



# Victoria's Clinical Mental Health System Plan

## Discussion Paper

***Design, Service and Infrastructure Plan for Victoria's  
Clinical Mental Health System***

Department of Health and Human Services

August 2016

# Executive summary

This discussion paper relates to the development of a high level Design, Service and Infrastructure Plan for Victoria's Clinical Mental Health System (the Plan). With one in five Victorians expected to experience a mental health condition each year and almost half of Victorians expected to experience a mental health condition in their lifetime, it is important that Victoria's clinical mental health system is designed to adequately respond to the future needs of the Victorian community.

The Victorian clinical mental health system provided services for close to 66,000 registered clients in 2014/15 as well as a much larger number of unregistered individuals for which the system provided support and treatment. In 2014/15 there were over 27,000 mental health related admissions and over 2,000,000 mental health community contacts. Recognising the importance of system design and planning in ensuring sustainable care provision for Victorians, the Plan will take a long term, aspirational view providing direction at the systems level.

Informed and aligned to the goal and outcomes articulated in Victoria's 10 Year Mental Health Plan, are the following clinical mental health system planning principles that will support the development of this Plan. These are underpinned by the notion that system design of the clinical mental health system should be led by the unique needs of individuals with a focus on individuals most vulnerable and at risk.

- individual choice and co-production
- access to appropriate mental health care is equitable, responsive and timely, providing care in a community setting where possible
- services are person and family-centred, and organised around maintenance of an individual's functioning - through both management of illness (mental and physical) and the process of recovery
- role delineation should facilitate system design that aims to develop a complementary capability and service mix with a focus on safety and quality
- earlier, more connected individualised care and support.

In planning the design of the overall clinical mental health system across Victoria the following key considerations will need to be addressed.

**Capacity planning for the future** - with population characteristics and the nature of demand changing it is important to consider the optimal mix of service models as well as approaches to forecasting demand to facilitate alignment of future supply and demand. Principles of recovery and co-production should underpin the design and planning of capacity and service models.

**Age based service configuration** – with age based service offerings being a key element of the current system architecture, there is a need for clarification of the definition and provision of child and youth based services, acknowledging that the 10 to 29 year age group is a critical time for early intervention given the significant onset of mental health conditions during this period. Further, with demographic trends clearly showing an ageing population there is a need to consider whether the definition for aged mental health services should be changed.

**Catchment based service configuration** - the catchment structure in Victoria has been unchanged since the 1990s. Review of this structure should consider: the appropriateness of maintaining existing fixed catchment areas for service delivery; suitable governance arrangements and enhanced alignment across age based services.

**Integration across service providers** - given the multifaceted nature of individuals' health care needs, integrated and interdisciplinary care approaches are necessary. Taking a holistic view of health care is encouraged given the often poorer overall health status of individuals with mental health conditions.

This discussion paper begins to identify some of the planning challenges for Victoria and emphasises the need to make clear choices regarding the future direction and configuration of the system.

We welcome your feedback and views on the questions raised throughout this discussion paper which can be provided via [Clinical Mental Health Service Plan survey](#).

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# 1 Introduction

The focus of this discussion paper is on developing a Design, Service and Infrastructure Plan for Victoria's Clinical Mental Health System (the Plan). Development of this high level systems focussed Plan provides an opportunity to review the structure and architecture of Victoria's clinical mental health system which has not been comprehensively reviewed since the mid-1990s. The Plan is a key element of the implementation of Victoria's 10 Year Mental Health Plan and will take a long term view aiming to be aspirational and develop a world leading clinical mental health system for Victoria.

30 years ago the clinical mental health system was structured around the need for deinstitutionalisation - that is, moving support and care for people out of standalone psychiatric hospitals toward care that is based in the community. Victoria's population growth in the 1990s was concentrated in the south eastern suburbs of Melbourne with suburbs such as Caroline Springs being undeveloped green space.

Fast forward 30 years, Victoria is a very different place, with population growth over the last 20 years being greater than the size of Adelaide's entire current population (growth of 1,400,000 people since 1996). Growth corridors and centres have emerged and are expected to continue growing, especially in the north, west and inner Melbourne areas. Rapidly changing population, service provider and care characteristics are contributing to, and exacerbating, the misalignment between supply and demand across Victorian clinical mental health services. With one in five Victorians now expected to experience a mental health condition each year and almost half of Victorians expected to experience a mental health condition in their lifetime, it is important that the system adequately responds to the future needs of the Victorian community. Through development of Victoria's 10 year Mental Health Plan and previous consultations with health services regarding catchment structures, there is both the vision and a solid platform of existing information upon which the future architecture of Victoria's clinical mental health system can be built. To realise the goal and outcomes of the 10 Year Mental Health Plan, the design and configuration of Victoria's clinical mental health system needs to be reconsidered, to ensure the right types of services are accessible in the right places at the right time for those who need them.

## 1.1 Scope and purpose

The purpose of this discussion paper is to outline key service design and planning considerations for the Victorian clinical mental health system. It aims to stimulate discussion about clinical mental health service planning approaches, providing insights that will contribute to developing an informed and innovative final Plan.

The Plan aims to provide high-level direction for the design, capacity and configuration of the clinical mental health system, including public inpatient, sub-acute and other bed-based and community-based settings across Victoria. The Plan will articulate the system architecture needed to support achievement of the outcomes articulated in Victoria's 10 Year Mental Health Plan, and will provide the foundations and direction for clinical service planning over the initial five years of that plan.

Informed and aligned to the goal and outcomes articulated in Victoria's 10 Year Mental Health Plan, are the following clinical mental health service planning principles that will support the development of this Plan. These are underpinned by the notion that system design of the clinical mental health system should be led by the unique needs of individuals with a focus on individuals most vulnerable and at risk.

- **Individual choice and co-production** – are built into service design with shared influence, choice and decision making between individuals, their families, carers and service providers.
- **Access to appropriate mental health care is equitable, responsive and timely providing care in a community setting where possible** - aiming for equitable access to appropriate and safe clinical mental health services. Access should be underpinned by the fair and sustainable distribution of service capacity that is able to flex up and down in response to periodic changes in the volume or complexity of mental health needs.
- **Services are person and family-centred, and organised around maintenance of an individual's functioning - through both management of illness (mental and physical) and the process of recovery.**
- **Role delineation should facilitate system design that aims to develop a complementary capability and service mix with a focus on safety and quality** – ensuring services have the clinical capabilities required to safely perform their role enabling people with mental illness to receive the level of care and support they need in the most appropriate setting.
- **Earlier, more connected individualised care and support** – orientating the mental health system around the earliest point of need for an individual with integrated services designed for the health and wellbeing needs of the individual.

These planning principles support and compliment the statewide health system design principles as agreed by the Ministerial Advisory Council for the Statewide Design, Service and Infrastructure Plan for Victoria's Health System, to which this plan will contribute. The agreed design principles for Victoria's health system include:

- Victoria's public hospitals have clear role delineations, are geographically coordinated and are well connected to the broader health system.
- Where safe and cost effective to do so, services will be delivered outside of the hospital setting.
- Enhanced system design and service planning and performance management will release existing capacity in our public hospitals and better distribute new capacity.
- An appropriate balance will be considered so that designated tertiary/specialist health services are able to provide access to their local community, while also ensuring access to patients from across Victoria who require specialist care.
- The causal relationship between the volume of services being provided and the quality of these services will be reflected in system design and service planning.
- The prioritisation and distribution of high cost medical equipment across the system will be undertaken by the department.

