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Clinical mental health service catchments

30 October 2013

1. Background

The Victorian Healthcare Association (VHA) is the peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health service, aged care facilities and Medicare Locals. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

The Victorian Department of Health (the Department) has released a consultation paper titled *Clinical Mental Health Service catchments* (the paper) that discusses the need to review and potentially redraft the catchment boundaries for metropolitan Melbourne's Area Mental Health Services (AMHS).

The VHA welcomes the opportunity to provide input to the consultation and agrees to this submission being treated as a public document and being cited in any reports that may result from this consultation process.

The VHA notes that while the information contained in this submission is based on member feedback, the VHA's submission does not supersede any made by its member agencies.

2. Introduction

The provision of mental health services is multi-faceted and reliant on a range of different organisations and approaches. In Victoria, the public mental health system largely consists of the community-based Mental Health Community Support Services (MHCSS) sector, and the clinical mental health sector, provided by hospital networks.

The Victorian system of organising mental health services into geographic catchments has been in place for 16 years and has delivered some system efficiencies and a logical arrangement for planning and resourcing mental health services. Regional relationships between health services,

social services and community organisations have developed a level of complexity and maturity, however the gaps caused by overlapping boundaries and changes to age-related eligibility are driving the case for change.

Gaps exist in the system; particularly those relating to consumer access and the continuum of care. The paper seeks to initiate the process of joining some of the areas of Victoria's mental health, health and social services systems together into a more coherent whole.

The VHA largely supports the aims and principles of the consultation, but offers some cautions that the Victorian Government should be mindful of if a reform of clinical mental health catchments is undertaken.

3. VHA Response

VHA Recommendations:

- That Option Two be considered the preferred option for change
- That undertaking any reforms to catchment boundaries be held off until the mental health sector has fully implemented the changes of the updated *Mental Health Act*, activity-based funding, and retendered the MHCSS and AOD sectors
- That areas experiencing significant fragmentation to service delivery due to poor alignment be addressed as a priority when any reform is implemented
- That the needs of consumers and carers continue to be prioritised
- That the Department be closely involved in the negotiation of any transfer of business between health services
- That unintended impacts, such as performance against NEAT guidelines, be accounted for prior to undertaking any reform
- That each region, where possible, have a lead health service that has strong connections with that community and a high degree of local accountability.

3.1. System integration

The paper discusses the integration of AMHSs with other elements of the mental health system, but does not give enough emphasis to the need for mental health services at all levels to closely integrate with the broader health system. The mental health system has progressed a great distance since de-institutionalisation and integration policies were implemented. However, the

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VHA fears that these gains may be undermined unless clinical and community-based mental health policies continue to emphasise integration with the medical and primary health systems.

3.2. Policy and reform context

The VHA cautions the Department that undertaking a redraft of AMHS catchments while the acute and community sectors are undergoing broad scale reform, both in mental health and related programs, could place too great a burden on providers. Should this consultation result in a recommendation to alter existing boundaries, the VHA believes that the benefits to the system and consumer must clearly outweigh the inevitable disruptions required to implement the required changes, and must only go ahead when the sector and the Department are able to dedicate their complete attention to the task.

Opportunities to undertake change at this level are rare, and it is important that the inevitable difficulties of changing boundaries and service agreements do not derail the overarching aims and goals of the reform. Expediency is far less important than achieving a high quality result. Thus, the VHA urges a considered and moderate approach in terms of setting time-based goals for any changes to be implemented.

3.3. National Emergency Access Target

The VHA notes that the discussion paper does not refer to any potential impact on hospitals achieving the benchmarks of the National Emergency Access Target (NEAT). Given the financial incentives associated with the NEAT, it is important that potential impacts on emergency department performance are scoped and accounted for prior to undertaking any transfer of business or redraft of catchment boundaries, particularly in cases where there is cross-management of emergency department presentations.

3.4. Terms of reference

While the VHA recognises that catchment boundaries are intended to be a tool to aid service planning and resource distribution, rather than for enforcing strict eligibility criteria, there is a legitimate need to discuss the broad impacts of changing policy and funding guidelines for

mental health services; in particular the move to activity-based and client-directed funding and how this will impact on consumer movement and clinical mental health service eligibility.

While this consultation paper is not the correct forum to be discussing the broader merits of applying client-directed funding in acute settings, it is worth noting that community-based mental health will be operating under a client-directed funding system, forcing providers to respond to community demand in innovative and competitive ways. It is important that the implications of this potentially mobile population of consumers be considered.

The VHA would like to see a long-term strategic view applied to any change options adopted; one that includes the potential impacts of client-directed and activity-based funding, and how a high degree of flexibility and choice for consumers will affect the provision of clinical mental health.

