Consultation paper

Clinical mental health service catchments

August 2013
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The case for change: summary

Victoria’s current system of area-based clinical mental health services is in need of change. Across the metropolitan area, the structure of 13 adult, 9 aged persons, and 5 child and adolescent services no longer offers an adequate basis for providing accessible, sustainable and mainstreamed specialist mental health services.

This structure involves a confusingly large number of clinical mental health service entities that, in many cases, lack a clear geographical relationship with the broader health services that manage them. Clinical mental health service catchments are also not well aligned with those of other types of health and human services. This makes service coordination difficult for consumers and carers, many of whom need support from multiple services.

The issues of system complexity and service fragmentation are further compounded by the mis-alignment of clinical catchments with local government area boundaries. Added to this, there has been substantial growth in Victoria’s population since the current clinical catchments were established, with highest population growth on the urban fringe.

Reconfiguring the catchment areas under which clinical mental health services are organised is a key step in delivering the kind of seamless, easy-to-navigate system that consumers and carers expect. It is also important for achieving optimal efficiency and effectiveness across the state. Whilst the realignment of clinical catchments alone will not guarantee all of these outcomes, it is an important prerequisite for achieving a more responsive and sustainable service system.

This proposed reform of clinical mental health catchments is not occurring in isolation. It complements a broad range of reforms such as the recommissioning of psychiatric disability rehabilitation and support services and alcohol and drug treatment services, the planned introduction of a new Mental Health Act, the transformation of human services through Services Connect, and nationally, the introduction of DisabilityCare Australia.

Together these reforms provide significant opportunities to build connectivity and strong engagement across different parts of the health and human services system. This focus on area based approaches to planning and a much greater emphasis on service integration aims to give consumers more streamlined access to ‘joined up’ services.

Outcomes for consumers and carers

- Easier access to, and movement through, age appropriate clinical mental health services by having one health service manage all clinical mental health services within a common catchment
- Services equipped to provide care across all age groups without disruptions
- A more navigable, easier to understand mental health service system
- People who require support from a range of services receive a coordinated, person-centred response.

Outcomes for the service system

- A much greater emphasis on service integration between clinical mental health services and other health and human services
- A more sustainable service system through streamlined delivery arrangements
- Enhanced opportunities for effective clinical governance, quality assurance and leadership
- Services more responsive and accountable to local need.
Part 1: Drivers for change

1. Introduction

The problem we are addressing

Clinical mental health services are a vital element of the services provided by Victoria’s public health services. At present, 17 health services across Victoria are managing Area Mental Health Services (AMHS). While current public mental health service catchment areas and the division of responsibilities of managing health services have served Victoria well over the past 16 years, they have become problematic in several respects.

Clinical catchments often do not align across the three age-related components of child and youth, adult and aged services. In some cases public clinical mental health service catchment areas do not align well with local government area boundaries, and with other service system boundaries. Some local areas have several health services providing clinical mental health services. These situations are particularly relevant to the Melbourne metropolitan area.

This has been an issue of growing concern, and is a pressing matter for many consumers, area mental health services and partner service providers such as Psychiatric Disability and Rehabilitation Support Services (PDRSS), alcohol and drug treatment services, primary health care services, human services and other community services.

These misalignments impede consumer access to services, compromise mainstreaming of mental health and provision of coordinated care, and present barriers to effective cross-sector planning and reforms that will offer consumers improved services.

The Victorian Government places a high priority on the achievement of stronger integration of services to support the coordinated delivery of person-centred services aligned to local needs. Major reforms have been completed or are underway in PDRSS, alcohol and drug treatment services, disability services, child protection, housing, homelessness and family violence services. Each is seeking to improve a part of the system; drive stronger integration between health and human services programs; and ultimately improve outcomes in people’s lives.

Reconfiguring public clinical mental health service catchment areas and health service management will:

- have benefits for consumers, carers and associated providers who want a service system that is easy to navigate
- strengthen the role of health services in leading the public clinical mental health service system
- provide a prerequisite for a range of mental health service reform priorities, for example, mental health service governance reform and the redevelopment of mental healthcare for children and young people aged 0–25 years
- facilitate better coordination of health and human services
- enhance sustainability through streamlined delivery arrangements.

In rural regions age-related components of public mental health services are generally aligned. However, access to services for people living close to Department of Health regional boundaries can be problematic if the closest service is located in an adjoining region and catchment. The department is keen to receive feedback on any additional issues affecting rural clinical catchments that have not been addressed in this consultation paper.

Current metropolitan and rural arrangements are outlined in Appendices 1 and 2 respectively.

This examination of public clinical mental health service catchment reform coincides with moves to take a more flexible approach to service eligibility and to enhance consumer choice. Under such an approach, 1

1 ‘Health service management’ refers to an arrangement whereby public mental health services are part of a Victorian health service and are accountable to and managed by that health service.
catchments would continue to be important as a basis for planning and providing services that meet the needs of local populations and ensuring that those most in need receive services. However, individuals may in some circumstances opt to use a service in a different area to where they live.

The purpose of this paper

The Victorian Government acknowledges that the reform of clinical catchment areas is a complex undertaking, involving possible governance change, funding adjustments, and potential changes to capital asset management and development directions.

The drivers for change are to:

• put consumers and carers at the centre of the service system
• promote service efficiency and effectiveness
• develop a more integrated mental health service system.

The benefits of change, in terms of improved service access and responsiveness as well as increased efficiency, must outweigh the significant effort potentially involved in reconfiguring clinical catchments and health service auspicing. Strong leadership will be required at all levels, along with robust solutions, that make sense across the state and in the context of other health and human services reforms.

This paper has been developed to assist a consultation process on options for change targeting health services and their AMHS in each Department of Health region, health services in the metropolitan region that are not currently managing AMHS, and other relevant stakeholders including consumers and carers.

Your views are being sought on possible change options for metropolitan public clinical mental health service catchment configuration and designation of managing health services. There is also the opportunity to provide feedback on:

• the principles and criteria for change
• service eligibility and enrolment policy
• other key issues that might require prior or concurrent attention
• local issues and priorities
• risks and opportunities associated with reconfiguration.

While the change options focus on the metropolitan areas, involving rural regions in the consultation process is important so we can:

• examine service access issues in border areas and options for improved responses
• test the need for a formal integration of age-related service components
• maintain a focus on the impact of metropolitan-rural wedge access arrangements\(^2\) for specialist mental health services arising from reconfiguring metropolitan catchments, and on access to statewide specialist services.

This first part of the paper addresses the context, need, purpose and guiding principles for change. The second part outlines options for change in the metropolitan area, each option responding to the main principles and criteria for guiding reconfiguration. Key questions are also posed.

Over the coming months, stakeholders will have the opportunity to comment and raise issues through a range of meetings, along with the option of providing a written submission using the template provided at section 10 by 31 October 2013.

The government will consider the feedback provided and decide on the extent of reform that is appropriate and achievable, and the process and timelines for implementation. It is envisaged that in 2013-14 a detailed blueprint for change will be developed and implementation planning will commence.

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\(^2\) These arrangements involve specialist services in a metropolitan region being made available to people living in an adjoining rural region or regions.
Examples of current problems for consumers

1. **Difficulties related to misalignment of age-related components of public clinical mental health services**

   In the suburb of Northcote, non-alignment of age-specific clinical mental health catchments causes confusion for consumers and challenges for service planning between service providers:
   - Child and Adolescent Mental Health Services (CAMHS) are provided through Austin Health as part of the North Eastern CAMHS catchment.
   - Adult mental health services are provided through Melbourne Health as part of the Northern Adult Mental Health Service catchment.
   - Aged persons mental health services are provided through St Vincent’s Health as part of the Inner Urban East Aged Persons Mental Health Service catchment.

   In all, three health services and three mental health service entities are involved in one local area. There is no clear public mental health ‘brand’ to guide local people seeking a service, and potential disruption for those transferring across the age-based service components. This misalignment creates additional complexities in coordinating service responses for consumers and families who suffer multiple disadvantage and contributes to the overall fragmentation of the broader health and human services system.

2. **Difficulties related to health services not providing the full range of age-related mental health service components**

   Peninsula Health does not manage mental health services for those younger than 16 years and must enter into complex arrangements with Monash Health and Alfred Health to ensure an integrated service system for children and young people in its catchment. This makes for potential confusion and disruption for children, young people and their families.

3. **Difficulties related to splitting local government area boundaries**

   Alfred CAMHS boundaries conform to pre-1994 Local Government Areas (LGAs). As a result, it provides services to a number of suburbs that are serviced by a different health service (Monash Health or Peninsula Health) for adult mental health services.

   This situation is impeding redevelopment of child and youth mental health services (for those aged 0–25 years) in the inner and middle areas of Southern Metropolitan Region, led by the Alfred Consortium. This development of new service models and configurations requires joint effort across CAMHS, adult services (ideally provided by the same health service) and a range of service sector partners that largely base their catchments on whole LGAs.

   Resolving catchment-related barriers will allow the full potential of the new 0–25 years service model to be realised, benefiting many children, young people and their families.

4. **Difficulties related to population shifts**

   Mitchell Shire is located in northern Victoria, about 80 kilometres from Melbourne. The shire shares a border with the cities of Whittlesea and Hume in the south. In recent years, Mitchell Shire has been one of the fastest growing municipalities in regional Victoria. Growth has mainly been in the southern section of the shire, closest to Melbourne, as more people have opted for living in rural residential areas or urban townships. Population growth is expected to continue in this area.

   People in the southern part of Mitchell Shire may look to metropolitan areas for shopping and schools; however, they are expected to use public specialist mental health services provided by Goulburn Valley AMHS, which is based in Shepparton, for all bed-based services, with some community services located in Seymour.
What is in scope?

The focus of this paper is primarily on public clinical mental health services and how catchments for core AMHS and associated designation of managing health services could be reconfigured.

