY

Existing Contracts

It is difficult to assess how effective the current contracts are either in providing the Ministry with input for policy development or in serving the separate function of helping legitimate the Ministry's policy development process by demonstrating that policy development is "sector informed".

Both SFNZ and MHAC state that they do not know what happens to the reports that they provide to the Ministry. They indicated to us that they receive no feedback and nor do they receive any significant guidance on what the Ministry's priorities are. Discussion with Ministry staff establishes that the reports are "circulated". The Director and Chief Advisor Mental Health has said that he does not see the SFNZ and MHAC reports, implying that they do not play a significant role in policy and service development. Other comment to MDL suggests that the Ministry may be rather more active than it is given credit for.

The concerns expressed by MHAC and SFNZ are matters that could be relatively easily remedied, especially if the Ministry were to adopt relational contracting principles. As a minimum, the potential for misunderstanding would be minimised if there were clear understandings of how contract input would be used and feedback provided.

Other findings on the existing contracts include:

- Significant elements of the mental health sector are either not represented or under-represented with the existing contract coverage (see the discussion of MHAC coverage at page 38).

- The triple roles of MHAC as an advocate for the mental health sector, a ministerial advisor (at least in its own perception) and a contracted provider of advice for policy development present a potential conflict. It is inappropriate, in the policy development process, that what should be a significant provider of input to a Ministry also has a direct and separate relationship with the Minister.

Advisory Groups

Subject to the development of appropriate protocols and understandings, the use of advisory groups targeted to particular policy issues, or interests, offers real potential. The opportunity is to work with people selected because of their skills, and thus able to complement the Ministry's own sources of input and expertise.

Other Sources

There are other and significant structures within the mental health sector which appear to be quite robust, well networked, and able to act as important channels for information collection (and dissemination). They include the regional and local networks associated with DHBs, Maori and Pacific Island, NGOs and a number of others. There is merit in the Ministry considering how to access input from structures such as these (noting that, at least with the DHB associated networks, there would be a need to ensure that any direct relationship with the Ministry did not compromise their primary role). We recommend that the Ministry consider, in conjunction with DHBNZ (and taking into account the need to ensure complementarity with the MHAC contract) the potential of using DHB networks as a source of input for policy advice and service monitoring.

Alternatives

Existing and emerging practice internationally highlights a number of possible alternatives ranging from an increased use of advisory groups to the establishment of special purpose entities designed specifically to encourage and manage the process of public participation in policy development.

Each of these has its own particular strengths and weaknesses and not all would necessarily be appropriate tools for the Mental Health Directorate on its own - all, though, should be evaluated by the Ministry.

An obvious constraint, of which the Ministry will be very aware, is the cost of adopting any new structure (or for that matter establishing relationships with existing structures). Those costs will include the resourcing needs of any new or existing structure in providing input for the Ministry, and the Ministry's own need for resources to process and provide feedback on that input.

8.2 CONCLUSIONS

The Ministry's initiative in commissioning this report reflects recognition of the fact that the context for public input into the development of policy has changed significantly since the Ministry first contracted with SFNZ and MHAC for this purpose.

There is now a much stronger expectation that policy development (and for that matter service monitoring) will be informed by input from the public – both as consumers/recipients of service, as people affected by the delivery of services to others, and as people/organisations who have knowledge and understanding of the issues on which the Ministry is expected to provide advice.

As well, current understandings include an expectation that the public, in some form, will not simply have an opportunity to provide input; there will also be in place feedback loops so that people know how their input was used or, if it was not, why not.

In parallel with this, contracting practices between government agencies and the public, especially voluntary and community sector groups, have also changed. There is now a much stronger emphasis on what is known as relational contracting, an approach which seeks to recognise and accommodate the objectives of both parties.

The current contractual arrangements with SFNZ and MHAC were designed to meet the circumstances of the mid 1990s. The main common issue identified with them is the lack of ongoing consultation between the Ministry and the contracting parties over the alignment of work programmes (which has been changing as a result of Ministry initiatives), and coupled with that, a claimed absence of feedback on what actually happens to the input provided to the contracts.

These matters can be easily remedied, and should be.

The MHAC contract raises a separate issue: the potential conflict of interest from the fact that MHAC not only provides input to the Ministry for policy advice but also seeks to act as an advocate for the sector and a ministerial advisor. It will be desirable for the contractual arrangements between the Ministry and MHAC to acknowledge these separate roles and include provisions designed to manage any potential for conflict (whilst recognising that the Ministry cannot contract for the provision of advocacy services and that it is for the Minister, not the Ministry, to take any decisions about MHAC's desired role as a ministerial advisor). Options for addressing the potential conflict are set out in Part Seven of this report.

