

Psychiatric Disability Support Services

Minimum Data Set Analysis 1998-2001

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Executive Summary

1. Introduction

Psychiatric Disability Support Services consist of five service types. The service types include:

- Psychosocial Rehabilitation Day Programs (DP) – Structured and Drop-In
- Home Based Outreach Support (HBOS)
- Planned Respite (PR)
- Residential Rehabilitation (RR)
- Mutual Support and Self Help (MSSH).

This report is based on the Minimum Data Set (MDS) returns from the Psychiatric Disability Support Services (PDSS) sector in Victoria for the reporting periods between 1998-2000.

2. Meeting the PDSS Standards

Cultural and Gender Awareness

- Only a small number of PDSS participants are from a non-English speaking background and have language difficulties.
- Participation of women in PDSS programs is largely consistent with the proportion of women accessing public mental health services. Participation of women is lowest in the drop in component of day programs.

Recommendation:

Services should compare the proportion of clients from a non-English speaking background in their service with the local population, giving particular consideration to the cultural backgrounds of the population. Services may wish to consider setting themselves a goal to increase participation of people from a non-English speaking background and/or people who have language difficulties and work towards addressing any access issues.

Service Integration

- There appears to be a reasonable degree of service integration of PDSS with clinical mental health services. PDSS participants have a similar profile to clients of the public mental health system. Over 50% of participants have a case manager. Where the client has a case manager, the PDSS has ongoing contact with the case manager over 70% of the time.

Documentation and Delivery of Support

- There has been a decrease over time in Individual Program Plans (IPP) being completed for new clients, while the number of six monthly reviews has increased. Of particular concern is the relatively low rate of IPP development and review in day programs (less than 80%).
- Of those participants whose IPP has been reviewed, over 85% of participants have achieved their short term goals. There has been a slight decrease (5%) in the achievement of goals in day programs.

Recommendation:

Further investigation is needed to determine why the rate of review of IPPs in day and home based outreach support is lower than expected. In order to emphasise the importance of developing and reviewing IPPs for all PDSS clients, completion of IPPs has been included as a Key Performance Measure in Service Agreements between agencies and the Department. Performance will be monitored and mechanisms developed to improve on current performance.

3. Participant Information

- There is an increase in the number of participants in the home based outreach and residential rehabilitation programs over the reporting period, reflecting the increase in funding in these programs over this time.
- Most people in PDSS programs are living in private or public housing. While there has been minimal change over the reporting period in most of the accommodation types of PDSS participants, there has been a slight decrease in the number of people living in Supported Residential Services and Boarding/Rooming Houses.
- The largest age group is people aged 35 – 44. The distribution of the age of participants has not changed over the three year period.
- Most PDSS participants have a primary diagnosis of schizophrenia. This has not changed over the reporting period.

4. Program Activity

- The number of participants in day programs, both for drop in and structured components has remained stable over the reporting period.
- Home based outreach support programs appear to be successful in the goal of assisting people to maintain and sustain long term suitable accommodation.
- Residential rehabilitation programs appear to be an important program for people leaving acute inpatient care. The proportion of people exiting residential rehabilitation into public housing has increased over time.
- Planned respite services are increasingly providing more than one occasion of respite. People who receive only one occasion of respite are likely to go on a holiday or camp.
- Mutual support and self help services have significantly increased service activity over the three year period. However, missing data in both 1998 and 1999 has affected the accuracy of this data.

Recommendations:

- Opportunities to diversify the range of respite options available should be explored.
- The trend to provide more than one occasion of respite to a client/family who are assessed as having higher needs is desirable and should continue.

5. Staffing Information

- Staff/client ratios have generally changed little over the reporting periods, although the average staff/client ratio in structured day programs has decreased over the reporting period.

1. Introduction

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- Planned Respite (PR)
- Residential Rehabilitation (RR)
- Mutual Support and Self Help (MSSH).

This report is based on the Minimum Data Set (MDS) returns from the Psychiatric Disability Support Services (PDSS) sector in Victoria for the July – December reporting periods between 1998-2000. The last published information for the Minimum Data Set covered the period July-December 1997 and was produced in March 1999.

The MDS data reports service activity and participant information from these services types to the Mental Health Branch, Department of Human Services. The PDSS MDS data is used by the Department of Human Services for a range of purposes. These include monitoring performance, providing accurate data to the Department of Treasury on the size of the workforce, and for planning and service development activities.