This discussion paper focuses on key considerations for Victoria's clinical mental health system over the next 20 years, including the broad areas of: age based service configuration, catchment configuration, integration across service providers, ensuring sustainable capacity and service models, individual choice and governance arrangements.

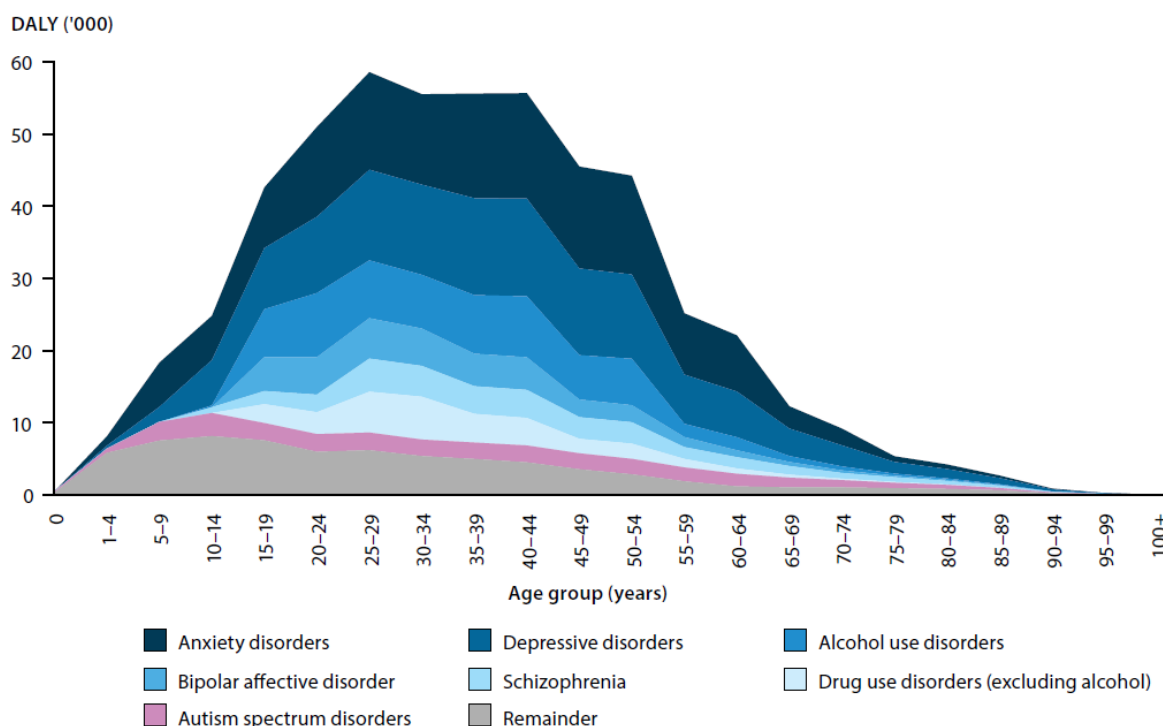
# 2 Mental health profile

## 2.1 Burden of disease

Mental and substance use disorders are the third highest burden of disease category (12 per cent of Australia’s burden of disease and 24 per cent of Years Lived with a Disability (YLD)), contributing significantly to Australia’s burden of disease profile. Women contribute a higher proportion of the non-fatal burden for mood, anxiety and eating disorders, whereas men appear to have a higher proportion for substance use disorders, schizophrenia and disorders that begin in childhood. Exploring trends over time, it appears that people are living for longer with illness, with the age standardised rate of total burden due to mental and substance use disorders decreased for fatal burden and increased slightly for the non-fatal burden across 2003 to 2011<sup>i</sup>.

Figure 2-1 below illustrates that the 10 to 29 year age group is a critical time for early intervention given the significant onset of mental health conditions during this period. The National Mental Health Commission (The Commission) acknowledge that early intervention is important for people of all ages, especially those with first time mental health issues or those for which mental health difficulties are becoming more complex. The Commission suggests that best practice encourages holistic, proactive and non-stigmatising approaches for timely identification of early warning signs<sup>ii</sup>.

Figure 2-1: Mental and substance use disorders burden (DALY), by age and disease - Australia

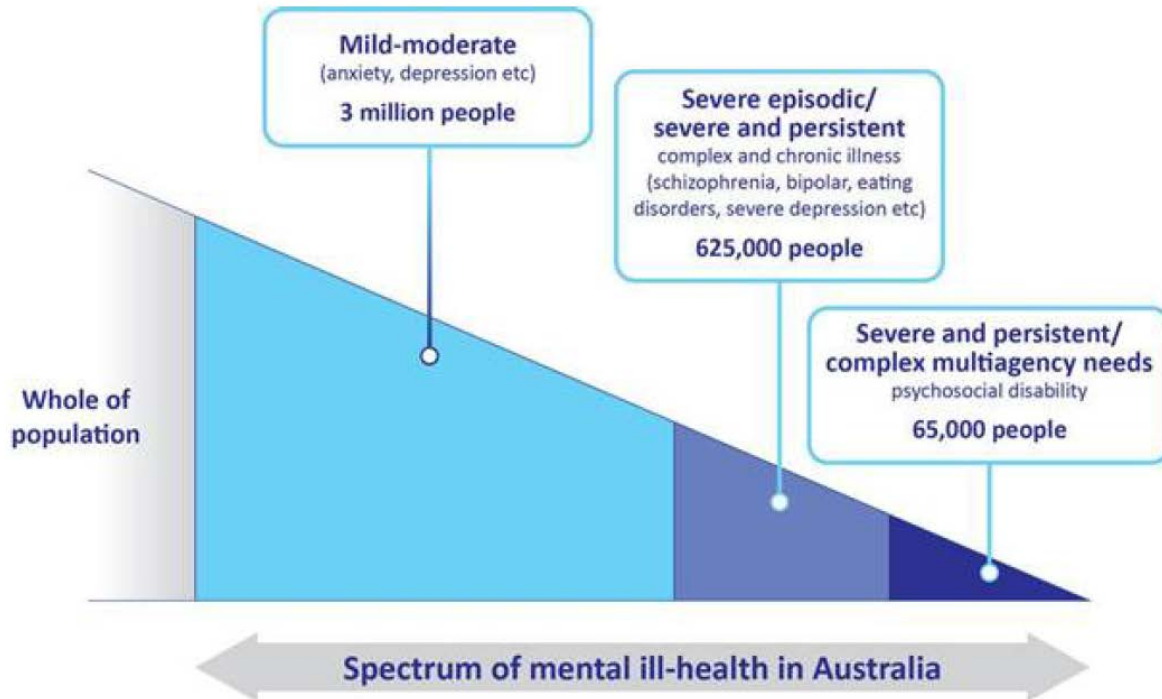


Source: Australian Institute of Health and Welfare, Australian Burden of Disease Study, 2011.

## 2.2 Continuum of mental ill health

Around three per cent of the Australian population experience mental illness with the severity spread across a spectrum of mental ill-health as shown in Figure 2-2 below.

