CHAPTER 3

COORDINATION

3.1 Coordination is a fundamental focus of the COAG Plan. The Leaders' Forward to the Plan stated:

> The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community.[1]

3.2 Coordination was addressed in the COAG Plan at two key levels: the strategic coordination needed to ensure that investment by different levels of government is delivered in the most effective way, and the grassroots integration and connection between services needed to coordinate health and community support services for individuals with mental illness.

3.3 The evidence to the committee indicates that despite the efforts made under the COAG Plan, coordination of mental health care in Australia remains inadequate. This chapter first reviews evidence about strategic coordination. This includes the existing government forums for coordination and advice, coordination across different levels of government and the fit between the COAG Plan and the different service structures across the jurisdictions. Second, the chapter discusses the 'care-coordination' initiative and coordination in the provision of services to people with mental illness.

Government forums for coordination

3.4 Several government forums have been established to improve coordination in the implementation of mental health initiatives across Australia. These forums are discussed below.

COAG Mental Health Groups

3.5 The COAG Plan recognised that improving mental health services in Australia requires the combined efforts of Commonwealth, state and territory governments. The Plan 'called upon governments to work together in a way that had no clear precedents in mental health'.[2] Under the COAG Plan flagship initiative 'Governments Working Together' each state and territory was to form a COAG Mental Health Group, convened by the Premier or Chief Minister's Department. These groups were to provide a forum for 'oversight and collaboration on how the different initiatives from the Commonwealth and State and Territory governments will be

---

1 COAG Plan, p. i.

2 Queensland Government, *Submission 49*, p. 79.

coordinated and delivered in a seamless way'. The groups were to 'involve Commonwealth and State and Territory representatives and engage with non-government organisations, the private sector and consumer and carer representatives'.[3] Each group was required to report back to COAG after six months and then at regular intervals.[4]

3.6 DoHA reported that COAG Mental Health Groups have been formed in each jurisdiction. They are made up of Commonwealth and state or territory government department officials, with NGOs, the private sector, consumers and carers being engaged to varying degrees across jurisdictions. DoHA advised that, on average, each COAG Mental Health Group meets quarterly.[5]

3.7 The committee's hearings indicated that there is great variability in the composition of the groups, regularity of their meetings and extent of involvement and communication with stakeholders. In some jurisdictions the groups are working effectively while in others there was confusion as to the existence, membership and role of the state COAG Mental Health Group.

3.8 The Queensland COAG Mental Health Group meets regularly, has a dedicated website and produces a quarterly newsletter providing information about progress under the COAG Plan. The terms of reference of the group, its membership and activities are publicly available. It includes non-government, private sector and consumer and carer representatives as well as Commonwealth and state government representatives. In the ACT the COAG Group is made up of Territory and Commonwealth Government representatives and is supported by a reference group comprised of consumers, carers, community agencies and relevant government representatives. Both groups meet quarterly.[6]

3.9 Victoria reported that its COAG Mental Health Group has been formed and involves representatives of key Commonwealth and Victorian agencies.[7] In Western Australia, NGO stakeholders were aware of their state's COAG Mental Health Group and had received newsletters from the group.[8] In New South Wales, stakeholders were also aware of the relevant group and some community members had been invited to its

3 COAG, National Action Plan on Mental Health 2006–2011, p. 6.

4 COAG Plan, p. 6.

5 *Proof Committee Hansard,* 16 May 2008, p. 75.

6 *Proof Committee Hansard,* 16 May 2008, p. 30; *Submission 37*, p. 1.

7 *Submission 41*, p. 5.

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

first meeting, but there had been no further contact.[9] The NSW Consumer Advisory Group had offered to provide consumer representation to the COAG Mental Health Group, but had received no response.

3.10 In South Australia, the Mental Health Coalition of South Australia (MHCSA) commented that the COAG Group had not been particularly effective in engaging broader stakeholders in discussions. Mr Harris, Executive Director, noted that 'It is not necessarily a good thing to just engage senior departmental people in that kind of process. There is more to the system than just the state government provided component'.[10] Indeed several of the NGOs and advocacy groups in South Australia were not aware of the COAG Mental Health Group's existence.[11]

3.11 COAG Mental Health Groups in some jurisdictions have been derived from existing stakeholder groups, perhaps suggesting why they were not readily identifiable. In South Australia, Mr Wright explained the COAG Mental Health Group is organised by the state's Social Inclusion Board.[12] It includes FaHCSIA, DoHA, state mental health services and other providers.

3.12 In Tasmania there was also confusion among stakeholders as to the existence of the COAG Mental Health Group, with some stakeholders unsure whether they were themselves members.[13] The state government clarified that its COAG Mental Health Group only includes state and Commonwealth officials, but that:

> There is another group which was an existing group for the state to use as a consultative forum for their partners, consumers and carers. The Mental Health Council is on that group, along with other non-government organisations involved with education, police, justice and general practice. That group is more like a working and advisory group.[14]

3.13 In the Northern Territory, stakeholders such as the Aboriginal Medical Services Alliance NT (AMSANT) were clear about the COAG Group's existence and its membership and were satisfied that the process is working satisfactorily. However, despite the intergovernmental coordination that the COAG Groups are intended to foster, AMSANT representatives expressed concern that divisions still existed

---

9 Ms Jenna Bateman, Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2008, p. 46; Transcultural Mental Health Centre, *Proof Committee Hansard*, 27 March 2008, pp. 31–32; Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2008, p. 40; NSW Consumer Advisory Group – Mental Health Inc, *Supplementary Information*, Response to questions raised at hearing 27.3.08, dated 4.6.08.