Public clinical mental health services comprise state-funded specialist clinical mental health services for children and adolescents, adults and aged persons, operated by a public hospital or health service within the meaning of the Health Services Act 1988.

Health service management will continue, with health services remaining the overarching governance entities for public mental health services.

While public clinical mental health services are the prime concern, this is part of a broader suite of government reforms that seek to coordinate clinical mental health treatment, with mental health community support services, alcohol and drug treatment services and with the broader human services system (through Services Connect) to achieve more integrated, person-centred services. As discussed in section 3, a core aim of the reforms is to ensure better coordination of services to improve outcomes in people’s lives.

This paper does not address internal health service governance structures. However, clinical catchment reconfiguration that involves establishing whole-of-life AMHS with strong cross-sector linkages would provide the opportunity and requirement for enhancing governance arrangements, both within auspicing health services and for cross-sector partnerships. Some health services have already established collaborative governance structures for their mental health functions.

The associated matters of access to beds through hospital emergency departments and to highly specialised mental health services (such as dual disability, personality disorder, neuropsychiatry and eating disorder services) would be considered in detail as part of further developing a preferred reconfiguration option. Highly specialised mental health services will continue to be an important part of the public mental health system, regardless of what reconfiguration option might be adopted.

Finally, this paper does not address the process for reaching agreement on, and undertaking any, changes that may be identified following this consultation. This will be the subject of a further phase of work.

Where have we come from?

The initial development of catchment-based public mental health service delivery in Victoria represented a very significant step forward in addressing the uneven geographic distribution of public psychiatric beds and the variable access to services. The use of catchments as an organising paradigm to plan and deliver mental health services has had definite benefits, while continuing to evolve.

In 1961 Dr Cunningham Dax, Chairman of the Victorian Mental Hygiene Authority, proposed focusing Victorian public mental health service delivery on five Melbourne metropolitan regions and five rural centres, each with its own inpatient and community-based services. Areas were to be determined based on overall geographical size, population size, major transport routes, and the location of existing psychiatric inpatient and general acute facilities.

By 1986 this had evolved into eight Victorian mental health regions, each with geographical ‘sectors’. However, despite a catchment focus, public mental health service delivery still reflected historical delivery patterns, with resources concentrated in large stand-alone facilities and people were often required to travel long distances to receive treatment.

Increasing demand for mental health beds led to changes to improve bed access including adjusting some metropolitan catchment boundaries, expanding psychiatric units in general acute hospitals, and developing outreach mental health services to reduce the need for inpatient admission. These changes were supported in the late 1980s by the progressive closure of the large stand-alone psychiatric
hospitals, freeing up resources for developing smaller, localised mental health services that incorporated co-located inpatient units in acute hospitals.

In March 1994, *Victoria’s mental health service: the framework for service delivery* was released. It described how the organisation of public mental health service delivery would be focused around existing Department of Human Services regions, with individual service areas within regions being determined by local departmental regional offices according to set criteria. The framework stipulated that each regional service would comprise child and adolescent, adult, and aged persons mental health programs provided as a comprehensive, integrated area-based service. Funding was redistributed across departmental regions based on a weighted population formula that proxied relative expected service utilisation as reflected by underlying population need.

The 1994 framework was followed in April 1996 by *Victoria’s mental health service: the framework for service delivery – better outcomes through area mental health services*. This document identified 22 mental health service areas (based on adult services) that were sub-units of departmental regions and emphasised area self-sufficiency, making available the full range of mental health service elements in all mental health areas. To support this, the weighted population formula was recalculated, based on the 22 areas.

The service purchasing process arising from the 1996 framework document resulted in 22 adult, 13 child and adolescent, and 17 aged mental health services across the state. The 22 adult areas subsequently became 21 with the merging of two areas in Hume Region to ensure the availability of the full range of core services.

Today, Victoria’s public mental health service delivery is based on 21 adult, 13 child and adolescent (along with Orygen Youth Health) and 17 aged persons mental health services. The variable catchment sizes and boundaries of these age-related service delivery components resulted from a competitive tendering process undertaken in the mid 1990s followed by organisational realignments across metropolitan health service providers.

**What has changed?**

Since current catchment areas and health service management arrangements for public clinical mental health services were established in the mid 1990s, there has been a range of significant developments in the operating environment:

**Demographic change**

- There has been significant population growth in Victoria, with an 18.9 per cent increase between 1996 and 2011. Over this period, the increase in the metropolitan area was 20.7 per cent, and 13.8 per cent in regional Victoria.
- Growth has been particularly marked in outer metropolitan areas of Melbourne. Between 30 June 2010 and 30 June 2011, the four LGAs with the highest growth rates were located on the urban fringe: Wyndham (7.8 per cent), Cardinia (5.9 per cent), Melton (5.6 per cent) and Whittlesea (5.6 per cent). The fifth highest was the City of Melbourne (2.6 per cent).³
- Victoria’s population is ageing, bringing with it changed patterns of demand for service provision. The proportion of the population aged 65 years and older is expected to increase from 13.7 per cent in 2011 to 22.1 per cent in 2051.⁴

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Broader service system change

- Clinical mental health services have become an integral component of public health services in Victoria.
- Local government boundaries were substantially reformed in the mid 1990s, while some public mental health service catchments remained aligned to the old LGA boundaries.
- The Primary Care Partnerships (PCP) strategy was initiated in 2000 to improve the health and wellbeing of people using primary care services and to reduce avoidable use of hospital, medical and residential services. A diverse range of member agencies, including the mental health sector, are involved in integrated health promotion, service coordination and integrated chronic disease management.
- The Commonwealth has increased its involvement in mental health, including through the introduction of ‘Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative’ in 2006, and the complementary initiative Access to Allied Psychological Services (ATAPS).
- The April 2010 and February 2011 COAG agreements on national health reform have further highlighted the need for Victoria to ensure optimal positioning for public mental health services in relation to new primary healthcare organisations, Medicare Locals. Victoria’s 17 Medicare Local catchments were announced in June 2011.
- Commonwealth interest and investment in public specialist mental health services was further extended through the 2011–12 Budget package National Mental Health Reform.

Changes and debate in mental health policy directions and service delivery

- The PDRSS sector has grown and diversified. Focused reform is occurring to make PDRSS more effective in a changing delivery environment, including ensuring these services operate as strong partners to AMHS. As part of this reform, the PDRSS program will be renamed the Mental Health Community Support Services (MHCSS) program.
- The need to rethink public mental health service catchments has been periodically explored, including by the Ministerial Advisory Committee on Mental Health in 2005.
- More recently, the mental health reform agenda has been a key driver for change, envisaging much greater collaboration across a range of service sectors and an integrated whole-of-life approach to service provision.
- In 2010 the Victorian Mental Health Reform Council placed strong emphasis on the need for more integrated, comprehensive area mental health systems, and on opportunities for streamlined, collaborative governance arrangements.
2. Victorian policy directions

**Victorian Health Priorities Framework 2012–22**

The Victorian Health Priorities Framework 2012–22 establishes the key outcomes, attributes and improvement priorities for the system. It provides a framework for planning and delivering an innovative, informed and effective healthcare system that is responsive to people’s needs, now and in the future. One of the key principles of the framework is local and responsive governance.

The framework outlines seven reform priorities:
• developing a health system that is responsive to people’s needs
• improving every Victorian’s health status and experiences
• expanding service, workforce and system capacity
• increasing the system’s financial sustainability and productivity
• implementing continuous improvements and innovation
• increasing accountability and transparency
• utilising e-health and communications technology.

The Metropolitan Health Plan and Rural and Regional Health Plan have been released, with key directions aligned to these reform priorities.

The Metropolitan Health Plan identifies 10 health planning areas, built on LGAs; the Rural and Regional Health Plan identifies 11 rural profile areas built on LGAs.

Reconfiguring clinical mental health service catchments and health service management particularly addresses two metropolitan health planning priorities:
• developing a system that is responsive to people’s needs: clinical mental health catchment reform lays the groundwork for area-based planning, better coordinated care and a more navigable mental health system
• increasing accountability and transparency: streamlining health service auspicing of mental health services is a necessary precursor to other improvements in governance and accountability.

For more information on these reforms go to: <http://www.health.vic.gov.au/healthplan2022/>

**Expectations of public mental health services**

Reform within AMHS involves improved access pathways and strengthened care coordination. Two key expectations relevant to the focus of this paper are:
• provision of integrated and shared care, based on enhanced collaboration with other relevant service providers
• development of an integrated ‘whole-of-life’ approach to service provision, with flexible transitions based on assessed need across age-related specialist mental health service delivery components.

While there will be no hard barriers related to age alone, key specialist mental health service delivery components will continue to be based on age, with key transition points adjusted to reflect contemporary and expected future conditions. The CAMHS 0–18 years focus is being redeveloped under a new 0–25 years framework, in recognition of the evidence on brain development, the trend for many young people to remain in the family home for longer, and the importance of providing youth-friendly service delivery environments for a cohort that is often reluctant to seek and accept help.

Transitions from adult to older persons specialist mental health services have also been reviewed. The period from age 65 to 70 years is being considered as a transitional period when, according to assessed need, people may enter or move to an older persons specialist mental health service.

In addition, AMHS will be expected to link to new targeted responses that are now being developed for particular conditions such as early psychosis, eating disorders and dual disability. These responses will be organised on a regional or shared area basis. Any reconfiguration of clinical catchments and auspicing will need to take this into account.
Psychiatric Disability Rehabilitation Support Services reform

PDRSS are a core part of the public mental health system, currently targeting the 16–64 age range. Maximising opportunities for efficient and effective service linkages between clinical mental health services and the community-managed mental health sector delivering PDRSS is critical.

Review of PDRSS over recent years has indicated a need to consolidate the important role played by this program in improving health, social and economic outcomes for people with severe and enduring mental illness. This is particularly important given the expected growth in demand for mental health support services under DisabilityCare Australia.