Figure 2-2: Distribution of severity of mental ill health in Australia



Source: National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services, 2014*.

Given only 46 per cent of individuals currently seek services per year, taking a holistic view of health care is encouraged<sup>iii</sup>. This is important given the often poorer overall health status of individuals with mental health conditions and the need to encourage individuals, their families and carers to access services. The stark reality is people with severe mental disorders on average tend to die earlier than the general population with there being a 10 to 25 year life expectancy gap<sup>iv</sup>.

## 2.3 Mental health system architecture

The structure of the clinical mental health system - the system architecture – should be aimed at providing resources and effort in the most appropriate form, in the right places, at the right time. Mental health architecture should consider the following groups and their unique care needs (Figure 3-2)<sup>v</sup>:

- Family and child health – acknowledging lifelong health approaches, developmental years and the need for early intervention.
- Youth and young adults – acknowledging a period of significant onset of mental illness and the need for early intervention.
- Adults – acknowledging chronic mental health difficulties and the need for provision of holistic health care.
- Older people – acknowledging the need for appropriate services that consider holistic aged care needs.

# 3 Victorian mental health system

Victoria’s clinical mental health system comprises acute, subacute and community services with acute services providing care for those with complex and severe needs, for example those who would sit closer to the tip of the triangle shown in Figure 3-1. At the other end of the spectrum, community services support people with a mental illness to manage their self-care, improve social and relationship skills and achieve broader quality of life via physical health, social connectedness, housing, education and employment<sup>vi</sup>.

The Victorian public clinical mental health system provided services for close to 66,000 registered clients in 2014/15 as well as a much larger number of unregistered individuals for which the system provided support and treatment. In 2014/15 there were over 27,000 mental health related admissions and over 2,000,000 mental health community contacts. Over the last seven years mental health service activity in terms of community contacts has remained stable and average contact hours per client have been falling (Figure 8-1).

Total admissions and client numbers have slowly increased and average length of stay per client have slowly decreased for children, youth and adults, however have increased for individuals aged over 65 years (Appendix Figure 8-2 to 8-4). Over the past 10 years the severity of problems that individuals present with on admission has increased as measured by the Health of the Nation Outcome Scale (HONOS) scores). The age standardised separation rate has increased at an uneven rate in the 10 years to 2015, illustrating an increasing utilisation of admitted patient services (Figure 8-5)<sup>vii</sup>.

Figure 3-1: Services and prevalence of adult mental illness in Victoria



Source: Victorian Department of Health and Human Services, 2016.

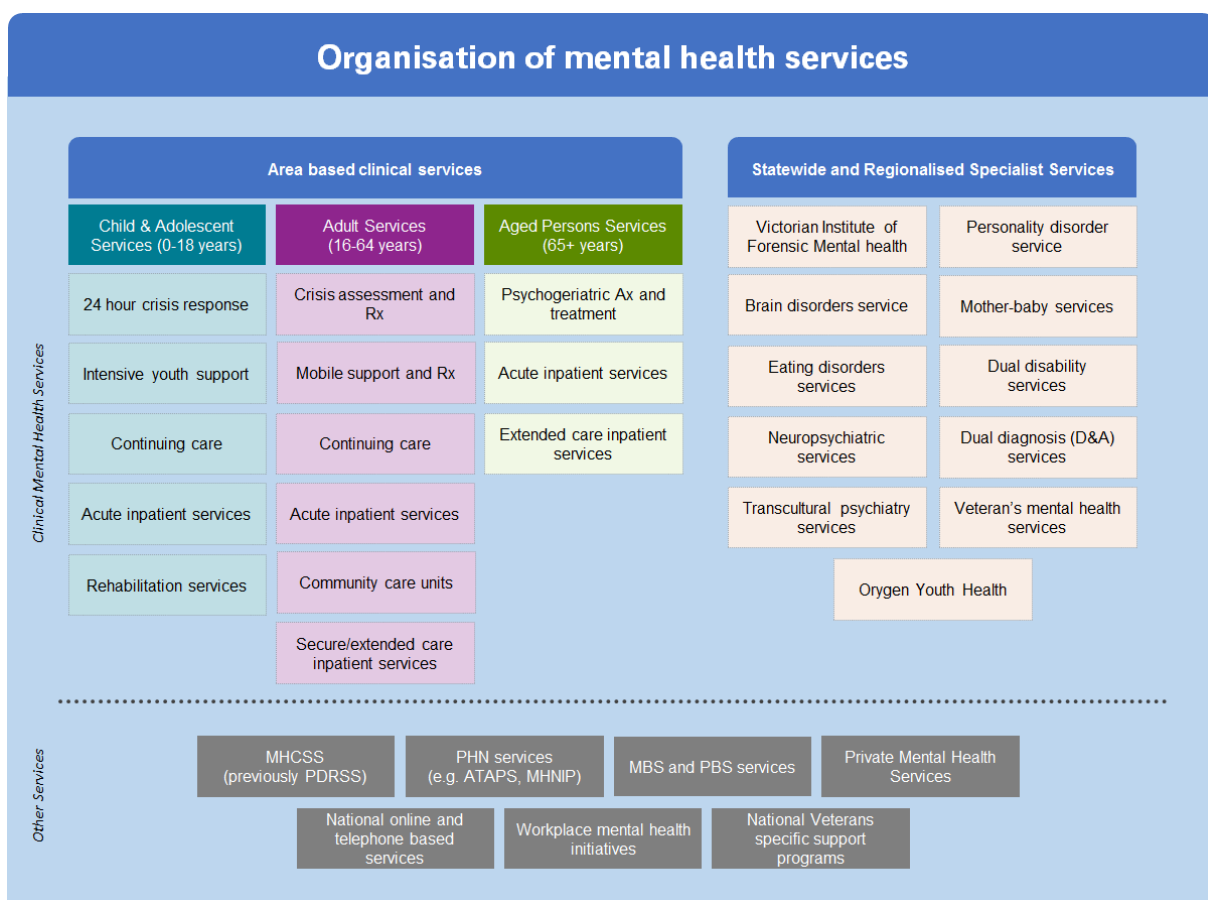
### 3.1 Service types and locations

Clinical mental health services are provided in a number of settings including acute inpatient services, community based services, residential care and non-government support services. The architecture of Victoria’s system includes elements around: acuity, population type and geographic catchments, with overlap across these system layers that can lead to complexity.

Public mental health funding in Victoria is relatively evenly split across acute (52 per cent) and sub-acute, outpatient and community services (receiving 48 per cent)<sup>viii</sup>; consistent with public mental health funding at a national level. The profile of inpatient services has changed significantly over time, with a changing balance between community and inpatient bed based services.

The Clinical Mental Health System Plan will focus on area based clinical services and specialist services (Figure 3-2). In developing a Plan for clinical mental health services the interfaces and relationships between other services sitting below the line in Figure 3-2 will also be considered.