10 *Proof Committee Hansard,* 8 May 2008, p. 16.

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

12 *Proof Committee Hansard,* 8 May 2008, p. 91.

13 *Proof Committee Hansard,* 31 March 2008, p. 5.

14 *Proof Committee Hansard,* 31 March 2008, p. 28.

between health services funded by DoHA and community services funded through FaHCSIA.[15]

3.14 The level of engagement of the COAG Mental Health groups with stakeholders outside of government was an area of concern. The Mental Health Coordinating Council of New South Wales recommended that the structure of all state COAG committees be revised to include representation from the NGO sector, to 'ensure that the philosophy and approach of NGOs as a component of the service system does not lose priority in future service planning'.[16]

3.15 Specific concerns were raised about the lack of representation of consumers on state COAG Mental Health Groups. Queensland is the only state that has a consumer member on its COAG Mental Health committee.[17]

3.16 While state and territory COAG Mental Health Groups may inevitably differ in their structure and approach, the committee considers that there is room to enhance the visibility of these groups and their role in coordinating not only across government departments but with non-government agencies, the private sector, consumers and carers. If the NMHS policy of including consumers and carers at all levels of decision making is to be more than rhetoric, the COAG Mental Health Groups are a key place to start. The committee commends the Queensland Government's approach of including a broader range of representatives, in addition to government officials, directly in its COAG Mental Health Group. It also sees merit in using the COAG Mental Health Groups, as Queensland has done, as a central point for communicating the progress made by each state and territory against the COAG Plan.

Recommendation 3

3.17 The committee recommends that each state and territory COAG Mental Health Group include consumer, carer, non-government organisation and private sector representatives within its membership. The committee further recommends that each COAG Mental Health Group make publicly available a quarterly progress report outlining the work undertaken in the state or territory against each commitment in the *National Action Plan on Mental Health 2006–2011.*

National Advisory Council on Mental Health

3.18 The announcement in April 2008 of the creation of a National Advisory Council on Mental Health reflects the priority that has been given to mental health at the national level.[18] The Council is expected to provide the Australian Government

15 *Proof Committee Hansard,* 1 May 2008, p. 33.

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

17 *Submission 49,* p. 61; *Proof Committee Hansard,* 26 March 2008, p. 34.

18 The Hon Nicola Roxon MP, Minister for Health and Ageing, Media Release 11 April 2008.

with independent expert advice on mental health and to assist the coordination of Commonwealth, state and territory mental health services so as to improve support for people with mental illness and their carers.[19] It has been allocated $2.4 million, from within the existing health budget, over three years from 2008–09.

3.19 The membership of the National Advisory Council on Mental Health, announced in June 2008, is as follows:

- Chair: John Mendoza, former CEO of the Mental Health Council of Australia, and author of the seminal Not for Service report;
- Michael Burge, consumer consultant/advocate for the Toowoomba District Mental Health Service;
- Neil Cole, Associate Professor in the Monash Medical School, who has had bipolar disorder, and is a former Victorian Member of Parliament;
- David Crosbie, current CEO of the Mental Health Council of Australia;
- Alan Fels, Dean of the Australia and New Zealand School of Government, whose daughter has schizophrenia;
- Ian Hickie, Professor of Psychiatry at the University of Sydney and Executive Director of the Brain & Mind Research Institute;
- Lyn Littlefield, Executive Director of the Australian Psychological Society;
- Helen Milroy, descendant of the Palyku people in the Pilbara, Child and Adolescent Psychiatrist, Associate Professor and Director for the Centre for Aboriginal Medical and Dental Health at UWA;
- Dawn O'Neil, Chief Executive Officer of Lifeline Australia; and
- Rob Walters, GP and former chair of the Australian Divisions of General Practice.

3.20 The committee is strongly of the view that it is important that this Council is able to function independently and provide independent advice, as has been clearly indicated by the Government. Mr Crosbie, Chief Executive of the Mental Health Council of Australia cautioned:

> My one initial cautionary note is that I hope that it is independent of government. In that sense I do not mean that it be public; I would hope that it is independent in its capacity to work within government.[20]

3.21 Mr Crosbie suggested that the Australian National Council on Drugs provides an example of the kind of body required, being an advisory committee that is auspiced outside of government but able to work within the confidential structures of government.[21]

---

19 Budget Paper No.2 2008–09, p. 213.

20 *Proof Committee Hansard*, 20 May 2008, p. 82.

21 *Proof Committee Hansard*, 20 May 2008, p. 82.