The Victorian Government is introducing large-scale reforms to the PDRSS program in order to better support adults with a psychiatric disability to live independently, maintain the best possible social and emotional wellbeing and live satisfying lives in the community. The reform will result in a move to client-directed, personalised support that delivers outcomes that really matter to the individual and the carers and family that support them. This involves supporting people to meet their goals in relation to independent living, physical health, personal relationships, housing, education, employment and social connectedness.

Under the renamed Mental Health Community Support Services (MHCSS) program, area based approaches to planning and a much greater emphasis on service integration will help give clients more streamlined ‘joined up’ services, in line with broader government reforms such as Services Connect. MHCSS will be delivered across 16 service catchments. In metropolitan Melbourne, there will be a total of nine catchments. The non-metropolitan area will be divided into a total of seven catchments.

The catchments will be used to organise service delivery and ensure accountability – they will not be used to restrict client access and choice in service provider.

A key feature of the reform is the move to client directed individualised support packages. This will be supported by a simplified funding model. This new program will replace standard, moderate and intensive Home Based Outreach Services, day programs, care coordination, aged intensive program and special client packages from 1 July 2014.

Funded providers in each catchment will be required to work collaboratively with one intake assessment point and a common catchment based plan. To support this, a new catchment level intake assessment function will be created. All referrals to MHCSS will be through this entry point.

These reforms will deliver better outcomes for clients, carers and Victoria’s service system. They will also help prepare the sector for the future shift to DisabilityCare Australia and its client-directed funding approach.

For more information on these reforms go to: <http://www.health.vic.gov.au/mentalhealth/pdrss-reform>

Alcohol and Drug Treatment Services Reform

The Victorian Government is reforming the state funded alcohol and drug treatment system in parallel with PDRSS reform. AOD reform will deliver more consistent, high-quality and coordinated treatment services for Victorians with substance misuse problems.

Sixteen service planning and delivery catchments will facilitate the commissioning and delivery of core alcohol and drug treatment services across Victoria. The catchments will help to determine the volume and alignment of services required to meet local population need and provide a more coherent basis for the equitable distribution of resources.

Given the complex links between mental illness and substance misuse, improved collaboration and service coordination will be required between providers of mental health community support and alcohol and drug treatment services.

For more information on these reforms go to: <http://www.health.vic.gov.au/aod/sectorreform.htm>
New mental health legislation

Proposed reforms to Victoria’s mental health legislation seek to improve consumer experience and outcomes by:

- introducing a supported decision-making model that gives all patients a voice in their assessment, treatment and recovery
- focusing on minimising the duration of compulsory treatment and ensuring that treatment is provided in the least restrictive and least intrusive manner possible
- increasing safeguards to protect patient rights and dignity including establishing a new Mental Health Tribunal and a Mental Health Complaints Commissioner.

Although primarily concerned with individuals requiring compulsory treatment, the new legislation and the practice and culture changes being promoted as part of its implementation will be important for all mental health service providers.

Area mental health service clinical catchment reform involving improved alignment with the boundaries of key service partners will support anticipated legislative changes. Implementing the new Act will depend on a robust area-based public mental health system that can effectively respond to requests to assess and treat individuals believed to require compulsory treatment. Managing patients on compulsory treatment orders will require effective working relationships with local GPs, police and emergency services, and other support services.

Up-to-date information about the legislative proposals can be found at: <http://www.health.vic.gov.au/mentalhealth/mhactreform>

Funding models

Currently public clinical mental health services receive funding based largely on inputs and negotiated targets for volume and throughput. Under these arrangements, there are potential distortions, limited flexibility and an inadequate focus on quality, efficiency, performance and outcome issues.

As of 1 July 2013, Victoria continues to fund inpatient mental health services on ‘available bed days’ as per existing funding arrangements. To enable Victoria to calculate activity levels in accordance with the transition to Activity Based Funding under the Independent Hospital Pricing Authority model, and to enable the Commonwealth Government funding contribution, Victoria will shadow ‘occupied bed days’ for non specialist inpatient services (i.e. acute child, adolescent, adult and aged mental health beds).

In the medium term, changes to catchments and health service auspicing are likely to require shifts in funding allocation. Funding will be aligned with service provision. If there are changes to catchment service provision requirements, then so too will funding change. The application of ABF, together with catchment population analysis, will assist in assessing the quantum of funds to be transferred between agencies, and for ongoing funding that is more responsive to shifts in volume of service provision over boundaries.

Up-to-date information about activity based funding can be found at: <http://www.health.vic.gov.au/abf/service-streams/mentalhealth.htm>

Human services reform

The Department of Human Services has embarked on a major transformation program. Services Connect – the model for integrated human services in Victoria - is the centrepiece of this program and aligns reforms underway in child protection, housing, homelessness, disability services, and violence against women and children. Services Connect: Better services for Victorians in need, released in May 2013, outlines how Services Connect shifts the focus of service delivery so that services are built around people and tailored to their unique needs, goals and aspirations. Services Connect aims to provide an improved experience for individuals and families accessing the range of DHS services, by delivering more integrated, family-centred services for vulnerable Victorians.
The prevalence of mental health issues amongst many DHS clients is well understood. For this reason, the issues dealt with in this paper are of real significance to the broad transformation program of DHS. At the same time, there are several other reform programs under way within human services which are relevant to the issue of mental health catchments:

- The Service Sector Reform project is exploring how government and non-government organisations can work together to deliver community services in the most efficient and effective way. This is a whole of government project, which closely involves the community mental health system – and PDRSS providers are part of the Sector Reference Group that is guiding this work. The project has involved broad community consultation from a wide range of services, including mental health services.

- In May 2013 the *Victoria’s Vulnerable Children - Our Shared Responsibility* strategy was released. This whole of government strategy sets out a number of outcomes – and performance indicators – against which the wellbeing of Victoria’s vulnerable children will be measured and monitored. The strategy commits government to the establishment of a platform of ‘local networks’, inclusive of all government departments delivering services to vulnerable children and families. These networks are intended to ensure effective information sharing, coordination of service provision and planning across departments. The networks will obviously consider issues of mental health service provision at the local area level.

- In December 2012 a major restructure of the Department of Human Services was implemented. The restructure involves organising the Department’s regional operations into 17 local areas based on groups of LGAs, which are devolved from four combined metropolitan-rural regional Divisions (See Appendix 4 for a map of the latest DHS areas.) This focus on stronger area-based planning and delivery has clear relevance for the issue of mental health catchments.

The key point to make with regard to the work underway in DHS is that there will be a strong need for close collaboration and cooperation with mental health service providers if the broad aims of the reform program are to be achieved. The final arrangements of the public mental health service catchments should therefore be mindful of ensuring support for such collaboration.

For more information on these reforms go to <http://www.dhs.vic.gov.au/about-the-department/ plans,-programs-and-projects/projects-and-initiatives/services-connect >

### 3. National policy reforms

**National health reform agreement**

The National health reform agreement, as agreed by COAG in August 2011, forms an important part of the policy environment in which reconfiguring public mental health service catchments and auspicing would occur.

Under this agreement:

- A devolved system of hospital governance, similar to Victoria’s model, will be introduced nationally. Victoria’s 13 metropolitan public health services have been designated as Local Hospital Networks.
- States remain managers of the public hospital system and continue to negotiate service-level agreements with health services and hospitals.
- The Commonwealth and states will continue to develop a national approach to Activity Based Funding, which was introduced from 1 July 2012 for admitted acute, outpatient and emergency departments. A new classification for admitted mental health services is currently under development by the Independent Hospital Pricing Authority (IHPA). In the interim, enhancements to the Australian Refined Diagnosis Related Group classification have been introduced to facilitate the transition to Activity Based Funding for inpatient mental health services.
- The Commonwealth has established a nation-wide network of Medicare Locals. The Commonwealth and states continue to work together on system-wide policy and statewide planning for general practitioner and primary healthcare services.
Medicare Locals, which are new primary healthcare organisations, will be a dominant organising paradigm. Their focus incorporates both physical and mental health. Seventeen Medicare Locals have been established across Victoria with catchments built on LGAs. The objectives of Medicare Locals include: developing integrated and coordinated services; providing support to clinicians and service providers; identifying the health needs of local areas; developing locally focused and responsive services; and facilitating the implementation and successful performance of primary healthcare initiatives and programs.

Medicare Locals will be important planning partners for AMHS, with a focus on access to state and Commonwealth-funded mental health services, coordination with Commonwealth-funded mental health programs, and linkages to primary health responses to the physical health needs of people with a severe mental illness.

Medicare Local catchments are being used as the basis for new care coordination functions for people with severe, enduring mental illness under the Commonwealth Partners in Recovery program, with stage one of the program to be rolled-out in 2013-14.

**DisabilityCare Australia**

DisabilityCare Australia is a groundbreaking reform to the way people with a disability, including those with a psychiatric disability, will access the supports they need. A cornerstone of DisabilityCare Australia is client-directed funding.

The Victorian Government is taking a lead role in driving the establishment of DisabilityCare Australia to ensure that eligible people with a disability, their families and carers have the lifetime support they need.

The Victorian Government is working with DisabilityCare Australia to support the scheme's launch in Barwon.

The Victorian Government has committed $2.5 billion per annum to the full rollout of DisabilityCare Australia in Victoria by mid 2019. It is anticipated the majority of Mental Health Community Support Service clients will transition to DisabilityCare Australia as it is rolled out across Victoria.

For more information on these reforms go to: [http://www.disabilitycareaustralia.gov.au/](http://www.disabilitycareaustralia.gov.au/)
4. Why is change required?

Public clinical mental health service catchments will remain an important organising framework for distributing resources, and planning and delivering locally accessible public clinical mental health services linked to a range of service partners. Consumers will continue to be encouraged to use services in their area of residence, although more flexible eligibility arrangements are likely to be developed, as discussed below.

