AUSTRALIAN MEDICAL ASSOCIATION
(VICTORIA) LIMITED.
ABN 43 064 447 678
293 Royal Parade
PO Box 21
Parkville, Victoria 3052
t 03 9280 8722
f 03 9280 8786
w www.amavic.com.au
Country Freecall 1800 810 451

1 November 2013

Executive Director
Mental Health, Drugs and Regions Division
Department of Health
50 Lonsdale Street
MELBOURNE VIC 3000

By email: mentalhealth.catchments@health.vic.gov.au

Dear Sir/Madam

RE: Clinical mental health service catchments – consultation paper

AMA Victoria welcomes the opportunity to comment on the consultation paper on clinical mental health service catchments.

The paper proposes three discussion options which suggest aligning adult area mental health boundaries with aged care, child and adolescent, Medical Local, Local Government Area and Department of Human Services boundaries. Some reasons for the changes were suggested however no clear evidence is presented as to why these changes were imminently or essentially required, or if they warrant disruption of existing catchments, structures and processes.

The mental health conditions that exist in each age group are significantly different, for example common child and adolescent disorders differ from adult mental health disorders managed by public mental health services (often psychoses) and the mental health disorders predominant in older age (such as cognitive disorders). The incidence and prevalence of these disorders in a particular region will vary according to the specific condition and population demographics within each area.

Optimal clinical management of conditions in each age group is vastly different and requires different skill sets, differential service provision and staff training requirements. Partly as a consequence of this, child and adolescent, adult and aged service models have evolved and operate very differently. Any transition of care between these services (for example from child and adolescent services to adult services), when it does occur, requires the patient to bridge these different service models and start again with a new treatment team, case manager and psychiatrist. The realignment of boundaries does not change this patient experience of transition.

However, the most common transition of care is of consumers moving residence from one catchment region to another (moving "Out of Area"). Adult area mental health services have developed very effective mechanisms and mutual agreements to manage these transitions. Currently, only one adult service is recognised as the provider for each consumer, based on residential location. There is only one single service (not a multiplicity of services) providing area mental health service care for a patient in any locality and there is generally no significant confusion.

Challenges do occur with access but these often relate to a lack of inpatient beds in the system or disagreements about the entry criteria into a clinical area mental health service. Complaints about accessing out of area services are generally not a common concern.

We note that there are significant future challenges in providing optimal care to Melbourne's population. There is significant population growth on the periphery of Melbourne with growth corridors, especially in the North, South Western and Dandenong-Casey regions. Care for consumers in these regions is sometimes provided by metropolitan services, but often by rural services. Services struggle to keep up with the rapid growth and development of these areas.

Consumers, carers and staff in these regions may not as easily have the same degree of access to relevant services and resources as are available to consumers and carers within the inner city metropolitan areas. The consultation paper does not clearly address how these evolving challenges will be managed.

Current service developments and integrations

In recognition of the complex and broader needs of consumers, multiple successful networks and partnerships have flourished in Victoria. These have been developed at a local and regional level through recognition of areas of consumer need, the benefits of collaboration and the progressive development of local services to manage these needs. In some cases there have been extensive formalised arrangements and governance agreements between neighbouring regions such as the North Western Health Care Network, Eastern Health and Southern Health.

In other places they have been smaller agreements to develop regional programs such as the BETRS eating disorders service in the Northern region, and the various agreements by public mental health services to support metropolitan Headspace Centres. Other agreements have related to bed utilisation, intake or specific aspects of care.

These partnerships have been very effective at recognising areas of unmet need and utilising the skills of different regions, and have developed in order to suit the specific region. Departmentally fostered specialist state-wide services have complemented this. Services such as specialist Dual Diagnosis, Dual Disability, Eating Disorders services and the Spectrum Personality Disorders service additionally support existing area mental health services in specialised care for specific consumer populations.