Other government forums coordinating mental health policy

3.22 Several other bodies exist within the structures of government aimed at coordinating policy and programs in mental health. These include:

- The Mental Health Standing Committee of the Australian Health Ministers Advisory Council (AHMAC);[22]
- An Interdepartmental Committee (IDC) on COAG mental health implementation; and
- DoHA's Stakeholder Reference Group.

State governments also have their own structures for coordination, such as state-based interdepartmental committees.

3.23 The Mental Health Standing Committee of AHMAC includes officials from each state's lead department in mental health, DoHA, FaHCSIA, the Department of Veterans' Affairs (DVA), consumer and carer representatives, the private mental health alliance and an official observer from New Zealand.[23] The recent inclusion of FaHCSIA within the Standing Committee is a positive reflection of governments' recognition that mental health and illness is not just a health responsibility; it requires a broader community based response.

3.24 The IDC was established in mid 2006, to coordinate across the Commonwealth Government portfolios involved in implementing the COAG Plan. It is chaired by DoHA, and includes participants from Prime Minister and Cabinet, the Department of Education, Employment and Workplace Relations, FaHCSIA, Centrelink, Human Services, Attorney-General's Department, Treasury, Department of Veterans' Affairs and Australian Bureau of Statistics.[24] DoHA considered that the IDC has worked well:

> This committee has been a very valuable forum for all of us, both for progressing individual measures and for ensuring that we identify all opportunities for collaboration and information sharing. The adoption of a whole-of-government interagency approach, which is a first for mental health, has significantly enhanced outcomes across our several portfolios and has brought a greater understanding of the role of the community service sector in achieving better outcomes for people with severe mental illness in particular.[25]

The committee notes that a whole-of-government approach is integral to improving mental health services.

---

22 DoHA, *Submission 45*.

23 DoHA, Supplementary information received 2 April 2008.

24 DoHA, Supplementary information received 2 April 2008.

25 *Proof Committee Hansard*, 16 May 2008, p. 75.

3.25 The establishment of the National Advisory Council on Mental Health, changes to the AHMAC Mental Health Standing Committee membership, establishment of the COAG Mental Health Implementation IDC and development of the COAG Mental Health Groups, are all a positive reflection that mental health is now higher on the policy agenda across government departments at state and federal levels. However, evidence to the committee suggests that coordinating mental health services across different areas of responsibility still remains a critical issue.

Coordination across areas of responsibility

3.26 Submitters and witnesses emphasised that the range of services needed to support people with mental illness to live in the community fall within both state and Commonwealth areas of responsibility. They were disenchanted by failures in coordination between the levels of government and the opportunities that have been lost when funding from one level has not taken into account the existing services and gaps generated by the other level. These concerns are discussed in the following sections.

3.27 The silos between areas of responsibility and levels of government create considerable frustration for those trying to deliver services and for the people that need support. Mr Calleja, from the Richmond Fellowship in Western Australia, raised the example of employment for people with mental illness:

> There is a significant policy gap by the state in relation to connecting with the employment strategy generally. The traditional state-Commonwealth divide applies. The state says 'That's a Commonwealth issue,' and the state forgets that these are real, living people. Their lives do not depend on whether there is a state-Commonwealth boundary, so there is really a need from the health department, in particular, to engage better with the thinking around employment…[26]

3.28 Indeed mental health care requires services in a range of areas such as accommodation, employment, disability services and social inclusion, that work with clinical health care. The Mental Health Coalition of South Australia looked towards the coordination of mental health initiatives with these other areas of support. Mr Harris, Executive Director, suggested that this kind of integration, across different areas of responsibility, should be a focus in the next generation of COAG initiatives.[27]

3.29 While coordination across levels of government was a focus of the current COAG Plan, progress has been slow. The Mental Health Community Coalition ACT commented:

> Care coordination is critical to achieving comprehensive care for individuals with mental illness, and clearly we need that at the government level and at the individual level, as the national action plan identified. But I

26 *Proof Committee Hansard,* 7 May 2008, p. 33.

27 *Proof Committee Hansard,* 8 May 2008, pp. 3 and 7.

> think it is fair to say that it remains quite a challenge for us to achieve that at the government level, in having strategic and integrated planning, when we are talking about services funded across two levels of government and across at least three or four departments in each level of government. So we have not quite cracked that nut as well as we might like.[28]

3.30 Similarly, Mr Quinlan, Executive Director of Catholic Social Services observed:

> Whilst the COAG National Action Plan on Mental Health certainly provides a step in the right direction, neither Commonwealth-state operations nor the links between community and clinical operations are systematically coordinated. In relation to the Commonwealth-state relations, this threatens the creation of gaps and overlaps as well as administrative red tape.[29]

3.31 Mr Wright, from the South Australian Government, commented that state and Commonwealth agencies are not working together as well as they should:

> I think we probably waste a lot of time and energy—the Commonwealth do and the states do—in terms of the discussions that we have with our non-government sector and our primary care sector, only to find that money has come from the Commonwealth to fund something which might be at odds with the work that we are doing. I guess part of that is about ensuring that some dialogue goes on. I think we all have the same sort of end goal in mind.[30]

3.32 The Tasmanian Government observed that state governments need to be kept aware of Commonwealth initiatives and how they fit with state programs:

> …as you roll out the initiatives based around GPs and individual psychologists and nurses—and social workers if you look at the funding in that area—that is done on very much an individual basis, through the Medicare Benefits Scheme. So it becomes necessary for us to keep abreast of who is doing what and where in a far-flung rural state. Part of our issue is trying to understand what it is that we can add value to and how we can do it…making sure we focus on the people for whom we are the most appropriate port of call—the people who have severe and enduring mental illness, requiring joined-up case management type systems—and whether it is more feasible for us to actually work with our GPs and other primary care providers to provide services with them.[31]

---

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

29 *Proof Committee Hansard,* 16 May 2008, p. 65.