Changes to the PDSS MDS have been made in the context of developing a data set that can be used nationally and also fulfils the data requirements of the Commonwealth State Disability Agreement.

1.1 Background and Context

Following the release of the 1997 PDSS MDS report in March 1999, feedback provided to the Mental Health Branch indicated that services are interested in more analysis of data and also in having a sense of any changes over time.

This report aims to address these issues. For example:

- Data is presented over a three year time frame, with comparisons made with earlier years as appropriate.
- While in most cases the focus of discussion is on statewide reporting, regional level information is available in the appendices.
- Characteristics of users of the public mental health system (using 1999-2000 Psychiatric Records Information Services Manager (PRISM) data) are compared with those of PDSS participants.

In addition, where possible the reporting of the data is related to the Standards for PDSSs. The following standards are referred to:

- Cultural and Gender Awareness (Standard 7)
- Integration Standard (Standard 8)
- Documentation (Standard 10)
- Delivery of Support (Standard 11).

Services are encouraged to consider their individual service data to assess how well they are meeting the standards and how they compare to others. In this way, services will be addressing Standard 9 – Service Development. This standard is about using information systems, service evaluation, outcome measurement, research and quality improvement so that “the PDSS is managed effectively and efficiently to facilitate the delivery of coordinated and integrated services”.

1.2 Reporting Processes

PDSS service providers are required to report on service usage characteristics through the MDS. Reports cover a six month period and are requested in February and August for the preceding six month period (ie. January – June, July – December). Service providers forward their returns through DHS regional offices to the Mental Health Branch.

1.3 Data Quality

The data is generally considered to be of a good quality and provides an accurate picture of activity within the PDSS sector. However, it should be noted that:

- Approximately 10% of data returns were received in hard copy with the agency advising that they were unable to export the data. The data quality of hard copy was very low and usually did not conform to the validation rules, thus explaining why the agency was unable to export. Where possible, the data was adjusted by DHS to conform to the validation rules.
- Data quality was negatively affected where agencies did not refer to the data dictionary, particularly in relation to number and type of places in home based outreach support, contacts and accommodation. Where possible, the data was adjusted by DHS to improve quality.

The data sets are relatively complete. Return rates varied - 60% in 1998, 95% in 1999 and 85% in 2000. However, it should be noted that most of the missing data is from small agencies and should not have a major impact on the analysis. Table 1 identifies the number of missing returns for the 1998 and 1999 periods on a regional basis.

Table 1: Number of Missing Returns 1998 and 1999.

Region	Day Program		HBOS		Resi Rehab		Respite		MSSH	
	98	99	98	99	98	99	98	99	98	99
Barwon South Western									6	
Eastern Metro	1		1	1	2				1	
Gippsland			2							
Grampians										
Hume	1									
Loddon Mallee			1							
Northern Metro					1				1	
Southern Metro	3	1	2	1	1		1		1	
Western Metro	2		2	1			1			
Statewide			1							
TOTAL	7	1	9	3	4		2		9	

Table 2 lists those services that did not provide July – Dec 2000 data in time for the preparation of this report. It is acknowledged that missing or late data has often been the result of difficulties with the data collection system. The redeveloped PDSS MDS addresses many of these difficulties, and a 100% return of data on time will be expected.

Table 2: Agencies Not Providing July–Dec 2000 Data in Time for the Preparation of this Report.

Region	Agency	Day Program	HBOS	MSSH
BSW	SFV			*
	Salvation Army	*	*	
Gippsland	CoCare			*
	Special Needs Access Program	*	*	
Hume	Wodonga Group Housing		*	
Northern	Anglicare Family Services		*	
	RFV PALS			*
	Jesuit Social Services		*	
Western	Salvation Army		*	
	Horizon and Outlooks	*		
Statewide	Action on Disability in Ethnic Communities			*
TOTAL		3	6	4