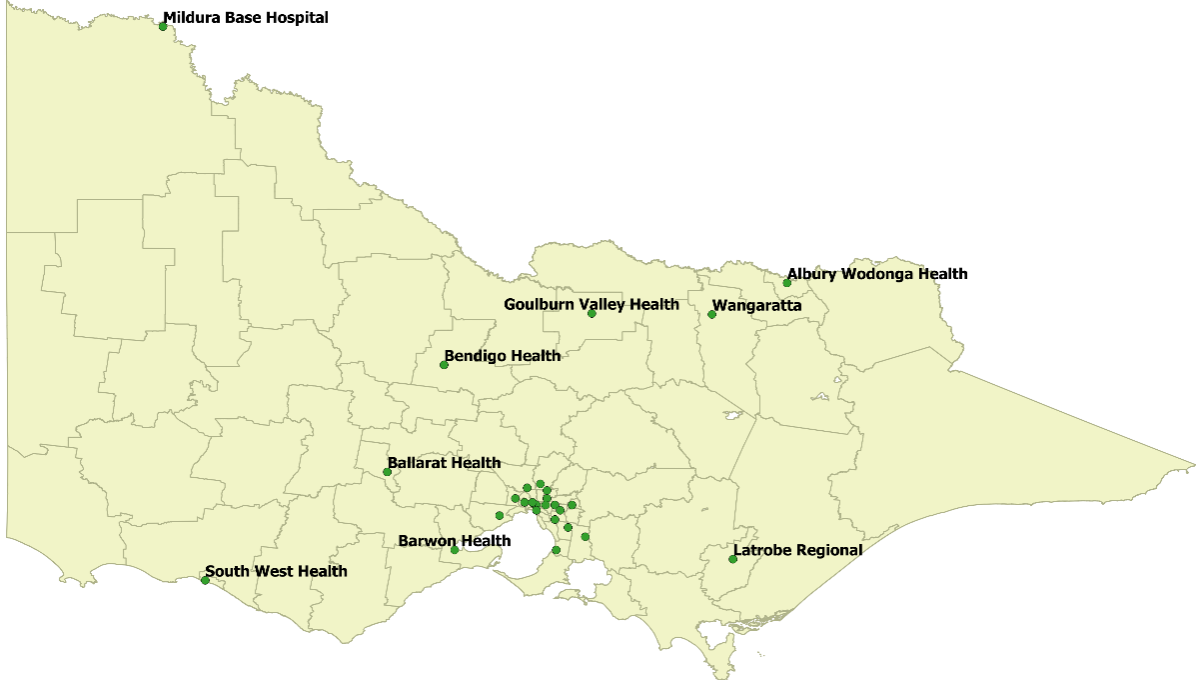
Figure 3-2: Organisation of mental health services



Source: KPMG, 2016 based on information from Victorian Department of Health and Human Services.

Figure 3-3 below shows the various public admitted mental health services across Victoria, showing that rural and regional units are located in the major regional towns. In metropolitan Melbourne there is a distribution across the major hospital sites.

Figure 3-3: Map of health services offering admitted mental health services



Source: KPMG, 2016 based on information from Victorian Department of Health and Human Services.

# 4 Capacity planning for the future

Population characteristics and the nature of service demand is changing. Being able to reliably estimate future demand across different consumer cohorts, service types and locations is important for developing appropriate capacity planning approaches and clinical service models.

## 4.1 Consideration – Optimal demand modelling approach

### *Demand and bed modelling*

Nationally, a range of approaches have been used to estimate demand for services. Historically, the use of normative population based benchmarks have been used to estimate total bed requirements for a state for a range of program areas.

The Mental Health Clinical Care and Prevention (MH-CCP) model was developed in New South Wales in the early 2000s. A key feature of MH-CCP is that the population prevalence of mental illnesses is stratified by age group and by defined levels of severity, described as mild, moderate and severe. Appropriate average care packages (bed based and community) are assigned to groups within each level of severity.

This approach has been adopted and further developed by the Commonwealth Department of Health into the National Mental Health Service Planning Framework (NMHSPF). This project aims to achieve a population based planning model for mental health that will better identify service demand and care packages across the sector in both inpatient and community environments.

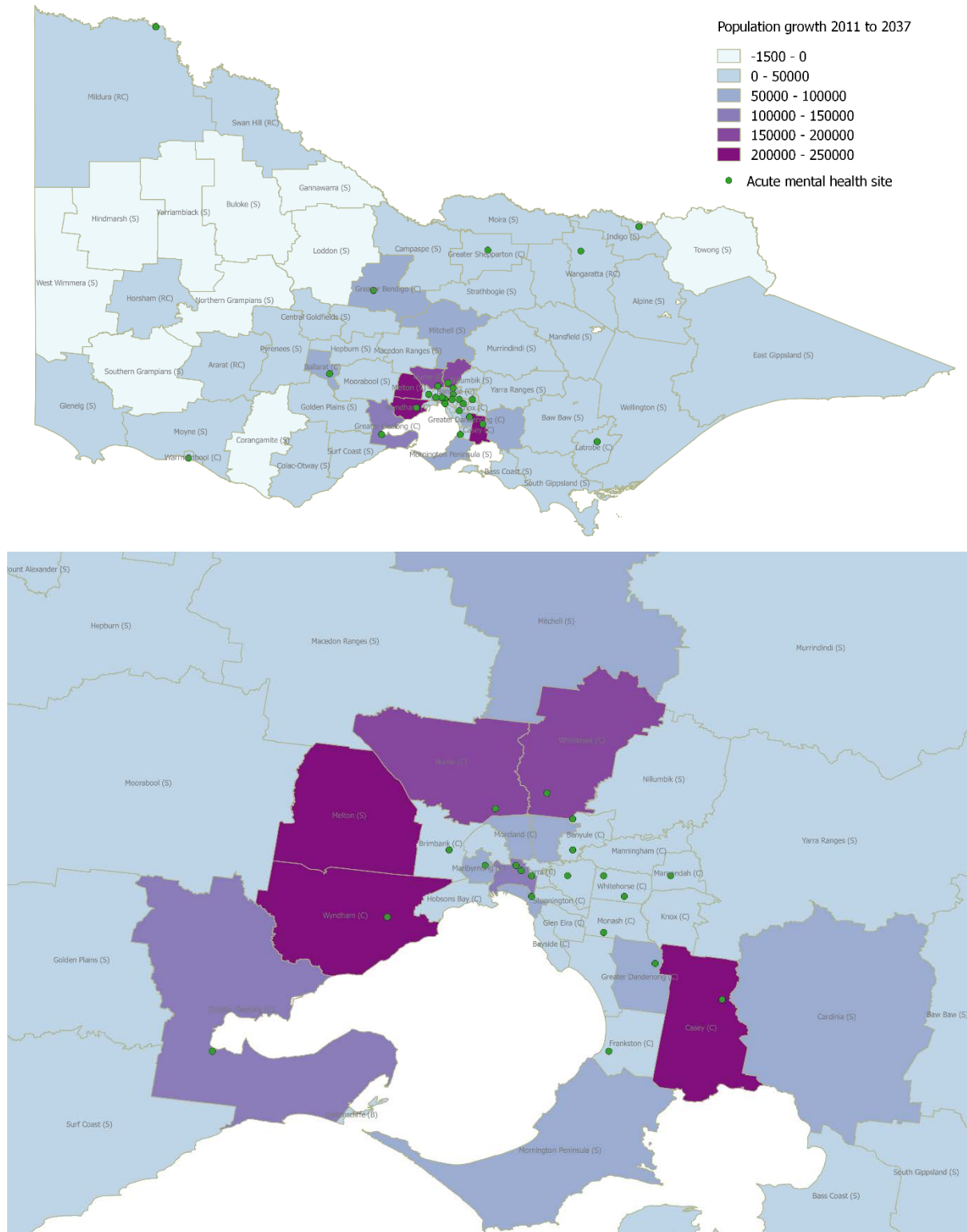
### *Impacts of population growth on supply and demand*

The 2015 version of Victorian government population projections estimate a 1.8 per cent annual average growth rate to 2037. This will result in 40 per cent growth in Victoria's population to a total of 8.3 million by 2037<sup>ix</sup>.