Current arrangements are unnecessarily complex

The current governance arrangements for public clinical mental health services, as outlined in Appendices 1 and 2, are unnecessarily complex:

- Public clinical mental health services are governed by public hospitals; however, the child and youth, adult and aged components may be managed by different health services and have different catchments.
- There are 21 adult AMHS areas, 13 CAMHS areas and 17 aged persons clinical mental health service areas, resulting in 51 individually named services using 30 different catchments across the state. Even though, in practice, some of these services are effectively integrated or under common management, overall arrangements remain complicated and confusing for too many consumers, carers and other service providers.
- Clinical mental health service catchments do not:
  - fully align with LGAs, which are the building blocks of all health and human services boundaries
  - align adequately with metropolitan health planning areas and Medicare Local boundaries.
- Clearer alignment of new MHCSS and AOD catchment boundaries with AMHS will facilitate area-based service planning and cross-sector coordination (see section 5).

Current arrangements have led to a range of problems

While current structures have served Victorians well in many ways over the past 16 years, the contemporary reality is that under these arrangements:

- Consumers and carers - and many local service providers, including GPs - find the mental health service system difficult to navigate.
- People who require support from a range of services want a more coordinated response. Providers of clinical mental health services need to work together and in partnership with MHCSS and AOD services to achieve improved mental health outcomes.
- Clinical mental health providers also need to work collaboratively with local primary health, human services and other community services to access and remain engaged with the full range of services needed by many consumers and carers.
- Continuity of care is impeded under current clinical catchment arrangements.
- There is a lack of consistency across geographical areas regarding how different mental health services fit together.
- The number of AMHS entities has created a complex and fragmented system requiring many different types of collaborative arrangements.
- The size of some AMHS is arguably too small to cover the range of functions and skills required, leading to a 'diluted' service.
- Service catchments do not necessarily reflect demographic trends, including city fringe population growth, long-term population movement trends in rural Victoria, and population ageing.
- The lack of catchment alignment is a drag on system efficiency.
Reconfiguration will facilitate wider system improvements

The reform of public clinical mental health service catchments is an important strategy to deliver more integrated, person-centred services. It aligns with reforms underway of mental health community support services and AOD services as well as the broader transformation of human services through Services Connect.

The reform of clinical mental health service catchments will benefit consumers directly in terms of access and navigability. They will also benefit as a result of improved capacity to manage and monitor quality standards, and to establish clinical governance arrangements that align with wider health services structures.

Key examples of mental health reform are:

- redevelopment of 0–25 age group specialist mental health services, requiring close working relationships between CAMHS and adult services, which has commenced in various ways across a range of sites. Lack of attention to catchment anomalies across CAMHS and adult services is being highlighted by some services as impeding reform and adding considerable complexity to some of this work. (While there has been some rationale for larger catchments for CAMHS compared to adult services, this is now open to question as we move to a larger cohort (0–25 years) and place more emphasis on local service partnerships in the delivery of child and youth services. However, this does not mean that more specialist functions such as early psychosis services or eating disorder services do not need to be planned on a wider scale.)

- efforts to move towards more flexible transitions between the adult and aged mental health service systems, with the age range 65 to 70 years possibly needing to be considered as a transitional period when people can enter or be moved to older persons mental health services, depending on assessed need and circumstances

- achieving efficiencies through:
  - optimal service size
  - sharing resources across age-related mental health programs, including triage, after-hours Crisis Assessment and Treatment (CAT) teams, and support for families and carers

- further developing the functions currently performed by collaborative initiatives such as clinical mental health–PDRSS alliances and training clusters

- developing partnerships between specialist mental health services and a range of health and community services, such as those that have been developed under the Community Mental Health Planning and Service Coordination Initiative

- developing delivery frameworks for particular specialised services such as for eating disorders, which require a clear stepped-care model involving local, regional and statewide services

- developing an approach for better sharing and utilising bed-based care capacity, which views beds as a critical resource but not a central element of each AMHS.

5. Related issues and developments

Along with the other aspects of mental health governance reform outlined in section 2, we need to consider how a number of key issues relate to reconfiguration, and whether they would need to be addressed early in, or alongside, a reconfiguration process.

Consumer choice, enrolment and eligibility for service

Reconfiguring public clinical mental health service catchments and health service management arrangements presents an opportunity to concurrently revise eligibility arrangements. Under current policy, consumers are, in the first instance, required to use the clinical mental health service in the catchment where they reside. This is not the case for most other health services in Victoria.
We are now working towards a more flexible approach. We recognise that the current ‘fixed eligibility model’ is no longer in line with community expectations regarding patient choice and person-centred care, nor does it make the most efficient use of state-funded services. In some cases, strict application of eligibility has created access difficulties and contributed to discontinuities in care.

In effect, some flexibility already exists in the system, with around 17 per cent of metropolitan inpatient admissions being out of the area of residence (often resulting from emergency department presentations). Current work to establish a better system for monitoring and accessing available inpatient beds further recognises the need for flexibility in the interests of access and efficiency.

The reform agenda’s focus on building responsive cross-sector area-based clinical mental health services should be an incentive for people to seek services near their place of residence. In addition, the benefits of an ‘enrolled population’ approach will continue to have particular relevance in mental health. It allows for individuals with a prior history of involvement with public mental health services and ongoing service needs to remain registered clients of a particular service, and ensures that services meet their responsibility for difficult and complex clients.

Any policy adjustment would need to address the particular issues pertaining to individuals placed on compulsory treatment orders to ensure workability of the Mental Health Act 1986. Assessment and admission to inpatient care would need to continue to be tied to area of residence for these individuals in the first instance. However, consistent with fostering greater emphasis on supported decision making and carer/family involvement, flexibility in determining the best place for community treatment may be possible for those on community treatment orders.

While services would continue to be planned on the assumption of service-user preference for the closest service and area self-sufficiency, it is unclear how allowing greater consumer choice would impact on the pattern of demand for individual clinical mental health services. It may be that few people take up the option, and those rejecting a local service might be balanced by out-of-catchment consumers. On the other hand, some especially well regarded services could receive a disproportionate level of demand. As many services are at capacity in meeting catchment responsibilities, there may be limits to the flexibility that can be achieved in practice.

The transition to Activity Based Funding for mental health will further assist in creating more flexible access. However, service targets will still need to be set and will be the basis for prospective budget planning.

In summary, realigned clinical catchment boundaries will constitute a planning and coordination tool, rather than essentially a device for strict determination of service eligibility.
6. Proposed principles and criteria to guide change

The following range of principles and criteria will be important in guiding reconfiguration; they are inter-related and should not be read as a prioritised list. Some are potentially in tension with each other. In optimising solutions, their use will involve assessing relative importance in specific situations.

a. **A clear, sole managing health service**: Clinical public mental health services will continue to be managed by health services. In most cases this should involve a sole-lead health service being responsible for an area’s mental health services, enabling both efficient governance and consumer perception of the health service/mental health service as synonymous. Where there are restrictions on the range of age-related service components being provided by a health service, partnership between two or three health services will be required; however, this will involve one health service being formally designated as the lead.

b. **Age-group alignment**: Age-defined components of the mental health service system should, as much as possible, come under common governance and planning catchment areas in order to enhance service planning, coordination and resource sharing, and to help develop integrated service responses across key life stages based on assessed need.

c. **Alignment with other health catchments**: Optimal alignment with other health catchments or boundaries needs to be considered, particularly in relation to MHCSS, AOD services, and Medicare Locals.

d. **Participation in broader regional and local area planning**: Mental health service boundaries should align, as much as possible, with Victorian Government regions and LGAs, facilitating participation in local area planning with other relevant service sectors. This includes optimal alignment with the new Department of Human Services areas.

e. **Area self-sufficiency**: High quality core mental health services for all age groups in a local population should be available in each area. These core services will comprise triage, acute response, bed-based care and community-based ambulatory care. This care continuum will be governed and managed for all ages to maximise continuity of care across levels of intensity, delivering responses to people with a range of needs.

f. **Accessing highly specialised mental health services**: Cross-service relationships for specialised mental health functions, through either shared access for adjoining areas, hub-and-spoke models or wedge access arrangements, should be easily facilitated.

g. **Optimal catchment and service size**: The size of consolidated whole-of-life public mental services should optimise efficiencies, allow for capacity to provide a full range of functions at an appropriate level of safety and quality, and be viable and sustainable. (It is acknowledged that CAMHS for 0-18 years – now in transition to a 0-25 year age group – have had larger catchments to achieve self-sufficiency.) Accordingly, the preference would be for larger rather than smaller catchment areas, with populations of 500,000–600,000 for metropolitan services and 250,000–300,000 for rural services.

h. **Responsive to demographic trends**: Any reforms need to take into account population growth projections, particularly the significant growth expected for the metropolitan fringe areas, in particular in North & West Metropolitan Region (N&WMR) and Southern Metropolitan Region (SMR).

i. **The best place to treat**: Mental healthcare will be provided wherever possible in community-based settings, providing services at people’s homes or close to where people live, work, shop, meet or relax, where it is safe and cost-effective to do so. The governance of mental health services will move to more strongly reflect this rather than be primarily tied to the acute hospital element. Catchments will be broadly planned on the assumption of service-user preference for the closest service. More flexible service eligibility arrangements would allow some people to travel further for a service of choice, or to use one in an adjoining catchment.

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5 Under a hub and spoke model, a central agency provides a service through – or in close partnership with – outlying ‘spoke’ agencies.
### 7. What could change?