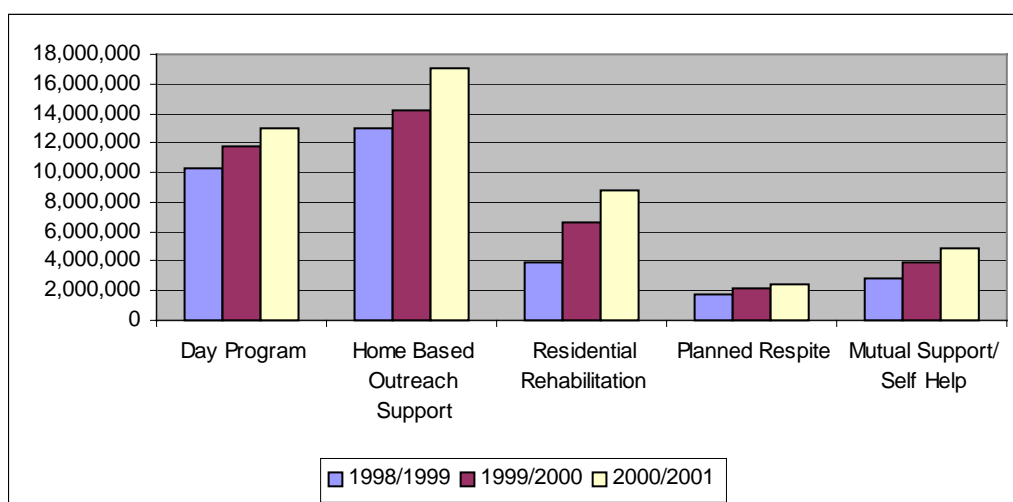
1.4 Service Location

Most PDSS services have a sub regional catchment. The data in this report is considered at a regional level. With the exception of statewide mutual support and self help services, for the purposes of this report statewide services have been recorded under the region in which they are located.

1.5 Funding Information

Table 3 shows the funding levels over the reporting periods. Funding increases for all service types are associated with indexation for wage rises and the Consumer Price Index. Further funding growth is evident in the Residential Rehabilitation and Home Based Outreach Support Services. However, it should be noted that the increase in residential rehabilitation funding after 1998/99 reflects the late start up of services.

Table 3: Distribution of PDSS Funding 1998-2000.



2. Meeting the PDSS Standards

Standards for PDSS have been developed to reflect the specialist function of the PDSS sector in facilitating and supporting the integration of people with psychiatric disabilities into their local community and its programs. The eleven standards relate to key aspects of psychiatric disability support service provision and build on existing human rights and equal opportunity principles.

2.1 Cultural and Gender Awareness (Standard 7)

Standard 7 requires that PDSS services deliver non-discriminatory support which is sensitive to the gender and social and cultural values of the participants and the role of the participant's family and community. Other relevant standards include 11.1.4 "The PDSS ensures effective equitable access to services for each person in the defined community" and 11.4.7 "That services are specialised in addressing the particular needs of people of culturally and linguistically diverse backgrounds".

2.1.1 Cultural Awareness

Table 4: Proportion of Clients Born in Australia, English Speaking Country or Non-English Speaking Country 1998–2001 and Proportion with Language Difficulty.

	Proportion Born In Australia	Proportion English Speaking Country	Proportion Non-English Speaking Country	Percent with language difficulty	Total clients
1998	82.90%	6.44%	10.66%	3.94%	7217
1999	81.64%	7.32%	11.04%	4.40%	8017
2000	81.61%	8.39%	10.00%	5.12%	8918

Point to Note:

While the proportion of clients from a non-English speaking background has not changed over the three year reporting period, there has been a small increase in the percentage of clients with language difficulty.

Comparison to earlier years:

In 1995/96, 23% of clients in HBOS programs, 12% in day programs and 6% in residential rehabilitation were from a non-English speaking background; 7% of clients were reported as having a language difficulty. By 1996/97 the proportions varied from 9 – 12%, which is similar to the data in this reporting period.

Discussion:

The same data at regional level (Appendix 1) does not show any consistent patterns regarding changes over time for people from a non-English speaking background or those with language difficulty. The data does however suggest that metropolitan services have a higher proportion of clients from a non-English speaking background and who have a language difficulty. This is consistent with the 1999/2000 PRISM records in which 3-5% of clients in a rural areas are from a non-English speaking background, compared to 30% in inner metropolitan areas.