There is a range of other possibilities that the Ministry could consider for seeking input for policy advice, depending both on the resources it has available for that purpose (both to fund providers with advice, and to resource the Ministry itself adequately to deal with additional input) and on its objectives for public input. They include:

- The use of advisory groups, subject to the development of an appropriate protocol.
- Tapping into the regional and local mental health networks supported by DHBs.

A combination of a different approach to managing the existing contracts, the use of advisory groups on specific issues or to deal with specific interests, and tapping into the DHB networks should give the Ministry a reasonably comprehensive coverage of current sector concerns regarding both policy and service monitoring.

For longer term developmental purposes, there may be merit in looking at an initiative such as Voluntary Planning – in essence the establishment of an independent entity with the task of managing the process of public participation in policy development.

APPENDIX 1: LIST OF INTERVIEWEES

List of interviewees

Person	Representation	Specific or additional perspective
Kayleen Katene	Chair, MHAC	
Materoa Mar	Chair, Mental Health Foundation (MHAC)	Maori
Barbara Halliday	CEO, SFNZ	
Dr Geoff Bridgman	President, SFNZ	Academic
Anna Ah Kuoi	National Coordinator, SFNZ	
Linda Simpson	Regional Consumer Network (Southern)	MHAC NGO Consumers
Susie Crooks	Regional Consumer Network (Central Potential)	NGO Consumers
Phyllis Tangitu	General Manager Maori Health, Lakeland DHB	Maori
Ian McKenzie/Phil Grady	General Manager Mental Health & Programme Manager Mental Health Counties-Manukau DHB	
Ron Dunham/Lareen Cooper	Chief Executive & General Manager Funding/Purchasing Bay of Plenty DHB	
Kirk Mariner	Service Manager, Pacific Mental Health, Alcohol and Other Drugs Waitemata DHB	Pacific Alcohol & drug
Janice Wilson/Linda Jacobs/Therese Egan/Graham Bussell	Deputy Director-General Mental Health and Staff Mental Health Directorate, Ministry of Health	
Dr John Marwick	Principal Clinical Advisor Primary Health, Ministry of Health	Primary care
Dr David Chaplow	Director & Chief Advisor Mental Health, Ministry of Health	Clinical
Arawhetu Peretini	Manager Maori Mental Health, Ministry of Health	Maori
Mary O'Hagan/Mark Jacobs/Gaylia Powell	Commissioner and Staff, Mental Health Commission	Consumers
Marion Blake	CEO, Platform (NGO)	
Tim Harding	CEO, Care NZ (NGO)	Alcohol & drug
Karl Pulotu-Endemann	Pacific peoples perspective	Mental Health Commission

APPENDIX 2: TRUST & RELATIONAL CONTRACTING

EXTRACT FROM MDL PAPER ON RELATIONAL CONTRACTING

1.0 THE RELEVANCE OF TRUST IN CONTRACTING

1.1 The role of trust in building relationships is fast gaining ground in the theory and practice of purchase and supply and the formation of partnerships, in business and, overseas, between public agencies and community services. This is not to do with "feeling good". There is a growing body of experience in the commercial world showing that trust-based relationships between buyers and sellers produce significant economic and strategic benefits in the form of sustainably lower costs of doing business and greater ability to meet strategic goals. The shift in business practice is towards managing relationships, from managing contracts.

1.2 The application of trust to public administration is complicated by the high levels of accountability required in the use of public money. It does however carry practical fiscal benefits (there is a growing recognition that there are fiscal risks associated with an absence of trust). Furthermore, high levels of trust will be important to Government if it wishes to rely in the future on the commitment voluntary organisations bring to the services they provide end users/clients, to fulfil Government policy objectives.

1.3 As reasoned in literature on the economics of trust, cost and trust are inversely related: the absence of trust requires resort to rules and compliance to regulate relationships, in turn incurring higher costs in the specification, negotiation, management and monitoring of contracts. A trust-based approach is inherently lower in transaction and compliance costs.

From business experience: "For relationships to bloom and achieve their full potential, they must have a degree of flexibility and informality. Long, detailed contracts are inconsistent with building relationships based on trust and simply tend to get in the way. Companies that base their relationships on trust either have minimal contracts or do away with contracts altogether. What holds these relationships together is not legal force but mutual obligations and opportunities rather than legal force."[38]

1.4 A *definition of trust*

The essence of a trust-based approach to contracting is that it rests on an understanding that each party should benefit from the relationship.

[38] The Power of Trust in Manufacturer-Retailer Relationships", Nirmalya Kumar, Harvard Business Review, Nov-Dec 1996, p 105.