30 *Proof Committee Hansard,* 8 May 2008, p. 88; see also Government of Victoria, *Submission41*, p. 9.

31 *Proof Committee Hansard,* 31 March 2008, p. 30.

3.33 Commonwealth funding through the COAG Plan has been able to create some shifts towards community-based care in states where this was not so forthcoming. Ms Bateman, CEO of the Mental Health Coordinating Council in New South Wales commented:

> I am a big fan of the fact that we have two funding streams at the moment. I am a really big fan because New South Wales has a long history of being very clinically focused in terms of the way it approaches mental health…these programs have allowed a space for NGOs to develop, grow and rebalance the system. I am nervous that if programs like PHaMs and Support for Day to Day Living in the Community were to come under the state government at this point in time, we would lose some of the value of NGOs—that is, those different referral pathways and accessing people who do not want to access clinical services.[32]

3.34 In South Australia, the MHCSA also noted the different focus of state and Commonwealth initiatives, observing that both are important:

> I think the characterisation that we would have is that the state, in general, is coming from a model where they are focused on supporting people who are already engaged with the state system, whereas the COAG initiatives are much more about people who present wherever they come from…I think that, in terms of moving towards better integration, it needs to be acknowledged that both of those approaches are valid and that if you moved one way or the other you would be disenfranchising, potentially, a range of people who need the services.[33]

3.35 While Commonwealth funding may have been able to shift the service make-up to some extent in some states, witnesses also noted that it is important that state governments do not abdicate their responsibility to provide community-based services. In South Australia, Ms Richardson, Community Services Manager with Carers SA noted the absence of state funding for carers in the COAG Plan. She wanted to ensure that Commonwealth funding was not seen by the state 'as a way to no longer have to fund the carers'.[34] Ms Richardson's concern points to the need for sound scrutiny and reporting of mental health expenditure, to ensure that new money provided by each level of government is going to greater service provision, and not being used by other levels of government to draw down their contribution. Certainly in some states, such as Queensland, it is clear that the state government has markedly increased its funding to mental health services in addition to the money allocated in the COAG Plan. Continued monitoring of the funding provided by different levels of government, and the distribution of this funding across different types of care and support, is required over time.

---

32 *Proof Committee Hansard*, 27 March 2008, p. 41.

33 *Proof Committee Hansard*, 7 May 2008, p. 4.

34 *Proof Committee Hansard*, 8 May 2008, p. 60.

The COAG Plan and existing initiatives

3.36 Witnesses to the inquiry were concerned that the COAG Plan had been developed and implemented without adequate consideration of the programs and initiatives that already existed. Ms Hughes, Carers Australia commented:

> I do not think enough work was done in what I would call the service development side of some of these initiatives. What I mean by that is that we need to look at what already exists in states, territories and nationally. Some of these programs already exist in a different way, and they could have built up and enhanced the existing programs. Sometimes I feel like we have started from scratch.[35]

3.37 Ms Hocking, from SANE Australia, questioned the COAG Plan's piecemeal approach and whether this was the best use of funding:

> My concern is that there are so many little splotchy things around the place and, unless we are talking with each other, we could end up with a real patchwork that does not make a quilt…just lots of little patches all over the place and then an awful lot of time and effort required to stitch them all around the edges rather than to make a new quilt in the first place. That is not to say that they are not welcome when they appear, but I do not think that we are making best use of the available funds and that is because there is not that initial planning and coordination.[36]

3.38 Some witnesses suggested that the rollout of new programs under the COAG Plan had not actually helped in coordinating services for consumers:

> The new COAG moneys provide new silos of funding but they are not actually connected. There is no connection between those funding streams and the evidence that says this is the way we should be organising things. I work with our local NGOs. They have got their helpers and mentors funding and in New South Wales we have the Housing Accommodation and Support Initiative, HASI, the Support for Day to Day Living in the Community program and the headspace program as well. But all of these things are set up in such a way that we are actually causing a disintegration rather than an integration.[37]

3.39 Indeed some submitters raised concerns that with so many new programs on the ground, many people involved in the sector are not aware of the full range of services that exist or which are the most appropriate for different consumers. This was apparent at the committee's hearings, with some witnesses not aware of programs such

---

35 *Proof Committee Hansard,* 20 May 2008, p. 60.

36 *Proof Committee Hansard,* 1 April 2008, p. 4.