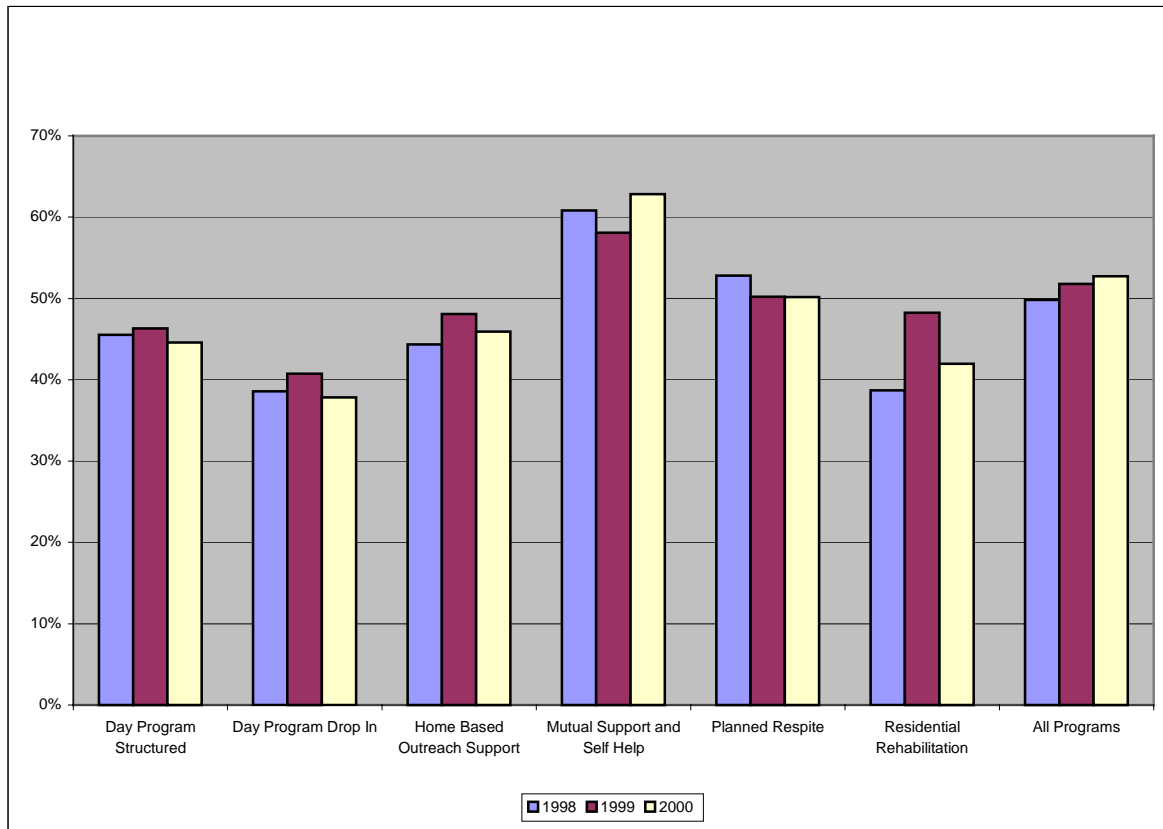
Recommendation:

Services should compare the proportion of clients from a non-English speaking background in their service with the local population, giving particular consideration to the cultural backgrounds of the population. Services may wish to consider setting themselves a goal to increase participation of

people from a non-English speaking background and/or people who have language difficulties and work towards addressing any access issues.

2.1.2 Gender Awareness

Chart 1: Proportion of PDSS Participants who are Female 1998–2000.



Points to note:

- The proportion of men and women accessing services has remained reasonably constant.
- Women remain at less than 50% of the PDSS population in all programs except mutual support and self help and planned respite.
- Day Program - Drop In attracts the lowest proportion of women (under 40%).

Comparison to earlier years:

In 1995/96 women made up 36% of the day program population, 40% of those receiving home based outreach support and 46% in residential rehabilitation. By 1997, the proportion of women in day programs had increased to 43% in both day programs and home based outreach support and 47% in residential rehabilitation.

Discussion:

PRISM data for clinical services in 1999/2000 records that female clients represented 48% of all clients (males 52%). While overall PDSS are providing reasonable access to women, it is necessary to look at ways in which to improve access in day, home based outreach support and residential rehabilitation programs.

Data issues:

The data does not include participants recorded as indeterminate or unknown gender. This varied from 10% of all participants in 1998 to 4% in 2000. In most cases, unknowns were recorded in the mutual support and self help category, probably reflecting people attending educational/information forums in which the gender of the person attending is unlikely to be recorded.

2.2 Integration (Standard 8)

Standard 8 requires that the area mental health service works in a coordinated and integrated way with a range of services to ensure continuity of care for the participant. It requires regular meetings between staff of different services with a shared client.