The concentration of population growth is dynamic and as such drives demand trends and the need for targeted service supply. The Wyndham, western, south east and northern growth planning areas are expected to experience a compound annual average growth rate exceeding 2.3 per cent between 2015 and 2037. The rapid emergence and continued growth of these corridors has led to a general misalignment between supply and demand for health services, including mental health services (Figure 4-1). This is particularly evident in the local government areas of Casey, Wyndham, Melton, Whittlesea, Hume and Greater Geelong that are all set to experience significant population growth, but appear to have limited access to public local clinical mental health services.



Figure 4-1: Projected population growth 2011 to 2037 and the current placement of acute mental health services



Source: KPMG, 2016 based on information from Victoria In Future, 2015.

## 4.2 Consideration – Enhancing the mix and sustainability of service models

Striking a better balance between community and admitted services and developing innovative service models is important in managing demand and in underpinning the design of the system.

### *Service type and model mix*

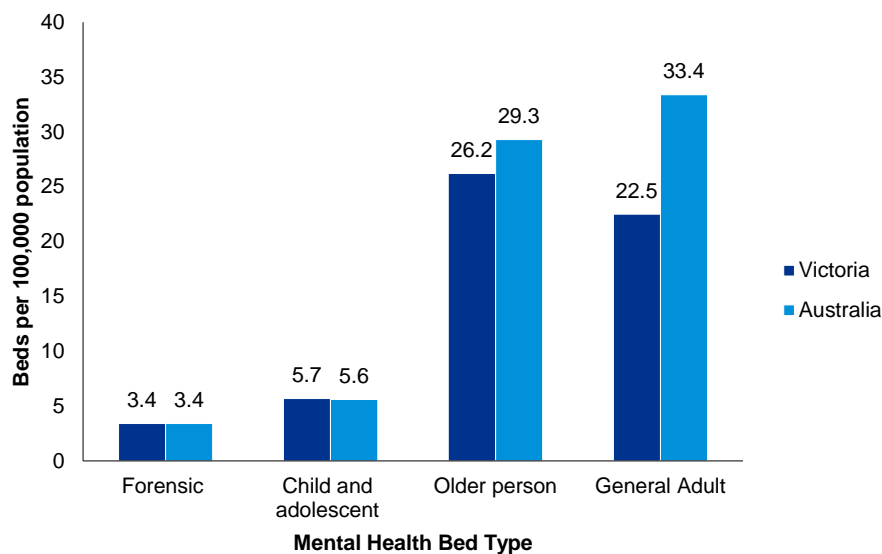
Victoria has moved beyond policy directions focused around deinstitutionalisation, to those based on patient choice and recovery<sup>x</sup>. While some mental health service systems have progressed further than others, Victoria has one of the lowest mental health bed bases across Australia and globally (Figure 4-2). Those with fewer beds per 100,000 population tend to reserve hospital care for emergency type care, as a ‘last resort’, or for a brief period to stabilise mental health during an acute episode of illness. Australia has progressively moved away from hospital care towards community-based mental health services.

Capacity across a wide range of individuals’ needs, taking into account community services, acute care, emergency care, subacute care and long term support needs to be explored. Suitable pathways for individuals following an emergency presentation should not be confined to an acute admission, and rather may be able to be supported in a subacute short stay facility or community based service setting.

As an example, in Queensland, South Australia and Victoria short stay mental health crisis care services that are collocated with emergency departments provide care for individuals requiring short term acute care. Importantly these models are not consistently available throughout Victoria. Further, some services in the Netherlands have reconfigured existing mental health emergency department resources to establish mental health urgent care services that provide follow-up support for individuals, their families and carers following an emergency department visit. Both of these examples of enhanced emergency mental health pathways have produced reductions in mental health related emergency department presentations and length of stay.

In planning the design of the overall clinical mental health system across Victoria, a decision should be made about further investment into increasing the admitted mental health bed base, considering the interplay between supply and demand in the system as a whole and on a catchment basis.

*Figure 4-2: Public sector specialised mental health hospital beds per 100,000 by target population and program type*



*Source: Australian Institute of Health and Welfare. National Mental Health Establishments Database, 2013-14.*

### *Design for recovery and co-production*

Victoria's 10 Year Mental Health Plan embraces recovery and co-production as both essential design features and outcomes of the service system, along with universal access to public services and access to specialist mental health services which are needed and chosen by people with mental illness, their carers and families. How the fundamental architecture of the clinical mental health system should be designed to support and give expression to recovery and co-production is a critical but challenging question for all stakeholders.

Victoria's Framework for Recovery-Oriented Practice describes recovery-oriented practice as encapsulating healthcare that:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves a holistic approach that addresses a range of factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship.

Victoria's 10 Year Mental Health Plan has noted that we are just beginning to understand how co-production can transform the way government and public services do business, by involving service providers and service users (people living with mental illness and their families and carers) in the design, development and delivery of services. The Expert Panel established by the Minister for Mental Health has been tasked to explore what co-production can and should mean for Victoria's mental health and other services.

### *Demand management*

Whilst demand management strategies that include opportunities to shift demand are intended to lead to a reduced reliance on acute bed based care they have not previously had significant impacts on changing the trajectory of demand. Subsequently future demand management strategies will need to be innovative in order to elicit change. Specific initiatives responding to clinical demand are currently being established under Victoria's 10 Year Mental Health Plan, aiming to ensure early access to services, plan additional services to meet demand, ensure safe and effective care and increase options for earlier discharge and preventing readmission.

### *Technology*

The use of technology in service delivery is increasingly being used as an alternate platform for service delivery. As an example, in the Netherlands there is a treatment platform for e-mental healthcare, facilitating blended service delivery (face to face and online) and flexibility in timing and pacing of treatment. The platform currently has treatment modules including, but not limited to, depression, social anxiety, burn out and panic disorders. There are similar approaches available across Australia (e.g. Blackdog Institute NSW), however these are not well integrated into state based mental health services<sup>xi</sup>.

### *Ensuring sustainable specialty service delivery*

Ensuring sustainable and effective delivery of specialty mental health services is important given the limited number of specialist services providing specialised services to the entire state.

Across Victoria there are over 97 dedicated specialist acute beds including those dedicated to: eating disorder services, Psychiatric Assessment and Planning Unit (PAPU), psychiatric intensive care, spectrum, neuropsychiatry, Koori, perinatal services and brain disorder services<sup>xii</sup>.