There are a number of significant broader successes, benefits and achievements of the current structure. Some metropolitan services have developed extensive mental health training programs at an undergraduate and post-graduate level to become leading centres of excellence in teaching and training, and research and innovation has been a key feature of some services. This has been facilitated by current structures and often builds upon key linkages that have formed with relevant tertiary and other institutions.

These developments have encouraged recruitment of new graduates from all disciplines into mental health and promoted retention. Some services who have invested in these areas have greater demand for positions and have created environments where research and innovation are a genuine integral part of service delivery.

Additionally, the transition in the 1990s to co-locating mental health services within general hospital services and general hospital 'ownership' of mental health for that region has led to significant integration, placing mental health firmly on the hospital-based health agenda. It has also developed significant efficiencies in integration with emergency departments utilising the shared skills and knowledge of both general and mental health services.

These significant benefits, optimisations and innovations risk being lost in any realignment with a loss of the strong and enduring partnerships that have developed to facilitate these programs. The flow on effects of these lost partnerships would result in the loss of real and perceived career development incentives which could have significant effects on future recruitment and retention to public mental health.

Difficulties with suggested models

Although aligning and externally imposing a structure will provide concordance with other community and government services, a number of the abovementioned key linkages and partnerships that are essential and extensively developed, risk being disrupted (in some cases permanently) with the associated loss of quality, inefficiency, risks, lack of coordination and potential confusion. Additionally, the significant challenges increasingly recognised in providing care to newly developing growth areas on the metropolitan fringes do not appear to have a solution in the models suggested.

The document focuses on community but does not strongly discuss the inpatient beds that are key to public mental health services. Area mental health services manage the most unwell mentally ill consumers and, despite technological and service based innovations, still require a strong focus on inpatient care. The co-location of mental health services with general health services have forced each general hospital to learn about and problem-solve key mental health challenges.

The fostering of strong bonds with emergency departments at a local hospital level – both by clinicians on the ground and at a governance/executive level has facilitated optimal management and rapid transfer of consumers with a complex range of psychiatric disorders. It has nurtured the development of quality acute care initiatives and minimised adverse outcomes, risks, and complaints. The co-location and integration at a local level with general hospitals has also led to a sharing of broader resources – facilities, catering, security, IT and other skills that are enhanced though this arrangement.

The consultation document does not discuss the location of inpatient beds with the structures proposed. However, if the beds were to follow the alignments suggested, particularly in Options 2 and 3, it would mean interruption of a number of these very positive arrangements. For instance, with current inpatient buildings, a consumer who becomes acutely unwell could be seen at one community mental health clinic, then sent to the emergency department of one general hospital and then potentially transferred to another hospital for bed-based inpatient mental health care, all as standard care in a large area mental health service.

Under some proposed models, inpatient mental health buildings which are currently fully under a single area mental health service could later be split to have one of the wards managing patients from one area mental health service and the next ward managing patients from another mental health service - this would lead to disruption to staff, facilities, catering and staff training, which would have to be aligned through their base health service. Appropriate inpatient ward alignment with other services could be made with Options 2 and 3, but will also require significant capital investment.

Recommendations

We would support building upon the already extensive local knowledge, skills and current partnerships to continue the optimisation and efficiencies that have developed over the past two decades. There are already significant precedent models of successful partnerships in managing the ongoing needs of populations, both at a very elaborate level as in North Western, Southern and Eastern Health services but also at a smaller local level. These approaches should be encouraged and fostered to develop further.

It is important to benefit from maintaining the very strong links that have been established between general hospitals and auspiced and co-located inpatient psychiatry wards. There are further newly developing population centres on the periphery of Melbourne that are not optimally met and which would benefit from being addressed early to ensure the best possible care is planned for.

To discuss any of the matters raised in the submission, please contact Elizabeth Muhlebach, Senior Policy Officer, on (03) 9280 8754 or elizabethm@amavic.com.au.

Yours sincerely

Rachael Edginton
Director, Policy and Public Affairs