37 Dr Gurr, Chair, Policy Committee, Comprehensive Area Service Psychiatrists Network of New South Wales, *Proof Committee Hansard*, 27 March 2008, pp. 60–61.

as PHaMs.[38] The MHCSA called for consistent information about where Commonwealth funded programs are available, who is eligible and how consumers can access the programs.[39] Representatives from the Queensland Alliance Mental Illness and Psychiatric Disability Groups, suggested that a 1800 number would be helpful, as a central point providing information about all the different programs available.[40] Similarly, the Mental Health Community Coalition ACT advocated a national information telephone service:

> Currently, it is just a maze out there, a jungle, and people with mental illness and their families often have no idea where to go or where to find out information, and it is often by accident or police intervention that they end up with help. We envisage a 24-hour national line that anyone anywhere can call, whether it is a person with mental illness or a family member or a friend, and say, 'What exists locally?'[41]

3.40 Mr Quinlan, Executive Director of Catholic Social Services commented that because there is no systematic coordination, community-based organisations have had to rely on their relationship-building skills to establish connections with the more clinically based mental health services that their clients require.[42]

3.41 The committee also heard positive examples indicating that increased capacity in the broad mental health care system has improved linkages. Mr Harris, Executive Director Mental Health Coalition of South Australia, commented:

> …the kinds of approaches that are linking up the non-government supports with people who are engaged particularly with the acute care system have improved over the last few years. The capacity to support people has improved.[43]

3.42 The Western Australian Association for Mental Health (WAAMH) emphasised the importance of understanding the big picture in terms of how the various COAG initiatives fit together:

> A major concern has been the lack of information about the new services provided; who is doing what, and where? That caused confusion for many agencies. WAAMH ran a forum in February that clarified some of the issues, and in February or March we did actually receive an update on the

---

38 See for example, Victorian Mental Health Carers Network, *Proof Committee Hansard,* p. 11; Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; *Proof Committee Hansard*, 27 March 2008, p. 15; Carers Australia also commented that knowledge about PHaMS among carers is 'very limited', *Proof Committee Hansard,* 20 May 2008, p. 61.

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

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

41 *Proof Committee Hansard,* 16 May 2008, p. 17.

42 *Proof Committee Hansard,* 16 May 2008, p. 65.

43 *Proof Committee Hansard,* 8 May 2008, p. 8.

> current status of Commonwealth initiatives, which was very useful. Certainly, when we circulated it, people were reassured that there was some sense in the map that we had not seen before.[44]

3.43 Confusion within the sector about the various initiatives included in the COAG Plan, their fit together and progress further highlights the case for including a broader range of stakeholders on state COAG Mental Health Groups. Involving service providers and other stakeholders directly in the 'oversight and collaboration' on how state, territory and Commonwealth initiatives will be coordinated, gives them a much better chance of understanding and working with the plethora of initiatives. Governments also need to be prepared to better coordinate their funding. With resources to the mental health sector limited, wastage through duplication and lack of communication cannot be afforded. The committee considers that clearer mental health service benchmarks, as recommended in chapter 2 will assist levels of government in identifying service gaps and coordinating their programs.

Legislative coordination and compulsory treatment orders

3.44 One particular aspect of coordination raised with the Senate Select Committee on Mental Health and again with this committee was coordination of mental health legislation and community treatment orders across jurisdictions. Mr Wright, Director of Mental Health Operations in South Australia, coming from a background in mental health services in New Zealand and Scotland, neatly summarised the situation in Australia:

> I find it strange that, in a country with 21 million people, you have eight different mental health bills…it is a problem for consumers and it is clearly a problem for us because we have to negotiate seven different cross-boundary agreements. It means that, if someone is on a community treatment order in South Australia, it actually becomes quite difficult for them.[45]

3.45 Mr Aspen, pointed to some well publicised examples to demonstrate shortfalls in this level of coordination. He also drew on personal experiences to talk about the limitations of community treatment orders across state boundaries.[46] Mr Aspen advocated that all states enter into agreements in relation to community treatment orders, but observed that so far there had been 'insufficient political will' to make these agreements.[47]

3.46 Progress on cross-border agreements has been made in some areas. For example, the Northern Territory Government noted that it has now completed a memorandum of understanding with South Australia and has commenced negotiations

---

44 *Proof Committee Hansard,* 7 May 2008, p. 3.

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

46 *Proof Committee Hansard,* 31 March 2008, p. 14.

47 *Proof Committee Hansard,* 31 March 2008, p. 16.

with Western Australia to develop a similar agreement.[48] The Hon Gregory James QC, President of the New South Wales Mental Health Review Tribunal also commented on an agreement between the ACT and New South Wales as a good example of cross-border coordination. However, the Hon James observed that no such cross-border arrangements exist for forensic patients. He outlined the incongruous situation that it is much easier to have forensic patients transferred home to an international location than if their home is another state within Australia.[49]

3.47 Cross-border agreements recognising compulsory treatment orders (CTOs) are important for ensuring continuity in the treatment of some people experiencing severe illness. The Select Committee on Mental Health recommended that all jurisdictions implement legislative reform to ensure that CTOs could be given effect regardless of the state or territory that a person was located in at a given time.