4. Consultation Questions

4.1. The Case for Change

The VHA agrees with some of the points cited in the case for change section of the paper. The current organisation of the clinical mental health system is hindered by poorly aligned catchments, and the lack of logic and clarity around which health service is the lead agency for age-specific mental health in some of metropolitan Melbourne's regions causes unnecessary confusion for consumers and carers.

However, the proposed change towards whole-of-life mental health service availability in each catchment is not necessarily a fair representation of a need for a significant system reform. The service focus of each age-specific AMHS is different, and consumers do not necessarily transition from one element to the next. Providing whole-of-life mental health capacity in each catchment is logical from a system planning perspective, however the VHA disagrees with it being a key driver for this reform.

The VHA agrees with the need to align catchment boundaries with other relevant health and social service catchments. Care for people suffering mental illness does not occur in a silo. Many organisations are often involved with a single consumer's care and an alignment of planning and service provision catchments is a positive driver for change.

The VHA recognises that there are significant benefits to system planners, health services and the Department to be gained from the alignment of catchment boundaries, but the needs of consumers and carers should continue to be the priority of the reform. A system that is logically organised from a funder, provider and system planner's perspective may not be ideal for consumers. The VHA suggests that the views of carers and consumers continue to be elevated throughout the reform process.

4.2. Principles and Criteria to Guide Change

a. The VHA supports assigning a lead health service in each catchment. There may not be capacity for the provision of whole-of-life clinical mental health care by a single health service in each region, necessitating partnership between health services to provide the requisite care. The Department must proceed with caution with any changes that may undermine existing clinical and corporate governance models. It is the VHA's position that the best care is provided by a health service with strong links to its community, which allows management to have a strong grasp of local needs, and provides stronger local accountability;

b. The VHA supports age-group alignment in each catchment, but questions whether it should be noted as a key driver for this reform. The mental health focus of each age-specific AMHS is different, and there is rarely a clear continuum for a patient through each of the age-specific services;

c. The VHA supports the alignment, where possible, of clinical mental health service catchments with other key health and planning boundaries, including MHCSS, AOD services, and Medicare Locals;

d. The VHA supports formalised planning participation between AMHSs and other health and social service organisations and collectives. While health services already commit a significant amount of time and resources contributing to Primary Care Partnerships, Medicare Locals, Local Government and related planning bodies, alignment of boundaries should assist in further clarifying the expectations related to collaborative planning;

e. The VHA supports the principle of area self-sufficiency, but area-based planning must be undertaken by the Department and relevant health services to determine protocols and expectations regarding the continuum of care in each region;

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f. The VHA supports the facilitation of access to specialised services in arrangements that are relevant and appropriate to each region;

g. The VHA supports the move to larger catchment areas for the promotion of regional self-sufficiency, but cautions the Department that much of the strong local connections that health services contribute to will be difficult to maintain in catchments that exceed a certain geographic area and population size. The VHA also notes the inconsistency within the paper, where the optimal catchment size is cited as 500,000-600,000 people, yet Option Three would entail catchment sizes exceeding 1,500,000 by 2021;

h. The VHA supports the principle of remaining responsive to demographic trends, including population growth and changes of incidence and prevalence of mental illness across metropolitan Melbourne and regional areas, and believes that locally managed AMHSs are best-placed to contribute to this;

i. The VHA supports the provision of mental health services in community-based settings and in places that are flexible and responsive to people's needs, including a degree of flexibility regarding service eligibility.

4.3. The VHA's views on the options for change

The needs of consumers and carers

The VHA would like to see the needs of carers and consumers elevated in this reform discussion. While there are many system benefits to be gained from reforming catchment boundaries, any changes must have consumer and carer access included as a priority. The VHA recommends that the Department consults closely with mental health consumer and carer representatives to ensure that any changes undertaken are done so in reference to their needs.

The VHA believes that the needs of consumers and carers at a macro level are best catered for by having a clear continuum of care, with seamless transitions between acute inpatient, specialised and community-based services. This should be a priority outcome in any reform.

The VHA believes that aligning catchment boundaries, in line with those recommended in Option Two, strikes the best balance between achieving a significant improvement to the system and for access for consumers, and a manageable degree of disruption for health services and consumers during implementation.

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The capacity of public mental health services to plan and coordinate with other parts of the sector and with the community services sector

A strength of the mental health sector is its integration and joint planning role with a range of mental health, health and social service organisations. The current catchment boundaries provide somewhat clear guidelines regarding which organisations and elements of the sector need to undertake collaborative planning, with some possible confusion at the edges of catchments as an exception.

The VHA believes that Option Two provides a logical balance between catchment size and boundary alignment, and would allow health services to continue their planning and coordination activities with relevant local organisations.

The larger catchments described in Option Three would stretch the capacity of health services to maintain close links with their communities and to continue the joint planning currently being undertaken with neighbouring health, social service and community organisations.