<table>
<thead>
<tr>
<th>Now</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Misalignment of age-related components of public clinical mental health service boundaries and health service management results in:</strong></td>
<td></td>
</tr>
<tr>
<td>• difficulties for consumers in navigating the service system</td>
<td><strong>Net gains from aligning boundaries for public clinical mental health services will result in:</strong></td>
</tr>
<tr>
<td>• sub-optimal planning and coordination across mental health and related service sectors, particularly where mental health service catchments are not consistent with LGA boundaries.</td>
<td>• more consumers able to easily access and navigate services</td>
</tr>
<tr>
<td></td>
<td>• enhanced planning and coordination across mental health and related service sectors.</td>
</tr>
<tr>
<td>Thirteen adult, five CAMHS, nine aged mental health catchments in the metropolitan area, with misalignment of boundaries and managing health services.</td>
<td>In the metropolitan area, nine or fewer public mental health catchments covering all ages.</td>
</tr>
<tr>
<td>Following governance change in the Hume region, eight out of eight rural health services manage public mental health services across all ages.</td>
<td>In rural regions, possible fine tuning.</td>
</tr>
<tr>
<td>Twenty-three LGAs (19 metropolitan, four rural) have multiple health services managing mental health services. This is largely dysfunctional in the metropolitan area; however, rural arrangements tend to address practical geographical access.</td>
<td>Most metropolitan LGAs will have one AMHS provider; a minority would have services provided by a newly negotiated partnership of health services. This would establish the conditions for metropolitan health services to plan boundary alignment of age-related mental health service components.</td>
</tr>
<tr>
<td>The boundaries of 12 LGAs (eight metropolitan, four rural) are split by mental health service boundaries. This is largely dysfunctional in the metropolitan area; however, rural arrangements tend to address practical geographical access.</td>
<td>Splitting of LGA boundaries in the metropolitan area will be largely eliminated, thereby setting the conditions for better planning alignment with other relevant service sectors. Opportunity to review arrangements in rural regions.</td>
</tr>
<tr>
<td>Four out of nine metropolitan health services manage all age-related public mental health service components. Eight out of eight rural health services manage all age-related public mental health service components.</td>
<td>Most, or all, health services managing mental health services could manage all age-related public mental health service components.</td>
</tr>
<tr>
<td>Poor alignment with catchments of key service sector partners, particularly Medicare Locals, planned new MHCSS and AOD services and new Department of Human Services areas.</td>
<td>Full or significantly improved alignment with the catchments of key service sector partners, allowing for better cross-sector planning and care coordination for people and families who need support from multiple services.</td>
</tr>
<tr>
<td>An uneven spread of catchment population levels across the Melbourne metropolitan area.</td>
<td>A better balanced spread of catchment population levels across the Melbourne metropolitan area.</td>
</tr>
</tbody>
</table>
Part 2: Options for change in the metropolitan area

8. Three broad options for change

Three broad metropolitan change options are presented for consideration; all respond to the principles and criteria to guide change (outlined in section 6) to varying degrees. These options represent indicative models only, with details open to comment.

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 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

For options 2 and 3:
- Both achieve alignment of the age-related specialist mental health service components and largely eliminate local government boundary splits; differentiating variables are:
  - whether only existing, or new, health services are involved
  - the number of health service partnerships involved
  - the degree of alignment achieved with other relevant health and human service boundaries
  - resulting catchment population sizes and range.
- Any health service partnerships would involve formal designation of a lead health service and particular requirements on how the partnership would operate.
- Variations of boundaries and auspicing arrangements are possible within each of these options.
- Maps include Medicare Local boundaries to demonstrate the degree of alignment with a key planning partner. Degree of alignment with other relevant boundaries is considered in section 9.
- Associated arrangements for highly specialised mental health services, including metropolitan-rural wedge or hub-and-spoke models, will require further consideration.

While this paper does not address the process for reaching agreement and undertaking the changes required, it is noted that:
- Option 1 would be more limited to voluntary, mutually agreed changes.
- Options 2 and 3 might involve some degree of contestability to the extent that lead providers are not obvious.
Option 1: Selected realignment of some metropolitan catchments and health service management arrangements

Description
This option would involve selected adjustments to realign clinical catchments for age-related mental health service components under the management of a single health service. Change would be most likely where all parties agree, and change is budget neutral or involves minor budget adjustments. No change to arrangements for beds and highly specialised services is expected.

Expected net change

- No change to the current number of nine managing health services is expected
- A reduction in the number of distinct mental health service entities is unlikely
- An increase in the number of health services managing mental health services across all ages is possible
- Overall, limited change with substantial misalignment remaining in the metropolitan area.

Benefits for consumers and carers

- People with severe mental illness in localities where the catchments of AMHS can be realigned for consistency with LGA boundaries will:
  - more easily identify and navigate the public mental health services planned for their area
  - enjoy better coordinated care across service systems with LGA-based catchments, such as community health and housing services.

- People with severe mental illness in localities where a sole health service can move to provide mental health services for all age groups will:
  - more easily identify and navigate the public mental health services planned for their area
  - enjoy more continuity of service provision across both mental health care pathways and age-related services.
**Option 1: Indicative examples of selected change scenarios**

<table>
<thead>
<tr>
<th>SMR</th>
<th>EMR</th>
<th>EMR–N&amp;WMR</th>
<th>N&amp;WMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peninsula Health</td>
<td>Alfred Health</td>
<td>Eastern Health</td>
<td>St Vincent’s Health</td>
</tr>
<tr>
<td>Creation of whole-of-life AMHS for: Frankston, Mornington Peninsula, French Island</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This would require transfer from Monash Health of: services in Frankston and the Mornington Peninsula. Peninsula Health would transfer services in Kingston.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of whole-of-life AMHS for: Greater Dandenong, Casey, Cardinia Monash Health would transfer services in Glen Eira, Bayside, Kingston, Frankston, Mornington Peninsula and Monash</td>
<td>Creation of whole-of-life AMHS for: Port Phillip, Stonnington, Glen Eira, Bayside, Kingston, City of Melbourne (south of the Yarra River) This would require transfer from Monash Health of services in Bayside, Glen Eira and Kingston</td>
<td>Monash to be solely serviced by Eastern Health for all ages Given the location of Monash Medical Centre in this LGA, a flexible arrangement across the Southern and Eastern AMHS for mental health Emergency Department presentations and inpatient access would be required. See possible changes to Austin Health catchment population</td>
<td></td>
</tr>
<tr>
<td>Monash Health</td>
<td>Eastern Health</td>
<td>St Vincent’s Health</td>
<td>Austin Health</td>
</tr>
<tr>
<td>This would require transfer from Monash Health of services in Bayside, Glen Eira and Kingston</td>
<td></td>
<td>No clear minor change suggested.</td>
<td>See possible changes to Austin Health and Werribee Mercy Health catchment populations</td>
</tr>
<tr>
<td>Monash to be solely serviced by Eastern Health for all ages</td>
<td>Creation of whole-of-life AMHS for: Darebin, Banyule, Whittlesea, Nillumbik This would require transfer from Melbourne Health of services for all ages in Whittlesea, and for aged services for Darebin, Banyule and Nillumbik – transfer from St Vincent’s Health of aged services in Darebin.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Given the location of Monash Medical Centre in this LGA, a flexible arrangement across the Southern and Eastern AMHS for mental health Emergency Department presentations and inpatient access would be required. See possible changes to Austin Health catchment population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See possible changes to Austin Health catchment population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melbourne Health</td>
<td>The Royal Children’s Hospital</td>
<td>Werribee Mercy Health</td>
<td>Addition of aged mental health services for the LGAs receiving AMHS: Maribyrnong Wyndham, Hobsons Bay. This would require transfer from Melbourne Health of aged mental health services for Maribyrnong Wyndham and Hobsons Bay</td>
</tr>
</tbody>
</table>
Option 2: Nine whole-of-life metropolitan area mental health services aligned to new MHCSS catchments, with possible changes to managing health services

Description:

This option fully aligns catchments with new MHCSS catchment boundaries, with age-related mental health service components under management of a single health service where possible, the elimination of LGA splits, and allowing for changes to designation of managing health services.

This option maximises alignment with planned new MHCSS catchment boundaries. There is improved alignment with health planning areas, PCP boundaries, Medicare Local boundaries and new Department of Human Services areas.

There is no splitting of the Melbourne LGA into separate areas north and south of the Yarra River. This means that the whole of the Melbourne LGA is covered by the Central Area Mental Health Service. The Alfred Hospital is located on the south-eastern perimeter of the Melbourne LGA and is geographically closer for some residents south of the Yarra River than to mental health services located north of the Yarra River (Melbourne Health, Royal Children’s Hospital, Orygen Youth Health and St Vincent’s Health). Accordingly, this configuration would require a flexible arrangement across the ‘Central Area Mental Health Service’ and ‘Inner Southern Area Mental Health Service’ for mental health emergency department presentations and inpatient access.

A similar issue of catchment flexibility is required for the Monash Medical Centre, located in the Monash–South West SLA, within the proposed catchment of the Outer Eastern Area Mental Health Service.

<table>
<thead>
<tr>
<th>Catchment population range:</th>
<th>Arrangements for beds and highly specialised services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011: 253,386 - 619,486; median: 478,928</td>
<td>• For beds, some cross-health service contracting/partnerships required.</td>
</tr>
<tr>
<td>2021: 309,331 - 686,774; median: 590,975</td>
<td>• Accessing highly specialised services will depend on auspicing, but it is expected that every AMHS will have access to most highly specialised services within the catchment or through adjacent AMHS.</td>
</tr>
</tbody>
</table>

Net change

- There is complete alignment between AMHS and MHCSS catchments
- Nine whole-of-life AMHS catchments replace 13 adult, five CAMHS and nine aged catchments.
- There is the same number (nine) of managing health service entities.
- Public clinical mental health service catchments align with LGA boundaries compared with the current eight cases of misalignment.

Benefits for consumers and carers

People with severe mental illness in all localities will have access to a whole-of-life area mental health service, allowing them to:

• more easily identify and navigate the public mental health services planned for their area
• enjoy more continuity of service provision across both mental health care pathways and age-related services
• experience more efficient and effective service provision arising from economies of scale.