3.48 While cross-border agreements go someway towards providing a national approach, they do not address the diversity in kinds of treatment and care received across jurisdictions. The Australian College of Mental Health Nurses called for nationally consistent mental health legislation:

> A national mental health act would also go a long way in ensuring consistent care and preservation of consumer rights across jurisdictions, and the college strongly supports this coming to fruition sooner rather than later.[50]

3.49 The Senate Select Committee on Mental Health also recommended that state and territory governments agree to harmonise Mental Health Acts relating to the involuntary treatment of people with mental illness. Submitters noted that progress has not been made on this type of integration.[51] The committee recognises that harmonising state and territory Mental Health Acts will have many advantages, including providing greater clarity and certainty regarding compulsory mental health treatment Australia wide. It encourages state, territory and Commonwealth governments to work towards achieving nationally consistent legislation as soon as possible. In the interim, the committee supports rapid finalisation of cross-border agreements between all states and territories.

Recognising different service structures

3.50 The structure of the sectors which provide mental health services differ markedly across the states and territories and submitters noted that mental health initiatives have not been well coordinated to take account of these differences. For example, Queensland has moved to a model in which all funding to NGOs is provided

48 *Proof Committee Hansard*, 1 May 2008, p. 47.

49 *Proof Committee Hansard*, 27 March 2008, p. 81.

50 *Proof Committee Hansard*, 20 May 2008, p. 48.

51 Mental Health Council of Australia, *Submission 22*, p. 5.

through Disability Services Queensland, with Queensland Health no longer having a role in NGO funding.[52] In the NT, mental health services are predominately delivered through the public sector, with a relatively under-developed NGO sector and 'extremely small' private mental health sector.[53]

3.51 Several governments raised concerns that the funding models underlying national COAG Plan initiatives did not account for differences in state and territory service structures. For example, the NT Government posited that:

> The funding parameters imposed by the Australian government at the time the national action plan was implemented did not sufficiently take into account the unique service delivery environment in areas such as the Northern Territory.[54]

3.52 The Northern Territory Government argued that because Northern Territory primary healthcare services were ineligible to apply for funding rolled out through competitive tendering, the jurisdiction was left at a disadvantage in accessing the Commonwealth funds distributed through NGOs.[55] The Aboriginal Medical Services Alliance NT noted that in some parts of the Northern Territory private providers have not tendered for programs such as PHaMs, so 'a significant amount of the money is unspent'.[56]

3.53 Several state and territory governments raised concerns that they were disadvantaged in terms of accessing the federal funding being distributed under Medicare through the Better Access initiative.[57] They argued that in areas with low numbers of GPs and few mental health professionals or allied health professionals, use of the initiative would be inherently limited. These concerns are discussed further in chapter 6.

3.54 The NT Government argued for more flexible funding arrangements, such as enabling NT Government primary health and public mental health services in rural and remote communities to be eligible for the Better Access initiative. Overall, the NT Government argued for a more flexible funding model in rural and remote areas, that 'looked at creating a critical mass that built on existing infrastructure'.[58] Several witnesses argued that available COAG Plan funding would be better used to

---

52 *Proof Committee Hansard*, 16 May 2008, p. 45.

53 *Proof Committee Hansard,* 1 May 2008, p. 49.

54 *Proof Committee Hansard,* 1 May 2008, p. 48.

55 *Proof Committee Hansard,* 1 May 2008, p. 48.

56 *Proof Committee Hansard,* 1 May 2008, p. 23.

57 See for example Government of South Australia, *Proof Committee Hansard*, 8 May 2008, p. 88; Northern Territory Government, *Proof Committee Hansard*, 1 May 2008, p. 49; ACT Government, *Submission* 37, p. 4.

58 *Proof Committee Hansard,* 1 May 2008, p. 55.

strengthen and expand public area mental health services, rather than supporting a range of services organised through different private providers.

3.55 The committee is concerned that the assumptions about mental health service structures that underlie some Commonwealth initiatives in the COAG Plan may disadvantage areas most in need of new services. In areas where services are already limited or non-existent, NGO providers may not exist or have the capacity to tender for available funding. Areas without mental health professionals and allied professionals will not benefit from Better Access funding. These already disadvantaged areas stand to miss out on the opportunity for new services.

3.56 The committee considers it essential that take up of the Commonwealth COAG Plan initiatives across different areas is closely monitored. Alternative funding arrangements may need to be considered in areas where there is insufficient private sector capacity to rollout the COAG Plan initiatives. Importantly, funding allocated for particular areas should be quarantined for use in those areas; if sites have been selected on the basis of need, that need remains real despite a lack of tenderers. The committee considers that there is a case for allowing some programs to be provided through public mental health services in targeted areas where other health infrastructure is not available.

Recommendation 4

3.57 The committee recommends that FaHCSIA track unspent funding under National Action Plan community initiatives rolled out through NGOs. The committee recommends that any underspent funds in sites selected for National Action Plan programs be quarantined for use in those areas and distributed through other mental health programs or direct purchase of services from public health or other providers.