In designing a clinical mental health system that responds to forensic service capacity and sustainability, key design issues and opportunities include consideration of avenues to:

- divert people with a mental illness from the criminal justice system by strengthening pathways to early community treatment and support,
- reduce initial and deepening contact with the criminal justice system by people with a mental illness through improvements to the range and availability of services,
- strengthen specialist mental health service capability to manage high-risk clients in the community and criminal justice workforce capability, and
- improve mental health treatment for high-risk offenders leaving prison.

***If you could change one part of the clinical mental health system in the next 12 months, what would it be and why would changing this aspect be so important?***

***What can be done to reduce reliance on acute beds (consider alternative service models and types)?***

***How do you think the principles of recovery and co-production should be reflected in the way Victoria's clinical mental health services are designed?***

# 5 Age based service configuration

Clinical mental health services are configured around age, with three broad categories recognised across the state, including: children and adolescent, adult and aged mental health services. In some regions a fourth category dedicated to young adult mental health services has also emerged. Appropriate definition and configuration of age based services is important to ensure a user friendly system which promotes partnership and complementary service provision, especially in times of consumer transition between age based services. This represents a commitment to achieving universal access to public mental health services as outlined in Victoria's 10 Year Mental Health Plan.

## 5.1 Consideration – Definition of children and youth based services

Currently there are particular catchments that have multiple providers of child and youth mental health services. Additionally, where there are multiple providers of services for children and adolescents, the definition of age groups does not align with the generally recognised state norm.

Specifically, across Victoria child and youth mental health services usually provide care for those aged from 0-18 years, however specific youth services such as those provided by Orygen Youth Health and *headspace* provide care for individuals aged 16 to 25 years. Age based service configuration definitions across jurisdictions vary, with the Netherlands providing care for children and youth up to the age of 23 years as an example. Ensuring appropriate definition of the child and youth cohort is important given that this life stage represents significant developmental milestones and onset of mental health issues as demonstrated by the data presented above in section 2.

In planning the design of the overall clinical mental health system across Victoria, a decision should be made around the appropriateness of separating child from youth service provision and further should ensure consistency of definition and service provision across child and youth services. A consistent approach based around the three age groups (children and youth, adult and aged) could focus on:

- streamlined access for individuals, their families and carers, health professionals and referrers
- equality of service provision and access
- reduced disruption during times of transition between child and adolescent services.

It is however important not to lose sight of having age appropriate service settings to cater for youth.

## 5.2 Consideration – Definition of aged services

Aged clinical mental health services are currently defined as those servicing individuals aged 65 years and over. With recent demographic trends clearly showing an ageing population and increased life expectancy, numerous changes at a broader level have been made including increasing the age requirement for age pensions from 65 to 67 years by 2023 and with the Commonwealth aged care planning benchmarks increased to the proportion of the population aged over 70 years.

In defining the most appropriate age based service definitions, the degree of flexibility should be considered. Jurisdictions such as New South Wales, Canada, New Zealand and the Netherlands allow significant flexibility relating to age definitions, choosing to focus instead on the unique care needs of each person. These approaches are in line with one of the major focus areas of Victoria's 10 Year Mental Health Plan, having a service system which is accessible, flexible and responsive to people of all ages, their families and carers. In planning the design of the overall clinical mental health system across Victoria, a decision should be made around whether the age definition for aged mental health services should be increased to reflect changing population characteristics. Impacts of this change may extend to assisting with the development of more appropriate service options for this group.

***Should Victoria's clinical mental health system be configured by age based services?***

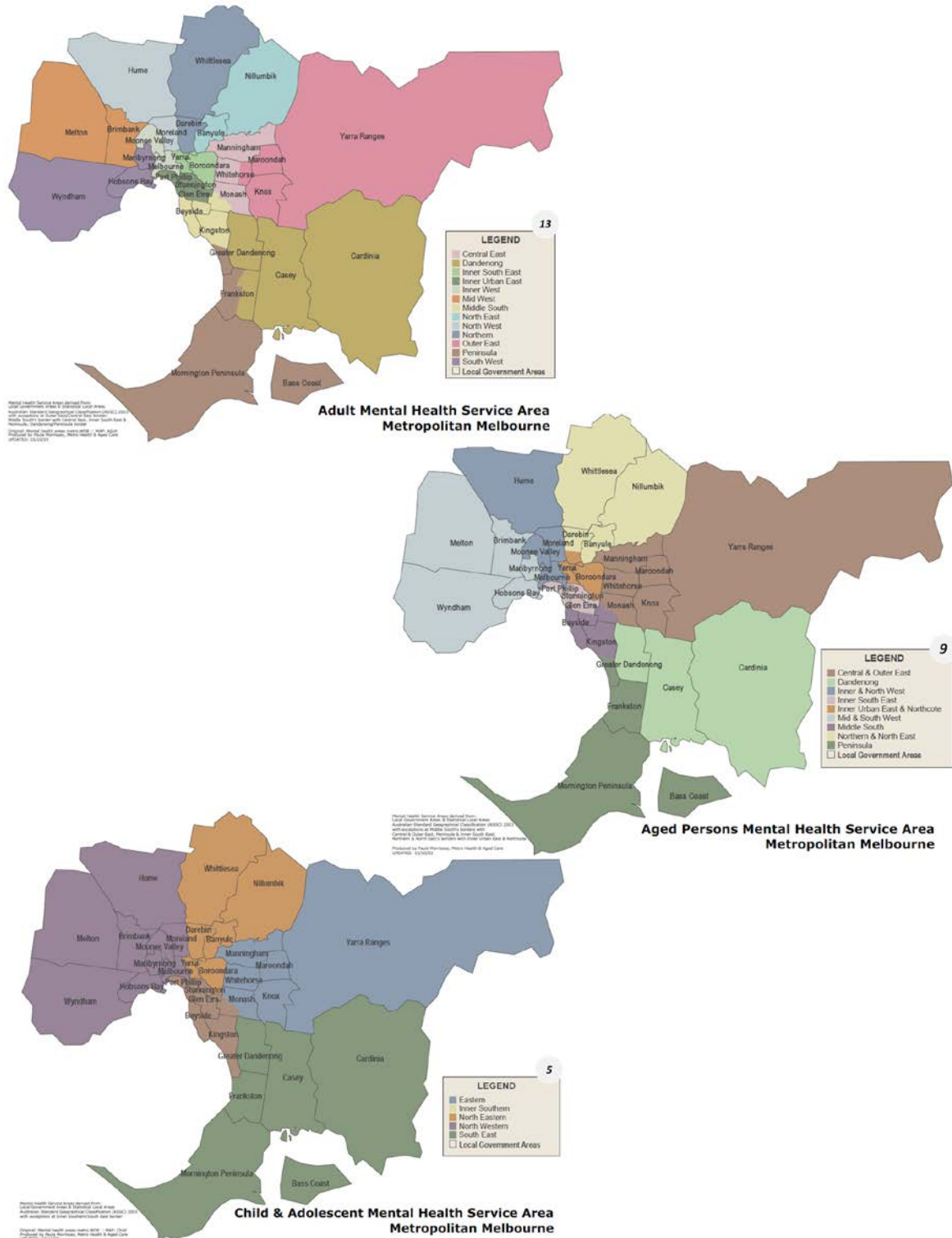
***Should clinical mental health services continue to be based around the three age based components of Child and Adolescent, Adult and Older Person?***

***What alternative age based service configurations could be used in Victoria (consider how youth based services can be consistently integrated across Victoria)?***

# 6 Catchment based service configuration

The current Victorian clinical mental health system is structured around fixed geographic catchments for service delivery. Figure 6-1 below demonstrates that the current catchment structure varies across the catchments for different age groups.