Trust can be seen as a rational form of cooperation which recognises risk - it is based on a hypothesis or prediction of how the other party will act, adding to that a judgement about how that action will affect the 'trusters' interests, weighing up likely benefits and costs. Finally, it rests on repeated tests of the trust invested in the other party. If those experiences support the trust invested, for example if cooperation is met with cooperation, trust becomes self-reinforcing (which is why trust is seen in the literature as fundamental to building social capital).

1.5 A trust-based approach does however need to be seen as requiring a longer term focus than the short-term funding contract, since by its very nature trust is the result of repeated experiences that either build trust or undermine it. It is a process of trial and error.

2.0 TRUST-BASED (RELATIONAL) CONTRACTING

2.1 The Relational Contract Model

2.1.1 The central premise of relational contracting is that it is trust-based, while still allowing for a legal core. A relational contracting approach implies:

- Moving towards commitment to common goals (outcomes).
- Recognition of and respect for the roles and expertise each has independently of the other.
- Risk allocation that involves agreed risk-sharing (including policy risks) between the parties, and, conversely, mutual acknowledgement of the gains from the relationship.
- Each party well-informed about the other, with appropriately open communication.
- Each party motivated to maintain credibility and reputation with the other, and ultimately with the client group the service is designed to serve.

2.1.2 The rationale of relational contracting is the value that accrues through taking a multi-year, holistic approach to the contracting relationship, rather than focusing solely on exchanges taking place at any one point of time. The contract contemplates a future relationship, rather than being conducted separately from that possibility.

2.1.3 Relational contracting has equal relevance to achieving desired policy outcomes, because it creates an environment that implicitly and explicitly promotes qualitative, or process, 'outcomes' such as co-operation and collaboration.

2.1.4 Over time, a relational contracting approach can potentially allow formal specification to be replaced, to a degree, by flexibility in the terms of the relationship and how it is managed by each party.

2.1.5 Relational contracting is of most relevance when Government funding has an 'investment' purpose, ie:

- When the funding is meant to achieve something more than defined outputs;

- When the service being funded is expected or intended to give rise to positive benefits in the wider community in which the outputs are being delivered;
- When the Government expects to want to "re-purchase" and there is a need for the funder and the provider to be focusing not just on the supply of outputs, but on acquiring an understanding of each other's objectives;
- Where collaboration rather than contestability or competition is the best way to reduce risk and promote innovation.

2.1.6 There are quite challenging conditions required of **both parties** to make relational contracting work in practice. The range of critical success factors includes the requirements that:

- Each party relinquish some of its independence, ie becomes more inter-dependent on the other (literature suggests that an organisation cannot build trust while seeking to maintain leverage over another);
- Both parties believe they will gain by becoming a more valuable resource to the other;
- Both parties acknowledge that the other will prize its self-sufficiency, and that inter-dependence does not equate with loss of this;
- The relationship involves sharing sensitive information, investing effort in understanding each other's business and customising systems to serve the mutual interests in the contract better.

2.2 Benefits

2.2.1 The benefits of relational contracting are very significant in terms both of efficiency and effectiveness.

2.2.2 *Efficiency*

Efficiency benefits arise from:

- Reduced transaction (informational) costs in the short term: relationship contracting relies on complementary expertise and information rather than each party inventing its own, or buying in, expertise and information the other party can bring;
- Reduced transaction (uncertainty) costs in the medium to longer term: more reliance on trust reduces the impact of uncertainty on achieving objectives desired from the contract, since trust reduces friction and opportunistic behaviour;
- Reduced compliance costs: cost savings are generated by reducing the need for close specification and monitoring;
- Less reliance on regulation: lighter control;
- Generally, easing working relationships.

2.2.3 *Effectiveness*

The funder's interest is not simply a least cost one. Relationship contracting enhances the likelihood of achieving policy objectives through:

- Encouraging collaboration over the use of scarce resources;
- Making it easier to adapt the contract to changing circumstances and priorities, without loss of focus on outcomes;
- Supporting the development of networks;
- The potential for the funder to be an important element in assisting the service organisation to develop ongoing capacity and capability;
- Helping create conditions favourable to the engagement of third parties such as employers, other community groups and local authorities;
- Creating a reservoir of goodwill that helps 'weather the situation' when one party fails in some way, as can happen.

2.3 Limits

2.3.1 It is necessary to recognise the limits on trust as the basis of contracting by Government, both to ensure expectations are realistic, and, paradoxically, to make it work:

- Regardless of the degree of trust between the contracting parties, there will always be areas of difference because the two parties will inevitably have some goals that are different.
- Any element of contestability will always carry some tension between the contracting parties.
- Trust is rarely all-encompassing: each party will trust the other on some things and not others; and there will be legitimate reasons for holding back on such things as the provision of information.