Care coordination

3.58 As well as efforts focussed on coordination at a strategic and institutional level, the COAG Plan recognised that connecting the available services on the ground is fundamental to improving Australia's mental health care. The Plan recognised that people with severe mental illness and complex needs are most at risk of falling through the gaps in the care system. One of the COAG Plan flagship initiatives, 'Coordinating Care', was intended to provide a new system of linking care for individuals. The aim of the initiative was to give people with severe mental illness the 'ability to better manage their recovery by giving them clear information on who is providing their care, including information on how to access 24-hour support, and who can help link them into the range of services they need'.[59]

3.59 The focus of the initiative was adults aged 18–64 years with severe mental illness who have enduring symptoms, associated disabilities and/or complex and

59 COAG Plan, p. 5.

multiple service needs. Estimates indicated that around 50,000 people across Australia would be in this target group.[60] The COAG Plan stated that people within the target group would be offered a clinical provider and community coordinator from Commonwealth and/or state and territory government funded services. These people would be responsible for the clinical management of the person and for ensuring that the person is connected to the non-clinical services they need, for example accommodation, employment, education, or rehabilitation.[61]

3.60 The committee received different perspectives on the merits of this approach. People were agreed that, at a systemic level, service connection and integration is essential. In terms of how care for an individual is coordinated, there were different responses. Mr Cheverton, of the Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, advocated the consumer role:

> What people with mental illness are finding is that they have three other people who think it is their job to coordinate their care. Their case manager thinks he or she is doing it; their NGO think they are doing it; maybe their parent or husband thinks they are doing it. There is no space left for the person in that. It is very complex. There is not going to be one model. It has to be individualised, it has to be flexible and it has to be person centred and person directed.[62]

3.61 Similarly, the Health Consumers' Council expressed concern that care coordination roles can be seen as 'some kind of panacea'. Ms Drake, Advocate with the Council, cautioned that care coordination can become another workforce that 'does unto the people' it is intended to assist, without necessarily providing the assistance that they need. Ms Drake pointed out that there can be an assumption of incompetence among mental health consumers, with the risk that control over their own lives can be taken away from them.[63]

3.62 There have been very different approaches to 'care coordination' across the jurisdictions and concerns that a lack of allocated funding has limited progress. These issues are discussed below.

Funding

3.63 No funding was allocated in the COAG Plan for the care coordination initiative. The committee was given to understand that rather than being a new program providing new services, with associated funding, care coordination was about a new model for service provision. It was intended that jurisdictions would look at

---

60 DoHA, Supplementary Information dated 31 March 2008, 'COAG National Action Plan on Mental Health *Care Coordination Principles and Implementation Guidelines*', received 2 April 2008.

61 COAG Plan, p. 5.

62 *Proof Committee Hansard,* 26 March 2008, p. 22.

63 *Proof Committee Hansard,* 7 May 2008, p. 87.

restructuring their existing service systems to facilitate a care coordination approach. Examples of the factors to be addressed in this restructure included how services could better work together to avoid duplication and minimise gaps, how services could be linked together more effectively, the governance arrangements required, the issues relating to privacy and information sharing that needed to be resolved, effectiveness of referral pathways and ways to track and manage the care provided to consumers.

3.64 There were different views about whether a new way of providing services could be achieved without designated funding. The WAAMH considered that in the long term, care coordination would become a central part of everyday work and be cost neutral, but that there were additional costs in the initial phases.[64] Representatives from Ruah Community Services, an NGO in Western Australia, commented that lack of funding for care coordination meant that progress in WA had been stripped down to a 'tiny, tiny pilot'. Representatives were concerned that 'care coordination was expected to improve with no additional resources', noting that the mental health system as a whole 'still does not have good case management and care coordination'.[65]

3.65 Mr Thorn, from the WA Department of Premier and Cabinet, considered that more contribution from the Commonwealth would assist the initiative:

> While we have not entirely done it without their help, I have to say their contributions to it have dropped away significantly in recent times.[66]

3.66 Some state governments have provided additional funding for implementing care coordination. For example the Queensland Government allocated $4.8 million for 20 Service Integration Coordinator positions to support the implementation of care coordination locally, as well as a full-time position with the COAG Mental Health Committee to drive the initiative state wide.[67] These positions were not to be case managers and the incumbents were not intended to have contact with individual consumers participating in the program. Rather, the coordinators were for engaging existing government, non-government and private sector local service providers to 'actively participate in the Care Coordination model'.[68] Dr Groves, Director of Mental Health, Queensland Health, noted:

> …whilst the Commonwealth was making an investment through the PHaMs measure, what we needed to do was have a process of getting care coordination throughout Queensland. We recognised that not everywhere in Queensland would necessarily get a PHaMs site and would not necessarily get them early on in the process. So what we have tried to do is look at how

64 *Proof Committee Hansard*, 7 May 2008, p. 4.

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

66 *Proof Committee Hansard*, 7 May 2008, p. 91

67 DoHA, Supplementary Information dated 31 March 2008, 'Update on State-based COAG Mental Health Groups including progress with care coordination', received 2 April 2008.