Figure 6-1: Metropolitan Melbourne mental health catchments (top: adult, middle: aged, bottom: child and adolescent)



Source: Victorian Department of Health and Human Services, 2015.

In 2013 the Victorian DHHS gathered feedback from stakeholders regarding enhancing catchment design. Consultation revealed divergent views across stakeholders, with a general acceptance that the current configuration was complex and fragmented.

Stakeholders have acknowledged that action in this area needs to consider broader issues and criteria, including:

- continuity of care
- individual choice
- funding reform
- quality
- safety
- service linkages
- area self-sufficiency
- demographic trends
- transition planning
- demand management
- care pathways
- adoption of a whole of life coverage approach
- improved and consistent service provision for people that are homeless
- alignment and service integration across the broader sector
- access to highly specialised mental health services
- a clear single managing health service in each catchment.

## 6.1 Consideration – Fixed catchments for service delivery

Fixed catchments are used for planning and service delivery in clinical mental health; this contrasts with the broader Victorian health system which only uses catchment areas for planning. The appropriateness of fixed catchments should be considered as should the impacts this architecture has on individual choice. Removing fixed catchment areas for service delivery could facilitate more individualised consumer movements, likely changing the balance of demand as individuals choose providers.

Making significant changes to the fixed catchment approach for service delivery presents challenges associated with:

- the risk of services ‘cherry picking’ clients
- forecasting and managing consumer flow (impacting on infrastructure and workforce planning)
- increased complexity of interagency partnerships with a broader array of services needing to collaborate.

## 6.2 Consideration – Catchments, alignment and governance

As discussed above, the DHHS has previously explored options to change mental health catchments, largely focused around the following three options:

1. Existing model with minor change: Selected realignment of some catchments and health service management arrangements.
2. Consolidated whole-of-life area mental health services: Nine whole-of-life Area Mental Health Services (AMHS), with further reconfiguration of catchments and possible changes to managing health services.
3. New two-tier model: Four whole-of-life area mental health services and separately defined arrangements for accessing highly specialised providers.

Stakeholders have previously expressed a diverse range of preferences relating to catchment configuration, with some suggesting entirely different options to those listed above.

When considering ideal catchment configuration it is important to consider the alignment of mental health catchments and provision with that of the broader health sector. Across Victoria there are five

local government areas (LGAs) in which multiple mental health catchments are placed. Further, as an example, New South Wales has clinical mental health service boundaries that align with Primary Health Network boundaries. This facilitates service linkage, partnerships and ease of navigating the clinical mental health system.

In planning the design of the overall clinical mental health system, a decision should be made around whether catchment areas should be revised. The following benefits may result from such changes:

- The introduction of consistent governance across catchments and age based services resulting in enhanced continuity of care (i.e. an individual would not need to transition to a different service provider as they move between age based service categories).
- Distribute catchment areas in alignment with current population and demand trends, ensuring that catchments have an appropriate population base.
- Reduced system complexity – simple navigation for individuals, their families, carers and referrers.

Changes to the catchment areas would not be without short term challenges such as continuity of service provision, the need for new service agreements and resource implications.

***Should Victoria's clinical mental health system have catchment areas at all (i.e. currently individuals must access clinical mental health services within the regional catchment in which they reside)?***

***If catchment areas were removed from Victoria's clinical mental health system, how would the system achieve continuity of care for the most complex and vulnerable individuals?***

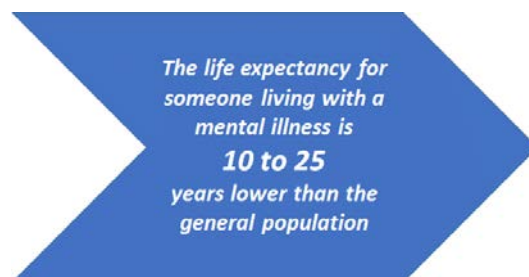
***Conversely, if Victoria's clinical mental health system continues to have catchment areas, should they be:***

- ***Configured differently?***
- ***Consistent in population size?***
- ***Aligned with primary health network catchments?***
- ***Aligned to acute health service regions?***
- ***Fixed for service delivery?***

# 7 Integration across service providers

Integration between clinical mental health providers and wider health service providers is required. Individuals with mental health conditions commonly have comorbidities and experience higher rates of coexisting physical health conditions. Alarming the life expectancy for someone living with a mental illness is 10 to 25 years lower than the general population<sup>xiii</sup>. Given the multifaceted nature of individuals health care needs, integrated and multidisciplinary care approaches are necessary. Integration between the mental health and wider health sector needs to involve:

- consistent and aligned policies and legislation
- establishment of inter-agency partnerships and a high level of organisational buy in
- consistent structures and funding arrangements
- information sharing as supported by common IT and data systems across mental health and wider health providers
- a focus on an individual's journey continuity to ensure individuals are not lost in the system.



There are multiple examples of where integration is working well, as listed below.

- The Ottawa Inner City Project in Canada supports integration across health and social care for the homeless population that have significant care needs within the subacute space. The project has seen multiple service providers come together to develop population health approaches that reduce reliance solely on hospitals and emergency departments.
- The Milwaukee Wraparound Model in the United States offers a comprehensive system of care for children and youth who have serious emotional, behavioural and mental health care needs. The model offers integrated mental health and support services to the individual and their family organised into a coordinated network covering the holistic needs of the individual, their family and carers.
- New Zealand has a strong interface between mental health and primary care supported by the five year 'Our Health and Mind' plan that aims to enhance the engagement and mental health capability of primary care, acknowledging that broader health system engagement is required in order to ensure future sustainability of mental health service delivery.

***What needs to be changed in the system to facilitate integration, allowing individuals to better navigate the system and drive their care decisions?***

## 8 Survey link and next steps

The development of the Design, Service and Infrastructure Plan for Victoria's Clinical Mental Health System offers a unique opportunity to advance the goals of Victoria's 10 Year Mental Health Plan by designing a better clinical mental health system for Victorians.

This discussion paper begins to identify some of the key service planning challenges that need to be resolved for Victoria and emphasises the need to make clear choices regarding the future direction and configuration of the system. Building on these initial discussions, there will be further exploration of mental health service planning considerations not raised in this discussion paper, including: technology, role of the private sector, infrastructure and service type requirements, workforce planning, governance and intersections with the broader health sector and reform (including National Disability Insurance Scheme, Victoria's Roadmap to Reform).

We welcome your feedback and views on the questions raised throughout this discussion paper which can be provided via [Clinical Mental Health Service Plan survey](#).

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<sup>i</sup> Australian Institute of Health and Welfare, Australian Burden of Disease Study, 2011.

<sup>ii</sup> National Mental Health Commission. Approaches that support recovery, including early intervention, 2016.

<sup>iii</sup> National Mental Health Commission, Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services, 2014.

<sup>iv</sup> World Health Organisation, Information sheet - Premature death among people with severe mental disorders, 2016.

<sup>v</sup> The National Mental Health Commission, 2014.