As PDSS are part of the continuum of services for people with mental illness with a high need for psychosocial and disability support, it can be expected that many of the participants of the PDSS programs will also be clients of a public mental health service.

This section looks at a range of data to make assumptions about the level of integration of PDSS with public mental health services including:

- Comparison of characteristics of users of public mental health services (only including clients with 12 or more contacts in a year) and PDSS clients (Table 5)
- Clients with case managers, level of contact with case managers, and referral source (Chart 2).

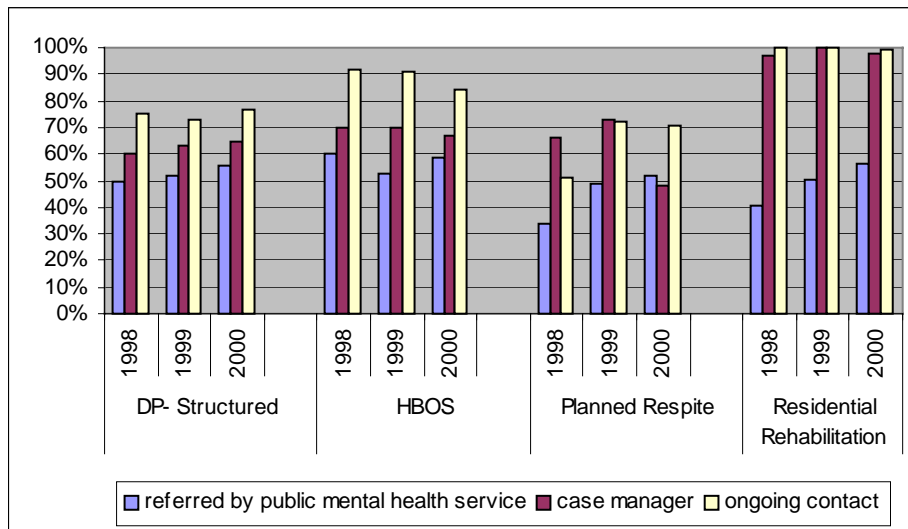
Table 5: Comparison of Profile of Clients Aged 16–64 years with 12 or more Contacts in the Year between PRISM 1999/2000 and PDSS Participants in 1999.

Category	Profile/Characteristics	Clients recorded on PRISM	PDSS participants
Primary Diagnosis	Schizophrenia	41.46%	54.60%
	Personality Disorder	3.93%	3.40%
	Major affective disorder	22.62%	20.00%
Cultural	NESB	15.18%	10.00%
	Language difficulty	5.91%	5.12%
	Indigenous	1.38%	1.80%
Gender	Female	47.68%	51.78%
Accommodation	House/Flat	83.47%	84.21%
	Supported Residential Service	2.46%	5.22%
	Boarding/Rooming House	2.56%	2.85%
	Homeless Persons' Shelter	0.49%	0.62%
	Psychiatric Inpatient Unit	NA	0.24%
	Caravan	1.08%	0.68%
	Residential	4.83%	2.32%
	No Accommodation	0.46%	0.30%
	Other	2.33%	1.18%
	Not Known	1.26%	2.39%
	Nursing Home	0.42%	0.00%
	Hostel	2.33%	0.00%

Points to note:

- The overall profile of PDSS and PRISM clients is similar.
- The most significant difference is in relation to NESB clients, with the profile of clients from a NESB 5% higher than for PDSS. However, the proportion of clients with a language difficulty is the same.
- PDSS support a higher percentage of people living in Supported Residential Services than do clinical services.

Chart 2: Percent of Clients with Case Managers, Ongoing Case Manager Contact and Referral from a Public Mental Health Service.



Points to note:

- In 2000, 69% (5866) of PDSS clients had a case manager. Of these clients, ongoing contact with the case manager was recorded in 83% of cases.
- Not all participants with a case manager were referred by the public mental health service.
- In day and HBOS programs there has been minimal change in the proportion of referrals received from public mental health services. There have been increases in the proportion of referrals from public mental health services to planned respite and residential rehabilitation programs.
- The referral rate from public mental health services has remained at less than 60% for all programs.
- Participants in day programs are least likely to have a case manager. Where the client does have a case manager, day programs are least likely to have contact with the case manager.
- There is a slight decrease over time of contact with case managers in the HBOS programs.
- Participants in residential rehabilitation services are most likely to have a case manager, and are most likely to have ongoing contact with the case manager.