Quality and clinical governance

The VHA notes that any changes that involve the delivery of services on the campus of another health service have the potential, if poorly managed, to undermine clinical and corporate governance models. Much work has been undertaken across the health sector to integrate emergency department, acute inpatient and community-based mental health services into the broader health environment, and this progress may be undermined by changes involving mental health services provided on the campus of another health service.

The VHA recognises that if the aim of providing whole-of-life mental health services within each catchment is to be realised, then a degree of service sharing is required. In regions where this is necessary, the VHA suggests that any changes be made with the priority of integrating health and mental health as closely as possible in that health service, and that there is a fair distribution of risk associated with performance targets. In all cases there must be a clear agreement in regards to performance, clinical governance, communications and accountability expectations between the Boards of all health services involved.

Viability of implementation

Option One could be implemented with minor disruptions to existing arrangements and is considered viable for that reason alone, however it is not sufficiently ambitious to justify undertaking, given the broader system benefits offered by other change options.

Option Two requires a greater degree of stewardship from the Department, given the requirements for some health services to transfer business, and the suggestion that the lead health services may change in some areas. Implementing Option Two may result in a temporary disruption to services, but the VHA considers it a viable option.

Option Three is less viable, and would result in a significant disruption of services and local partnerships. The VHA is concerned that Option Three may require significant governance changes and service agreements to allow health services to manage acute mental health on other health services' campuses, and a change to local partnership arrangements. It also contradicts the Department's position that the ideal catchment population is between 500,000-600,000 people.

4.4. Undertaking change and associated implementation issues

The VHA is aware of the engagement work that the Department has undertaken directly with health service Boards and Executives and commends this approach. As two of the three proposed change options would result in transfers of service, it is imperative that the sector remains a closely engaged and collaborative partner in any changes.

In cases where health services would have their budgets and service targets adjusted, the Department would need to undertake a strong change management and leadership role to determine how such adjustments are applied.

4.5. Local issues to be considered

The VHA's submission will not detail examples of local issues requiring consideration, as its members will do so in individual submissions and via direct engagement with the Department.

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4.6. Service eligibility requirements

The VHA supports the use of catchment boundaries as a planning and organisational tool, rather than a device for strict determination of service eligibility. There are longer-term questions about the role of mental health services in an environment where activity-based and client-directed funding is the norm, but that is beyond the terms-of-reference of this consultation.

The question of service eligibility requirements highlights a number of issues relating to system fragmentation and inter-health service compatibility. Catchment-based service eligibility has some benefits to both consumers and health services, specifically in that patient records are consistently maintained, and there is a clear logic in terms of which health service is responsible for providing care in any region. While the VHA supports the increased freedom and flexibility for consumers and carers to choose a health service based on their personal preference and requirements, this may cause some issues for sharing patient records between health services, particularly for consumers living in complex socially disadvantaged situations, including homelessness, and those with significant co-morbidities.

Such troubles are not insurmountable, but do underscore the work ahead of the health system if it is to be able to fully support the flexible movement of consumers between hospitals and health services.

5. Conclusion

Of the three proposed change options, the VHA supports Option Two for a number of reasons:

- It most closely aligns with the principles and criteria to guide change;
- It offers the best balance between flexibility and responsiveness for consumers and carers, and system clarity and improvement for the Department and health services;
- It provides tangible improvements to the planning and organisation of local responses to community health needs;
- The use of catchment boundaries to organise and plan resources rather than enforce service eligibility is a priority that should not be lost.

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There are elements of the reform that could be strengthened and broadened, or that require greater consideration:

- There is insufficient emphasis on Melbourne's areas of social disadvantage and the different responses that are required;
- The policy context for mental health is conspicuously complex at present and may hinder any moves to implement catchment reform;
- Some metropolitan regions would end up with smaller catchment populations than is cited as ideal in the paper, potentially leading to issues of sustainability.

The VHA views this reform as necessary and supports its implementation, provided it is at a time when the sector is not occupied with managing a raft of other significant legislative, funding and policy reforms. The opportunity to refine the catchment boundaries is important, and while there will be areas of Melbourne where focused negotiation and a transfer of business is required, the long-term benefits to the system and its users will outweigh the immediate troubles associated with implementing change.

It is important that two key focuses are maintained and supported through any reform to catchment boundaries; the needs of consumers and carers must always be considered and included, and that the integration of the mental health system into the broader health system is an ongoing priority and should not be sacrificed for a focus on better integration between mental health services.

6. Further information

For further information, please contact:

Chris Templin

Policy Advisor
Victorian Healthcare Association
Level 6, 136 Exhibition Street,
Melbourne, VIC 3000
Email: chris.templin@vha.org.au
Phone: 03 9094 7777

Tom Symondson

Director, Policy and Strategy
Victorian Healthcare Association
Level 6, 136 Exhibition Street,
Melbourne, VIC 3000
Email: tom.symondson@vha.org.au
Phone: 03 9094 7777