2.3.2 Perhaps most of all, there will be challenges for both parties in adopting a trust-based approach. For reasons of accountability, for example, both parties will need to recognise that the other may wish to monitor their trust of the other's actions, including checking on areas of distrust.

2.4 Steps Towards Relational Contracting

2.4.1 A shift towards relational contracting can be supported by a number of practical measures.

2.4.2 *A Longer Time Horizon*

As noted above, one characteristic of relational contracting is that it has a longer term focus than is typical of conventional contracting. It therefore requires integrating a longer time horizon into contracting systems and into individual contracts.

It is quite possible that this can be achieved within a system of annual contracting, and even single year contracts if those are approached with a direct understanding of the kinds of outcomes the contract is intended to create. There does however need to be an expectation of future contracts to sustain the focus on outcomes.

2.4.3 *Outcomes Focus*

For a whole variety of reasons[39] budgeting and contracting on outcomes has taken time to develop in Government and most contracts are still written in output terms.

There is however scope to adopt "intelligent" output-based contracting that builds in some of the strengths of relationship contacting. This would for example involve the contracting agency knowing, in advance of going to contract, what it wishes to achieve over time through the contract, even if outputs are specified and funded short-term. Another example would be to recognise, when renewing a contract or re-tendering for outputs, that the existing provider will have some of the institutional knowledge the contracting agency requires and to factor this explicitly into the next contract decision.

2.4.4 *The Status of the Parties in the Contract*

As has been discussed earlier in this paper, most contracting relationships in practice are unbalanced and favour the funder.

A key to breaking through this barrier is for the contracting agency to treat the service organisation fairly - in terms both of fairness of outcome for the parties (how the benefits and loads are divided) and fairness of procedure (the process for managing the contract).

Both forms of fairness are important in establishing trust, but procedural fairness may in fact be considerably more important because the contractor will be seen as being always in control of its own policies and practices, whereas outcomes will often be influenced by factors external to both parties.

Practical steps to consider in achieving these two kinds of fairness are:

Fairness of outcome - having the funder accept some responsibility for the health and viability of the service organisation, such as by paying a value that allows the service organisation to invest in improving services to the client group.

Fairness of procedure - adopting as matters of practice bilateral (rather than unilateral) communication including frankness by the funder of its own shortcomings, and encouraging the service organisation to disclose problems with meeting the terms of the contract when they arise; having ways to air concerns and appeal decisions; taking care to explain the rationale for decisions; being familiar with the local conditions under which the service provider operates; acting with respect for the service organisation and the people in it.

Both forms of fairness obviously carry a cost to the funder in direct costs and in the effort, energy, change in organisation culture and perhaps re-organisation they call for. But fairness may be less transaction-costly in the medium and longer term because of better results and efficiency from improved services, and more productive relationships.

[39] Set out for example in OAG reports.

2.4.5 *Providing Evidence of Trustworthiness*

As with reputation, in any organisation, building trustworthiness takes time. It can be demonstrated on a number of fronts:

- By consistency and predictability so that the other party knows what to expect.
- By transparent and clear actions which the other party can 'read'.
- By clear expression of intent.
- By acknowledgement of funding constraints on both sides.
- By being open to the likelihood that either side will pursue sectional interests, without necessarily being in conflict with the funding contract.

2.4.6 *Internal operational conditions*

These will include:

- Good internal communication and delegation.
- Clearly expressed outcome statements and strategies.
- Consistency in the application of rules.

2.4.7 *Personnel management*

When trust-based approaches have been adopted in business, it has been found necessary to allow time and opportunity for trust to evolve through the staff at various levels on both sides. This means low staff turnover, or alternatively a team approach so that the contracting relationship is less dependent on one person.

3.0 RELATIONAL CONTRACTING AND THE OPTIONS IN THIS REPORT

3.1 Full relational contracting clearly involves a philosophical shift as well as significant changes in systems and procedures.

3.2 It is more demanding of contract design and management and would put stronger disciplines on the contractor. For example, establishing a trust relationship would require the funder/purchaser, who is usually in a monopoly position, to take the first step.

3.3 Specific changes are possible however that would represent an achievable shift in the direction of relationship contracting, not necessarily its wholesale adoption. The suggestion above of "intelligent output-contracting" is one avenue that should be explored.

3.4 Much that characterises relationship contracting is true of effective relationships generally.

3.5 Ideally, the options presented in this report should be evaluated against the benchmark of trust and relationship contracting, as well as against immediate changes sought in current contracting practice.

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