Comparison to Previous Years:

There has been minimal change in the number of participants with case managers since 1997. Contact with case managers was higher for those in the HBOS program (95% in 1997) and planned respite program (83% in 1997) and much lower for those in residential rehabilitation programs (68% in 1997).

Discussion:

This data suggests a reasonable level of integration between the PDSS and the clinical mental health services. The profile of the PDSS population appears similar to that of the clinical mental health services, which is not surprising given that the majority of PDSS participants do have a case manager.

While almost 70% of PDSS clients have a case manager, only 50% of referrals to PDSS are from public mental health services. The reason for why case managers are not, or are not being recorded as, the referral source needs further exploration.

The decrease in contact with case managers in the HBOS program from 1997 to 2000 may reflect the length of time that participants have been in the program and subsequent stability in their health and wellbeing, resulting in a decreased need for ongoing contact with case managers.

The high level of case manager involvement with clients of residential rehabilitation programs is expected, as these programs are targeting more complex clients and using a partnership approach to meet the needs of their clients. The increase of referrals from public mental health services over time may also indicate an increasing acceptance and valuing of these services. However, in 2000, almost half of the referrals still came from outside the public mental health system.

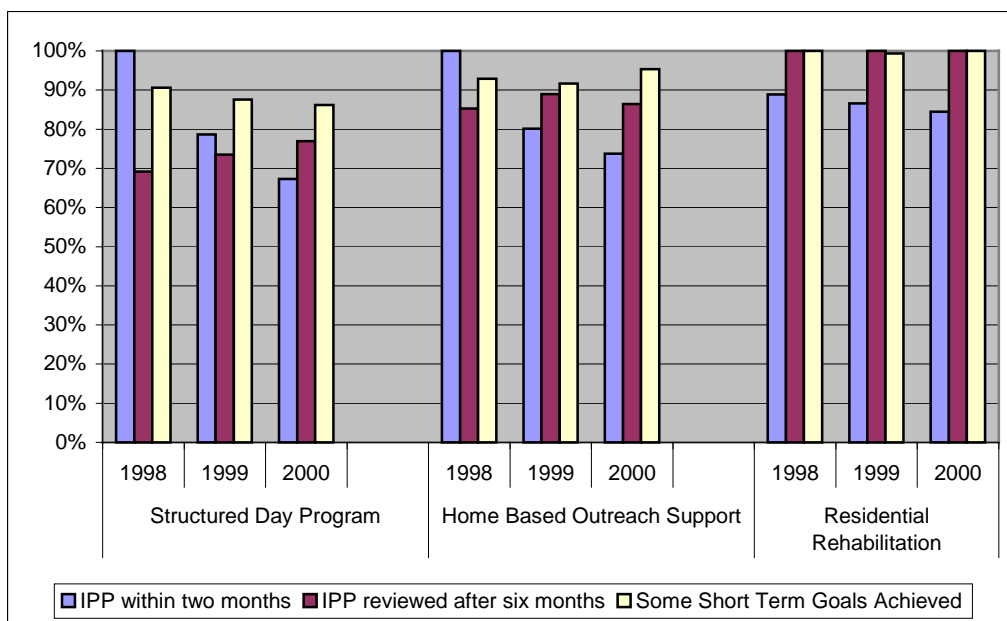
Data issues:

In planned respite programs there were a high number of participants for whom it was not known whether there was a case manager. This may reflect an incorrect practice of some planned respite services recording details about the carer rather than the client. The proposed new data collection will collect data on both carers and client characteristics, which together with improved guidelines to assist in data collection, should address this issue.

2.3 Documentation and Delivery of Support (Standards 10 & 11)

Standard 10 states “Service activities are documented to assist in the delivery of support and rehabilitation and in the management of services”. Quality and continuity of care can be partly assessed through the criteria that “Each participant in a structured program has an individual program plan, which documents the participant’s goals, strategies, support required and review of outcomes” (Standard 10.6).

Chart 3: Completion of Individual Program Plans and Achievement of Short Term Goals by Program Type 1998–2000.



Points to note:

- Over the three year period, there has been a proportional decrease in the number of Individual Program Plans (IPPs) completed for new consumers within two months in both day programs and home based outreach programs. The decrease in completion of IPPs for new clients within two months contrasts with the slight increase or no change in the percent of IPPs reviewed in the six month period.
- In all programs there has been a slight decrease in the percentage of people recorded as achieving their short term goals.