People with severe mental illness in most localities will be able to use AMHS with catchments aligned to LGA boundaries, allowing them to:

• more easily identify and navigate the public mental health services planned for their area
• enjoy better coordinated support across the range of service sectors relevant to their physical health, accommodation, education, employment and social inclusion needs
## Option 2

<table>
<thead>
<tr>
<th>N&amp;WMR</th>
<th>EMR</th>
<th>SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Central Area Mental Health Service’</td>
<td>‘North Eastern Area Mental Health Service’</td>
<td>‘Inner South Area Mental Health Service’</td>
</tr>
<tr>
<td>Managing health service to be determined (relevant health services: Melbourne Health, The Royal Children’s Hospital, St Vincent’s Health)</td>
<td>Managing health service to be determined (relevant health services: Western Health, Melbourne Health, The Royal Children’s Hospital)</td>
<td>Managing health service to be determined (relevant health services: Alfred Health, Monash Health)</td>
</tr>
<tr>
<td>Melbourne, Yarra, Moonee Valley, Moreland</td>
<td>Maribyrnong, Brimbank, Hume, Melton</td>
<td>Frankston, Mornington Peninsula, French Island</td>
</tr>
</tbody>
</table>

* Australian Bureau of Statistics 2012, Regional population growth. Australia; Released 31 July 2012, Table 2 Estimated resident population, local government areas, Victoria.  
** Department of Planning and Community Development 2012, Victoria in the future population projections, State Government of Victoria, Melbourne
Option 3: Two-tier model – four whole-of-life metropolitan area mental health services and changed arrangements for accessing highly specialised providers

Description:

This option proposes a new two-tier service model:

**Tier 1:** Four larger whole-of-life AMHS (community-based services and inpatient units), with managing health services to be determined.

**Tier 2:** Selected health services designated to service the state, or parts of the state, as highly specialised mental health providers covering areas such as neuropsychiatry, brain disorders, dual disability, eating disorders and mother–baby care. These highly specialised providers would also respond to mental health presentations through their emergency departments and refer to the appropriate AMHS.

In most, or all cases, it is expected that different health services would manage the mental health services at each level, allowing certain health services to focus on the specialised mental health functions alone.

Melbourne LGA north of the Yarra River is part of the ‘Inner South Area Mental Health Service’ catchment in recognition of the location of The Alfred south of the Yarra River in the Melbourne–Remainder SLA.

Monash LGA is part of the ‘Eastern Area Mental Health Service’ catchment; however, Monash Medical Centre (MMC), a Monash Health facility, is located in the Monash–South West SLA. Given that MMC is closer for some Monash residents than Box Hill Hospital, this configuration would require a flexible arrangement across the Southern and Eastern Area Mental Health Services for mental health emergency department presentations and inpatient access.

The specified optimal metropolitan catchment size (populations of 500,000–600,000) is significantly exceeded.

Catchment population range:

2011: 744,205 – 1,356,833; median: 1,003,991
2021: 946,859–1,581,505; median: 1,140,596.

Net change

- Four whole-of-life AMHS catchments replace 13 adult, five CAMHS and nine aged catchments.
- The number of managing health service entities for AMHS is reduced from nine to four, plus up to four other health services likely to manage tier 2 services
- Public clinical mental health service catchments align with LGA boundaries with one exception (City of Melbourne), compared with the current eight cases of misalignment.
- Changed arrangements for accessing highly specialised providers.

Benefits for consumers and carers

People with severe mental illness in all localities will have access to a whole-of-life area mental health service, allowing them to:

- more easily identify and navigate the public mental health services planned for their area
- enjoy more continuity of service provision across both mental health care pathways and age-related services
- experience more efficient and effective service provision arising from economies of scale.

People with severe mental illness in most localities will be able to use AMHS with catchments aligned to LGA boundaries and optimally aligned to those of other service partners, allowing them to:
• more easily identify and navigate the public mental health services planned for their area
• enjoy better coordinated support across the range of service sectors relevant to their physical health, accommodation, education, employment and social inclusion needs.

People who need a highly specialised mental health response may benefit from an increased focus on the organisation of these services.
## Option 3

### Area mental health services (tier 1)

<table>
<thead>
<tr>
<th></th>
<th>N&amp;WMR</th>
<th>EMR</th>
<th>SMR</th>
</tr>
</thead>
</table>
| ‘Northern Area Mental Health Service’ | One managing health service  
(to be determined )  
(relevant health services: Northern Health, Austin Health, Melbourne Health: Orygen Youth Health; The Royal Children’s Hospital; St Vincent’s Health) | One managing health service  
(to be determined )  
(relevant health services: Werribee Mercy Health, Western Health, Melbourne Health, The Royal Children’s Hospital) | One managing health service  
(to be determined )  
(relevant health services: Eastern Health St Vincent’s Health) |
| ‘Western Area Mental Health Service’ | Melbourne (north of the Yarra River), Yarra, Darebin, Banyule, Moreland, Whittlesea, Nillumbik, Hume | Boroondara, Knox, Manningham, Maroondah, Whitehorse, Yarra Ranges, Monash | Melbourne (south of the Yarra River), Port Phillip, Stonnington, Glen Eira, Bayside, Kingston, Greater Dandenong, Casey, Cardinia, Frankston, Mornington Peninsula, French Island |
| ‘Eastern Area Mental Health Service’ | Estimated catchment population:  
2011*: 978,500  
2021**: 1,177,181 | Estimated catchment population:  
2011*: 744,205  
2021**: 946,859 | Estimated catchment population:  
2011*: 1,029,481  
2021**: 1,104,011 |
| ‘Southern Area Mental Health Service’ | Estimated catchment population:  
2011*: 1,356,833  
2021**: 1,581,505 | ** | ** |

### Highly specialised mental health services (tier 2)

Selected health services will manage highly specialised mental health services (such as neuropsychiatric, brain disorder and dual disability services) and respond to general mental health presentations. Their catchments could be statewide, or involve metropolitan-rural wedges or multiple tier 1 areas.

* Australian Bureau of Statistics 2012, Regional population growth, Australia; Released 31 July 2012, Table 2 Estimated resident population, local government areas, Victoria.

** Department of Planning and Community Development 2012, Victoria in the future population projections, State Government of Victoria, Melbourne.
Option 3: Two tier model - four whole-of-life area mental health services

- Medicare Locals
- Department of Health regions
- Northern Area Mental Health Service
- Western Area Mental Health Service
- Eastern Area Mental Health Service
- Southern Area Mental Health Service

Note: Northern AMHS includes Melbourne north of the Yarra River; Southern AMHS includes Melbourne south of the Yarra River.
9. Comparison of metropolitan change options against principles and criteria for change

<table>
<thead>
<tr>
<th>Principles and criteria</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A clear, sole managing health service for each AMHS (a single lead managing health service where possible, or a health service partnership with a designated lead)</td>
<td>Minimal or no change expected.</td>
<td>While managing health services are not identified, all AMHS would have a designated lead health service, six out of nine AMHS could have a sole managing health service without a partnership with other health services.</td>
<td>For tier 1 (AMHS), sole managing health services without partnership with other health services are anticipated. It is expected that different health services would manage tier 2 services.</td>
</tr>
<tr>
<td>2. Alignment* with other health catchments</td>
<td>A significant degree of misalignment likely to remain.</td>
<td>Full or near full alignment with single or combined health planning, PCP and Medicare Local areas in SMR and EMR. Improved alignment in N&amp;WMR.</td>
<td>Larger AMHS catchments allow alignment with clusters of health planning, PCP and Medicare Local areas. Larger than desirable MHCSS areas.</td>
</tr>
<tr>
<td>Note: Some metropolitan health planning and Medicare Local areas include whole or part of an interfacing rural LGA</td>
<td></td>
<td>Full alignment with MHCSS catchments.</td>
<td></td>
</tr>
<tr>
<td>3. Planning participation  (alignment with Victorian Government/Department of Health regions, LGAs and new DHS areas)</td>
<td>It may be possible to eliminate most LGA splits in SMR.</td>
<td>Full alignment with LGAs and with Department of Health regions.</td>
<td>Full alignment with LGAs, except for Melbourne. Full alignment with Department of Health regions. Full alignment with clusters of new DHS areas for ‘Southern AMHS’ and ‘Eastern AMHS’. With the exception of Melbourne LGA, alignment with clusters of new DHS areas for ‘Northern AMHS’ and ‘Western AMHS’.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For new DHS areas: ‘Southern AMHS’ aligns with DHS Southern Melbourne Area, ‘Eastern AMHS’ comprises the DHS Inner Eastern Melbourne Area and DHS Outer Eastern Melbourne Area, Peninsula and Inner South AMHS each cover part of the DHS Bayside Peninsula Area. Respective catchments in N&amp;WMR do not align.</td>
<td></td>
</tr>
<tr>
<td>5. Age-group alignment</td>
<td>Small number of selected realignments expected, but significant degree of misalignment likely to remain.</td>
<td>Full alignment.</td>
<td>Full alignment.</td>
</tr>
</tbody>
</table>
### Principles and criteria

<p>| 6. Optimal metropolitan AMHS catchment and service size (500,000–600,000) for viability and sustainability |</p>
<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>No significant change from current total catchment population for each metropolitan health service, which is:</td>
<td><strong>2011</strong> range: 187,427 – 1,005,927; median: 270,498</td>
<td><strong>2011</strong> range: 253,386 - 619,486; median: 478,928</td>
</tr>
<tr>
<td><strong>2021</strong> range: 238,248 – 1,245,755 median: 298,416</td>
<td><strong>2021</strong> range: 309,331 - 686,774; median: 590,975</td>
<td><strong>2021</strong> range 946,859–1,581,505; median: 1,140,596</td>
</tr>
<tr>
<td>Median well below optimal catchment size.</td>
<td>Improved alignment with optimal catchment size.</td>
<td>Optimal catchment size significantly exceeded.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Responsive to demographic trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low responsiveness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Accessing highly specialised mental health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Best place to treat (provision of services in accessible, community-based settings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change.</td>
</tr>
</tbody>
</table>

* Alignment is defined as the boundaries of AMHS catchments and other entities (single or in groups) being consistent.*
10. Have your say

Interested organisations and individuals, including consumers and carers, are invited to submit a written submission to the Executive Director, Mental Health, Drugs and Regions Division, Department of Health by 31 October 2013.