68 *Submission 49*, p. 68.

> the Queensland government agencies work together in terms of providing services, linking to the public mental health sector and also into primary mental health care, because that is an important interface that we have invested in to try and strengthen it.[69]

3.67 While the care coordination initiative may be based in a big picture perspective of how mental health care should work and the issues that need to be addressed to make coordination a reality, the COAG Plan also made the commitment that:

> People within the target group will be offered a clinical provider and community coordinator from Commonwealth and/or State and Territory government funded services.

3.68 FaHCSIA reported that most jurisdictions have identified that the Commonwealth funded Personal Helpers and Mentors (PHaMs) will be the first providers to fill the role of community coordinators for the purposes of the COAG coordinating care initiative. However, FaHCSIA noted that the two programs are not interchangeable. There are somewhat different participation criteria for each initiative. For example, consumers have to have a clinical diagnosis before they are offered a community coordinator, whereas PHaMs participants do not have to have a formal diagnosis. Further, PHaMs has a maximum capacity of around 10,000 participants, whereas some 50,000 people may be eligible for care coordination. FaHCSIA commented that therefore 'it is important that other services are identified as having a role as community coordinators under the care coordination framework in addition to the Australian Government's commitment'.[70] As noted, most state and territory governments have not identified funding for this.

Implementation across the jurisdictions

3.69 The Mental Health Standing Committee of AHMAC has endorsed principles and guidelines for the implementation of care coordination Australia wide. However the evidence to the committee's inquiry indicated the diversity in approaches to, and progress of, care coordination across the states and territories. In some states, such as New South Wales and Tasmania, care coordination was being trialled in selected sites using existing Commonwealth programs such as PHaMs. In New South Wales, over 100 clients were already participating in the program and issues involved in care coordination, such as privacy and information sharing, referral pathways and tracking of clients were being worked through. In other states, such as South Australia, little progress had been made beyond initial planning and framework development.[71]

3.70 In the ACT, officials reported that care coordination remained a challenge:

---

69 *Proof Committee Hansard*, 16 May 2008, p. 46.

70 *Submission 28*, pp. 8–9.

71 DoHA, Supplementary Information dated 31 March 2008, 'Update on State-based COAG Mental Health Groups including progress with care coordination', received 2 April 2008.

> ACT is currently undertaking a pilot study on care coordination to examine how we can improve the coordination and address the many challenges that exist in trying to coordinate care where it involves multiple agencies. Some of those challenges are around the sharing of information, recording of information and, indeed, just the different expectations of different sectors and different agencies.[72]

3.71 The approach to care coordination in Tasmania was not clear, according to Anglicare representatives:

> I think what care coordination is in Tasmania is still a little bit unknown to me. I participated in one meeting where the Personal Helpers and Mentors Program in Launceston was also invited. It was really just an opportunity for both programs to talk about what they were doing and where they were at. As a manager of mental health services, I am still not really sure what I would call care coordination in Tasmania. It is a bit of a concern to me and something that NGOs and government services are likely to come back to and have a look at.[73]

3.72 Representatives from the Western Australian Government stated that they saw care coordination as 'fundamental to the delivery of mental health care'. Dr Patchett, Executive Director Mental Health, while noting that there was a long way to go, saw that individual care plans agreed with consumers should drive the care of individuals:

> What we should all be trying to do is to have a consenting cooperative agreement to go forward as to what care components are being delivered to each person in Western Australia.[74]

3.73 Although there are clear differences in how care coordination is viewed and being progressed across the states and territories, the evidence to the committee was definite that coordinating the services that do exist is fundamental to improving mental health care in Australia.

Concluding comment

3.74 By including 'Care Coordination' as a flagship initiative, the COAG Plan took an important step in recognising that funding more services is not the only element to improving mental health care in Australia. Making sure that services fit together in response to individuals' needs and circumstances is equally essential. On the basis of the evidence given to the committee, care coordination is one of the lesser developed concepts in the COAG Plan. Its fit with other initiatives such as PHaMs and the likelihood of comprehensive implementation, without any specific funding, is not clear.

---

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

73 *Proof Committee Hansard,* 31 March 2008, p. 40.

74 *Proof Committee Hansard,* 7 May 2008, p. 89.

3.75 Care coordination is a particular area of the COAG Plan for further follow up and review. It will not be simple to evaluate the progress made in care coordination. For one, it is not simply an additional service which can be looked at in terms of dollars spent and service episodes provided. It requires a much more holistic view as to how mental health care is and is not working for individuals, including clinical services, in-patient and community-based care, psycho-social and other supports. Adding to the challenge is that care coordination is being approached differently across the states and territories.

Recommendation 5

3.76 The committee recommends that COAG review the progress of the Care Coordination initiative in each state and territory prior to the completion of the *National Action Plan on Mental Health 2006–2011*, including an assessment as to whether allocated funding is needed to enable the aims of the initiative to be achieved.

Recommendation 6

3.77 The committee recommends that each state and territory government include in its reports to COAG the number of people in the Care Coordination target group that have actually been offered a clinical coordinator and community coordinator.