Discussion:

The decrease in the completion of IPPs for new clients is of concern, particularly in day programs as staff/client ratios have also decreased over the same time period. The decrease in the completion of IPPs in both day and home based outreach programs between 1999 and 2000 could be partly explained by an increase in the number of new clients (11% increase or 81 people for day programs; 24% increase or 120 people in home based outreach support programs) and therefore increasing workloads. However, there is no such increase between 1998 and 1999. Other factors may include an increased complexity in the presentation of clients, and two months not being a feasible time frame in which to engage with the client and prepare a plan.

Despite the decreasing attention to completing IPPs within a two month time frame, the slight increase in the review of existing IPPs suggests that services acknowledge the importance of the IPP and its use in the program.

The consistent rate of review of IPPs in the home based outreach program is 85%. A possible explanation for this relatively low rate is that there is a proportion of residents for whom agencies may have decided a goal focussed program is no longer appropriate but instead provide ongoing support to assist maintenance of accommodation and wellbeing.

The data from residential rehabilitation programs suggests that there is an intense focus on individual program planning and review, as evidenced in the 100% IPP review rate.

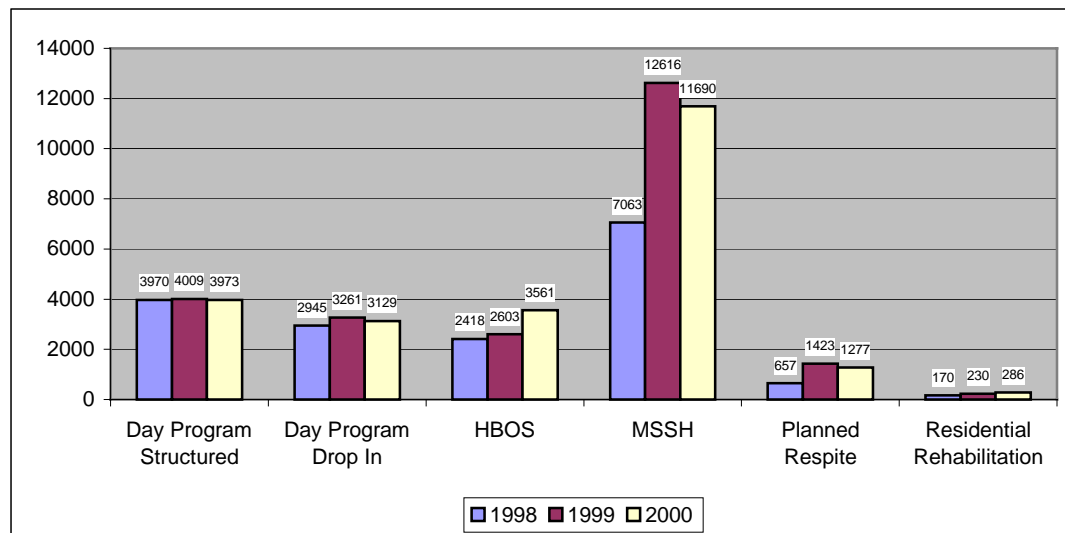
Recommendation:

Further investigation is needed to determine why the rate of review of IPPs in day and home based outreach support is lower than expected. In order to emphasise the importance of developing and reviewing IPPs for all PDSS clients, completion of IPPs has been included as a Key Performance Measure in Service Agreements between agencies and the Department. Performance will be monitored and mechanisms developed to improve on current performance.

3. Participant Information

3.1 Number of Participants

Chart 4: Number of Participants by Program 1998-2000.



The number of participants in the PDSS program reflects growth in the home based outreach support program and the residential rehabilitation programs. The changes in the number of people accessing mutual support and self help services most likely reflects improved data quality.

3.2 Accommodation Type

Table 6: Accommodation Type of PDSS Participants by Program 1998-2000.