Written feedback should be emailed to <mentalhealth.catchments@health.vic.gov.au>, or posted to:

Mental Health Reform Strategy
Mental Health, Drugs and Regions Division
Department of Health
Level 17
GPO Box 4541
Melbourne VIC 3001

Views on the following questions are sought.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Reconfiguring public mental health service catchments and health service management arrangements to achieve better outcomes for consumers, carers, the service system and the community.</td>
<td></td>
</tr>
<tr>
<td>1. a. What are your views on the ‘case for change’ (p 1) and the scope of change required?</td>
<td></td>
</tr>
<tr>
<td>1. b. What are the most compelling reasons for change?</td>
<td></td>
</tr>
<tr>
<td>2. a. Are the ‘principles and criteria to guide change’ (p 17) appropriate?</td>
<td></td>
</tr>
<tr>
<td>2. b. Is any important consideration missing?</td>
<td></td>
</tr>
<tr>
<td>3. What are your views on each of the options for change in terms of:</td>
<td></td>
</tr>
<tr>
<td>• the needs of consumers and carers</td>
<td></td>
</tr>
<tr>
<td>• the capacity of public mental health services to plan and coordinate with other parts of the health sector and with the community services sector</td>
<td></td>
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<tr>
<td>• facilitating the redevelopment of public mental health services</td>
<td></td>
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<tr>
<td>• quality and clinical governance</td>
<td></td>
</tr>
<tr>
<td>• viability of implementation?</td>
<td></td>
</tr>
<tr>
<td>4. a. Are there variations on any of the options presented that should be considered? Why?</td>
<td></td>
</tr>
<tr>
<td>4. b. Do you have an alternative suggestion for reconfiguration? If so, please outline your reconfiguration option, explaining how it responds to the ‘principles and criteria to guide change’ (p 17).</td>
<td></td>
</tr>
<tr>
<td>5. a. What are your views on how access to highly specialised mental health services should be organised?</td>
<td></td>
</tr>
<tr>
<td>5. b. How might the proposed changes facilitate better access to these more specialised services?</td>
<td></td>
</tr>
<tr>
<td>6. Are there key issues that may require prior or concurrent attention before reconfiguration? Please explain.</td>
<td></td>
</tr>
<tr>
<td>7. How should change be undertaken and what are the associated implementation issues?</td>
<td></td>
</tr>
<tr>
<td>8. Are there particular local issues that need to be considered in planning and implementing reconfigured public mental health service catchments?</td>
<td></td>
</tr>
<tr>
<td>9. What potential adverse unplanned consequences can you foresee and how might these be averted or managed?</td>
<td></td>
</tr>
<tr>
<td>10. Should service eligibility requirements be revised to allow for more flexibility? How important is this to achieving the intended benefits of reconfiguration?</td>
<td></td>
</tr>
<tr>
<td>11. Other comments</td>
<td></td>
</tr>
</tbody>
</table>
Appendices

Victorian public clinical mental health services: current catchments and managing healthy services

Notes
The following information is provided to illustrate the current complexities in metropolitan arrangements: age-related public clinical mental health catchments do not align and a number of LGAs are split. There is also poor alignment with the boundaries of key planning and service provision partners; as an example, the degree of alignment with Medicare Local boundaries is noted.

Current arrangements are presented on the basis of published maps, and local service and regional office advice. Reflecting current problems, these sources of information do not always align.

Traditional age ranges for CAMHS (0–18), adult (16–64) and aged (65+) clinical mental health services are used. It has not been possible to reflect moves to establish services for 0–25 year olds, although this reform activity is critical and a major driver for catchment realignment.

To avoid ‘double-counting’ populations within the age 16 to 18 year range, the following counting rules apply: the share of the 16 to 18 year population allocated to CAMHS is 62% and to Adult services, 38%. This is based on relative service utilisation rates for clients aged 16 to 18 years for the two service types.

In the case of the nine metropolitan LGAs served by RCH and Orygen Health, and for the LGAs served by Barwon Health, the following counting rules apply:

- **Child** 0 to 14 years (total count of persons aged 0 through 14 years)
- **Adolescent/young adult** 15 to 24 years (total count of persons aged 15 through to 24 years)
- **Adult** 25 to 64 years (total count of persons aged 25 through to 64 years)

Appendix 1: Current arrangements for metropolitan public clinical mental health services
**Metropolitan: Nine health services managing public mental health services for various age ranges**

Thirteen adult service areas, nine aged, five CAMHS. Misaligned catchments for age-related service components in a range of cases; 19 LGAs have more than one health service managing public mental health services and the boundaries of eight LGAs are split by public mental health service catchments. A complex relationship with Medicare Local boundaries in many cases. In 2011 the total catchment population of each health service managing public mental health services ranged from 187,427 to 1,005,928.

<table>
<thead>
<tr>
<th>SMR</th>
<th>EMR</th>
<th>EMR-N&amp;WMR</th>
<th>N&amp;WMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peninsula Health</td>
<td>Monash Health</td>
<td>Alfred Health</td>
<td>Eastern Health</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Mental health services</td>
<td>Mental health services</td>
<td>Mental health services</td>
</tr>
<tr>
<td>One adult MHS: Peninsula</td>
<td>Two adult MHS: Middle South, Dandenong</td>
<td>One adult MHS: Inner South East</td>
<td>Two adult MHS: Central East, Outer East</td>
</tr>
<tr>
<td>One aged MHS: Peninsula</td>
<td>Two aged MHS: Middle South, Dandenong</td>
<td>One aged MHS: Inner South East</td>
<td>One aged MHS: Central &amp; Outer East</td>
</tr>
<tr>
<td>One CAMHS: South Eastern, Peninsula</td>
<td>One CAMHS: Inner &amp; Middle South</td>
<td>One CAMHS: Inner Urban East &amp; Northcote</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LGAs</th>
<th>LGAs</th>
<th>LGAs</th>
<th>LGAs</th>
<th>LGAs</th>
<th>LGAs</th>
<th>LGAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult and aged: Kingston (South SLA), Frankston (West SLA), Mornington Peninsula, French Island</td>
<td>Adult and aged: Cardinia, Casey Greater Dandenong, Frankston (East SLA), Bayside, Monash (South West SLA), Glen Eira (South SLA), Kingston (North SLA)</td>
<td>Adult and aged: Port Philip, Stonnington, Glen Eira (Caufield SLA), Melbourne (south of the Yarra River)</td>
<td>All ages: Knox, Manningham, Maroondah, Whitehorse, Yarra Ranges, Monash, Waverley East SLA, Waverley West SLA (excluding Chadstone for CAMHS)</td>
<td>Adult: Boronoodara, Yarra, City of Melbourne (East Melbourne only)</td>
<td>Adult: Darebin (Northcote SLA)</td>
<td>Adult: Melbourne (north of the Yarra River), Moreland, Moonee Valley, Brimbank, Hume, Melton, Maribyrnong Wyndham, Hobsons Bay</td>
</tr>
<tr>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
</tr>
<tr>
<td>0–15:</td>
<td>Melbourne (north of the Yarra River), Moreland, Moonee Valley, Brimbank, Hume, Melton, Maribyrnong Wyndham, Hobsons Bay</td>
<td>Adult &amp; aged: all of Brimbank, Melton, Melbourne (north of the Yarra River, except for East Melbourne), Moonee Valley, Whittlesea, Hume, Moreland, Darebin (Preston SLA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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6 Appendix 3 provides a map showing the three sub-areas of the LGA of Melbourne served by different catchments.
Metropolitan: Nine health services managing public mental health services for various age ranges

Thirteen adult service areas, nine aged, five CAMHS. Misaligned catchments for age-related service components in a range of cases; 19 LGAs have more than one health service managing public mental health services and the boundaries of eight LGAs are split by public mental health service catchments. A complex relationship with Medicare Local boundaries in many cases. In 2011 the total catchment population of each health service managing public mental health services ranged from 187,427 to 1,005,928.

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<th>N&amp;WMR</th>
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<td>Peninsula Health</td>
<td>Monash Health</td>
<td>Alfred Health</td>
<td>Eastern Health</td>
</tr>
<tr>
<td><strong>CAMHS:</strong> Greater Dandenong, Cardinia, Casey, Frankston, Mornington Peninsula, Kingston South SLA, Monash (South West SLA – exc’g Chadstone)</td>
<td><strong>CAMHS:</strong> Port Phillip, Stonnington Glen Eira, Bayside, Kingston (North SLA), Melbourne (south of the Yarra River), Monash (suburb of Chadstone)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Orygen Youth Health (15–24):** Hobsons Bay, Maribyrnong, Wyndham, Brimbank, Melton, Melbourne (part), Moonee Valley, Hume, Moreland
Metropolitan: Nine health services managing public mental health services for various age ranges

Thirteen adult service areas, nine aged, five CAMHS. Misaligned catchments for age-related service components in a range of cases; 19 LGAs have more than one health service managing public mental health services and the boundaries of eight LGAs are split by public mental health service catchments. A complex relationship with Medicare Local boundaries in many cases. In 2011 the total catchment population of each health service managing public mental health services ranged from 187,427 to 1,005,928.