<sup>vi</sup> Victorian Department of Health and Human Services, Mental Health Community Support Services, 2015.

<sup>vii</sup> Victorian Department of Health and Human Services, 2015.

<sup>viii</sup> Victorian Department of Health and Human Services, 2015.

<sup>ix</sup> Victorian Department of Transport, Planning and Local Infrastructure. Victoria in Future data, 2015.

<sup>x</sup> Organisation for Economic Co-operation and Development (OECD), Making Mental Health Count. 2014.

<sup>xi</sup> Karify, 2016.

<sup>xii</sup> Victorian Department of Health and Human Services, 2015.

<sup>xiii</sup> World Health Organisation, Information sheet - Premature death among people with severe mental disorders, 2016.

# Appendix: Activity data summary

Figure 8-1: Community contacts

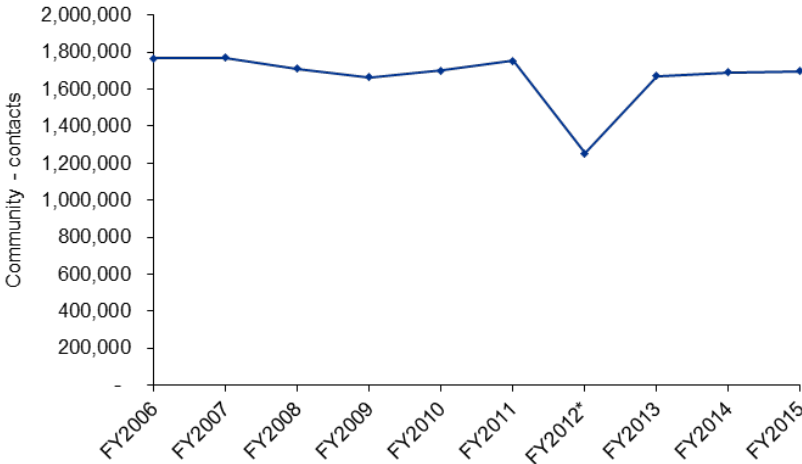


Figure 8-2: Admitted separations by client type

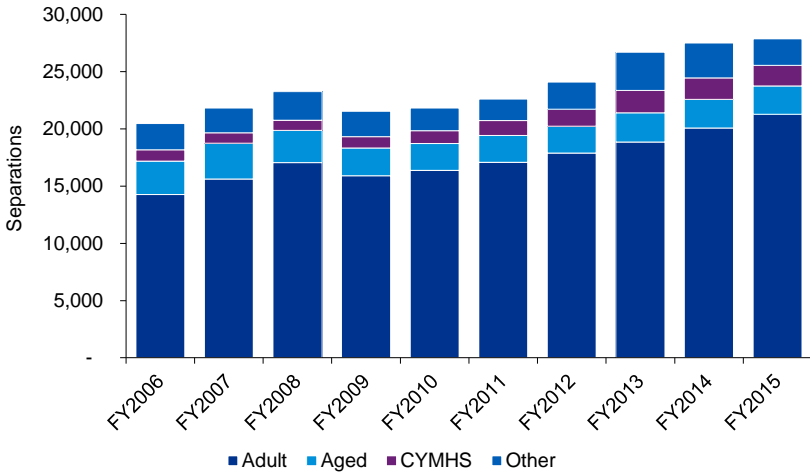


Figure 8-3: Admitted bed days by client type

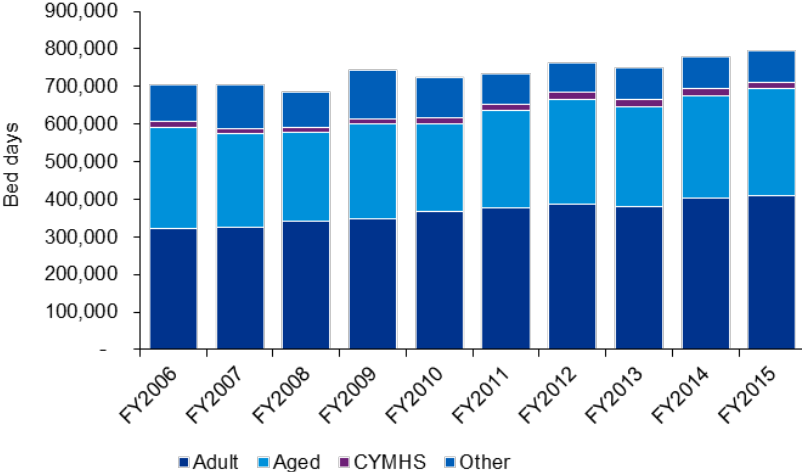


Figure 8-4: Average length of stay by program type

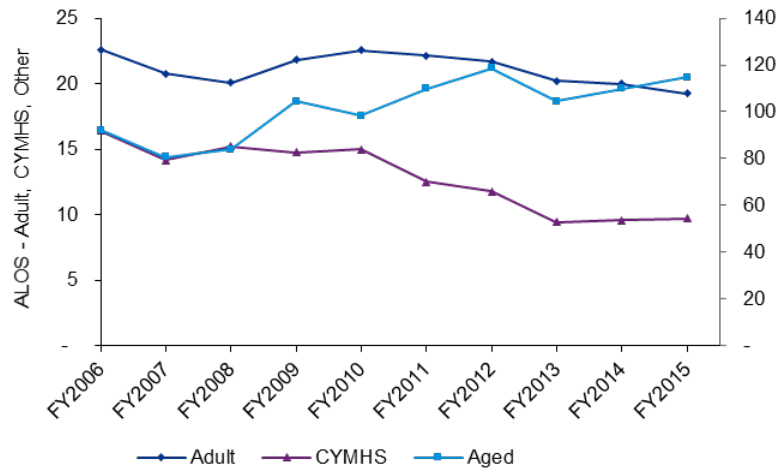
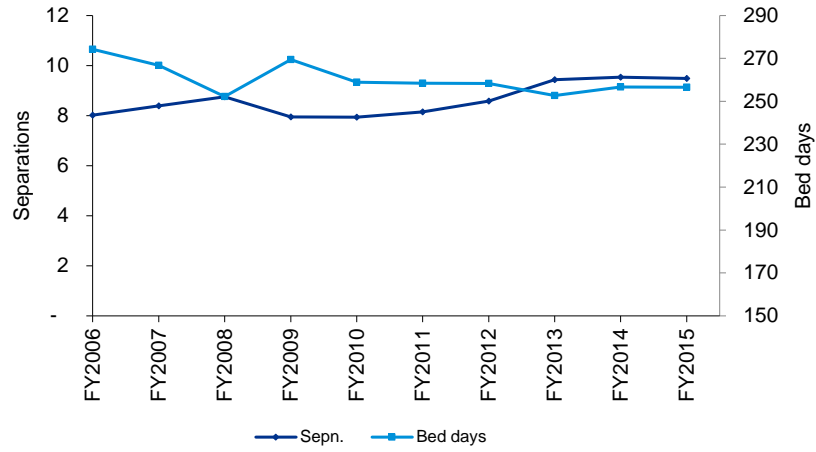


Figure 8-5: Direct aged standardised rate - separations and bed days



Source: DHHS CMI-ODS, ABS, VIFSA.

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The findings in this discussion paper have been formed on the above basis.



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