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<th>EMR-N&amp;WMR</th>
<th>N&amp;WMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peninsula Health</td>
<td>Monash Health</td>
<td>Alfred Health</td>
<td>Eastern Health</td>
</tr>
</tbody>
</table>

Catchment overlap with Medicare Locals
Frankston Mornington Peninsula ML: Frankston, Mornington Peninsula

Catchment overlap with Medicare Locals
Bayside ML: Port Phillip, Stonnington, Glen Eira, Bayside, Kingston
South Eastern Melbourne ML: Greater Dandenong Cardinia, Casey
Frankston Mornington Peninsula: Frankston, Mornington Peninsula

Catchment overlap with Medicare Locals
Inner East Melbourne ML: Boroondara, Manningham, Monash, Whitehorse
Eastern Melbourne ML: Knox, Maroondah, Yarra Ranges

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Darebin, Banyule, Whittlesea, Nillumbik, Hume (part)
Inner North West Melbourne ML: Melbourne, Yarra, Moonee Valley, Moreland

Catchment overlap with Medicare Locals
Inner West Melbourne ML: Melbourne, Yarra, Moonee Valley, Moreland
Macedon Ranges and North Western Melbourne ML: Brimbank, Maribyrnong, Melton, Hume (part)

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Melbourne, Yarra, Moonee Valley, Moreland
Macedon Ranges and North Western Melbourne ML: Brimbank, Maribyrnong, Melton, Hume (part)

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Melbourne, Yarra, Moonee Valley, Moreland
Macedon Ranges and North Western Melbourne ML: Brimbank, Maribyrnong, Melton, Hume (part)

Catchment overlap with Medicare Locals
Northern Melbourne ML: Darebin, Banyule, Whittlesea, Nillumbik, Hume (part)

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Boroondara, Manningham, Monash, Whitehorse

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Boroondara, Manningham, Monash, Whitehorse

Catchment overlap with Medicare Locals
Macedon Ranges and North Western Melbourne ML: Brimbank, Maribyrnong, Melton, Hume (part)

Catchment overlap with Medicare Locals
Northern Melbourne ML: Darebin, Banyule, Whittlesea, Nillumbik, Hume (part)

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Boroondara, Manningham, Monash, Whitehorse

Catchment overlap with Medicare Locals
Northern Melbourne ML: Darebin, Banyule, Whittlesea, Nillumbik, Hume (part)

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Boroondara, Manningham, Monash, Whitehorse

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Boroondara, Manningham, Monash, Whitehorse

Catchment overlap with Medicare Locals
Northern Melbourne ML: Darebin, Banyule, Whittlesea, Nillumbik, Hume (part)

Catchment overlap with Medicare Locals
Inner North West Melbourne ML: Boroondara, Manningham, Monash, Whitehorse

Catchment overlap with Medicare Locals
Northern Melbourne ML: Darebin, Banyule, Whittlesea, Nillumbik, Hume (part)
Appendix 2: Current arrangements for rural public clinical mental health services

Mental health service areas
Rural Victoria

[Map of rural Victoria showing mental health service areas]
Rural: Eight health services managing public mental health services for all ages in their catchment

In 2011 catchment populations ranged from 56,474 to 283,636. The boundaries of four LGAs are split by public mental health service catchments. There is a high level of consistency with Medicare Local boundaries.

<table>
<thead>
<tr>
<th>Barwon-South Western Region</th>
<th>Grampians Region</th>
<th>Loddon Mallee Region</th>
<th>Hume Region</th>
<th>Gippsland Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon Health</td>
<td>Southwest Health Care</td>
<td>Ballarat Health Services</td>
<td>Ramsay Health Care Group</td>
<td>Goulburn Valley Health</td>
</tr>
<tr>
<td>Barwon Area Mental Health Service (CAMHS, adult, aged)</td>
<td>Southwest Area Mental Health Service (CAMHS, adult, aged)</td>
<td>Loddon Campaspe Southern Mallee Area Mental Health Service (CAMHS, adult, aged)</td>
<td>Northern Mallee Area Mental Health Service Area (CAMHS, adult, aged)</td>
<td>North East and Border Mental Health Service Area (CAMHS, adult, aged)</td>
</tr>
<tr>
<td>Barwon Health</td>
<td>Southwest Health Care</td>
<td>Ballarat Mental Health Services</td>
<td>Ramsay Health Care Group</td>
<td>Goulburn Valley Health</td>
</tr>
<tr>
<td>Barwon Area Mental Health Service (CAMHS, adult, aged)</td>
<td>Southwest Area Mental Health Service (CAMHS, adult, aged)</td>
<td>Loddon Campaspe Southern Mallee Area Mental Health Service (CAMHS, adult, aged)</td>
<td>Northern Mallee Area Mental Health Service Area (CAMHS, adult, aged)</td>
<td>North East and Border Mental Health Service Area (CAMHS, adult, aged)</td>
</tr>
<tr>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
</tr>
<tr>
<td>Estimated total catchment population:</td>
<td>Estimated total catchment population:</td>
<td>Estimated total catchment population:</td>
<td>Estimated total catchment population:</td>
<td>Estimated total catchment population:</td>
</tr>
</tbody>
</table>

Barwon Health
Southwest Health Care
Ballarat Health Services
Bendigo Health Care Group
Ramsay Health Care Group
Goulburn Valley Health
Latrobe Regional Hospital

Barwon Area Mental Health Service (CAMHS, adult, aged)
Southwest Area Mental Health Service (CAMHS, adult, aged)
Ballarat Mental Health Services
Loddon Campaspe Southern Mallee Area Mental Health Service (CAMHS, adult, aged)
Northern Mallee Area Mental Health Service Area (CAMHS, adult, aged)
North East and Border Mental Health Service Area (CAMHS, adult, aged)
Gippsland Area Mental Health Service (CAMHS, adult, aged)

LGAs
Greater Geelong, Queenscliffe, Surf Coast, Colac-Otway, Golden Plains -South East SLA, Corangamite–South SLA
Glenelg, Southern Grampians, Moyne, Warrnambool, Corangamite–North SLA
Ararat, Ballarat, Golden Plains–North West SLA, Hepburn, Hindmarsh, Horsham, Moorabool, Northern Grampians, Pyrenees, West Wimmera, Yarram, Glengarry
Buloke, Campaspe, Central Goldfields, Gannawarra, Greater Bendigo, Loddon, Macedon Ranges, Mount Alexander, Swan Hill–Central SLA, Swansea Hill – Balance SLA (part)
Moira (excluding City of Yarravonga), Greater Shepparton, Strathbogie, Mitchell, Murrindindi
Alpine, Benalla, Indigo, Mansfield, Towong, Wangaratta, Wodonga, Moira (City of Yarravonga)
Bass Coast, Baw Baw, East Gippsland, Latrobe, South Gippsland, Wellington

Estimated total catchment population:
2011: 283,636
2021: 344,817

Estimated total catchment population:
2011: 94,193
2021: 108,233

Estimated total catchment population:
2011: 252,308
2021: 293,596

Estimated total catchment population:
2011: 56,474
2021: 65,610

Estimated total catchment population:
2011: 141,307
2021: 181,882

Estimated total Victorian catchment population:
2011: 125,764
2021: 143,678

Estimated total Victorian catchment population:
2011: 259,271
2021: 305,374
Rural: Eight health services managing public mental health services for all ages in their catchment

In 2011 catchment populations ranged from 56,474 to 283,636. The boundaries of four LGAs are split by public mental health service catchments. There is a high level of consistency with Medicare Local boundaries.

<table>
<thead>
<tr>
<th>Barwon-South Western Region</th>
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<th>Hume Region</th>
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<tbody>
<tr>
<td>Barwon Health</td>
<td>Southwest Health Care</td>
<td>Ballarat Health Services</td>
<td>Bendigo Health Care Group</td>
<td>Ramsay Health Care</td>
</tr>
<tr>
<td>Largely aligns with Barwon Medicare Local catchment</td>
<td>Largely aligns with Great South Coast Medicare Local catchment</td>
<td>Aligns with Grampians Medicare Local catchment, except for Bacchus Marsh, which is part of the Macedon Ranges and North Western Melbourne Medicare Local catchment</td>
<td>Partial alignment with Victorian part of Loddon-Mallee-Murray Medicare Local catchment</td>
<td>Largely aligns with Victorian part of Lower Murray Medicare Local catchment</td>
</tr>
</tbody>
</table>
Appendix 3: Areas of the LGA of Melbourne served by different clinical catchments

The Melbourne (C) LGA has been split into three sub-areas:

- Melbourne (South of the Yarra)
- Melbourne (North of the Yarra - East Melbourne)
- Melbourne (North of the Yarra - Remainder)

It should be noted that these sub-areas are not the same as Statistical Local Area (SLA) boundaries. The sub-area boundaries have been chosen such that each sub-area is an aggregate of whole Statistical Area 1s (i.e. there has been no splitting of SA1s). The SA1 is the smallest area at which the ABS generally releases detailed population data and Census statistics.
The 2011 population by SA1 can then be used to calculate the population for each sub-area as shown below.

**Estimated Resident Population as at 30 June 2011 by Melbourne LGA sub-areas**

<table>
<thead>
<tr>
<th>Components areas of Melbourne LGA</th>
<th>No. of persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne (C) - North of the Yarra (East Melb)</td>
<td>5,195</td>
</tr>
<tr>
<td>Melbourne (C) - North of the Yarra (Remainder)</td>
<td>75,394</td>
</tr>
<tr>
<td>Melbourne (C) - South of the Yarra</td>
<td>20,027</td>
</tr>
<tr>
<td><strong>Melbourne LGA</strong></td>
<td><strong>100,616</strong></td>
</tr>
</tbody>
</table>

The table below lists the Health Services currently serving the three sub-areas within the Melbourne LGA by age group.

**Health services managing the three sub-areas in the Melbourne LGA**

<table>
<thead>
<tr>
<th>Components areas</th>
<th>CAMHS</th>
<th>Adult</th>
<th>Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>North of the Yarra (East Melb)</td>
<td>RCH (0-14) Orygen Youth Health (15-24)</td>
<td>St Vincent's Health</td>
<td>St Vincent's Health</td>
</tr>
<tr>
<td>North of the Yarra (Remainder)</td>
<td>RCH (0-14) Orygen Youth Health (15-24)</td>
<td>Melbourne Health</td>
<td>Melbourne Health</td>
</tr>
<tr>
<td>South of the Yarra</td>
<td>Alfred Health</td>
<td>Alfred Health</td>
<td>Alfred Health</td>
</tr>
</tbody>
</table>
Appendix 4: DHS catchment areas