Accommodation Type	1998			1999			2000		
	DP-Structured	HBO	PR	DP-Structured	HBO	PR	DP-Structured	HBO	PR
Private Housing	56%	35%	67%	54%	34%	61%	54%	36%	62%
Public Housing	15%	17%	14%	16%	20%	20%	18%	19%	20%
Supported Public Housing	11%	30%	10%	11%	33%	8%	11%	29%	9%
Supported Residential Service	9%	7%	4%	8%	3%	3%	6%	4%	3%
Boarding/Rooming House	3%	5%	2%	3%	3%	1%	2%	3%	1%
Homeless Persons' Shelter	1%	0%	0%	1%	1%	0%	1%	1%	0%
Psychiatric Inpatient Unit	0%	0%	0%	0%	1%	0%	0%	0%	0%
Caravan	1%	1%	2%	1%	1%	1%	1%	1%	1%
CCUs	2%	0%	0%	3%	1%	0%	3%	1%	0%
Resi Rehab NGOs	1%	0%	0%	1%	0%	0%	1%	0%	0%
No Accommodation	0%	0%	0%	0%	0%	0%	0%	2%	1%
Other	1%	2%	0%	1%	2%	2%	0%	2%	1%
Not Known	0%	1%	0%	3%	1%	4%	4%	3%	3%
Marginal	15%	16%	9%	15%	11%	11%	14%	15%	9%
Non-marginal	85%	84%	91%	85%	89%	89%	86%	85%	91%
Total Number	3720	2415	636	3879	2534	1364	4001	3354	1277

Points to note:

- Minimal change in the type of accommodation in which people live.
- The majority of people live in stable and secure environments. The number of people in marginal type accommodation (boarding houses, SRS, no accommodation, unknown, other, caravan park) is reasonably low.
- There is a slight decrease in the proportion of people living in boarding/rooming houses and supported residential services.

Comparisons with previous years:

In 1995/96 approximately 33% of PDSS clients were living in ‘at risk accommodation’ compared to between 13–15% for this reporting period.

Discussion:

The slight decrease in the number of PDSS participants residing in Supported Residential Services and Boarding/Rooming Houses is across the day and home based outreach programs, but is more marked in the home based outreach support program. This may reflect the decrease in the availability of this type of accommodation.

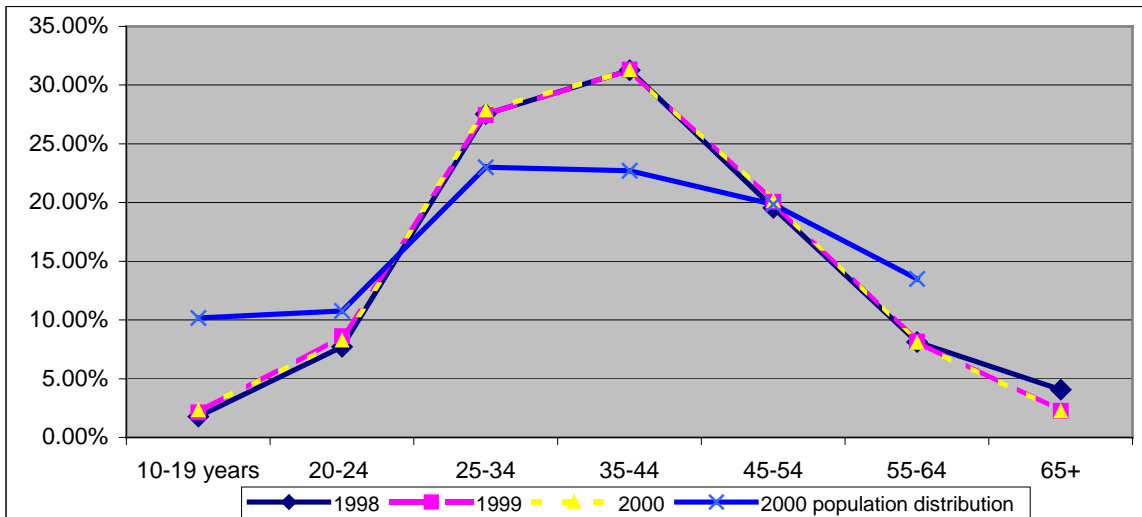
Participants in day programs are most likely to reside in private housing while home based outreach program participants are most likely to reside in public housing. The difference is expected, given a significant proportion of home based outreach support is linked to public housing through the housing and support program.

3.3. Age of Participants

Table 7: Age of PDSS Participants 1998–2000 Compared to Age of Population 2000.

	1998	1999	2000	Population distribution 16–64 years 2000
10-19	1.76%	2.13%	2.30%	10.18%
20-24	7.72%	8.61%	8.23%	10.78%
25-34	27.52%	27.45%	27.83%	23.00%
35-44	31.27%	31.33%	31.26%	22.71%
45-54	19.55%	20.06%	20.13%	19.84%
55-64	8.13%	8.16%	8.04%	13.50%
65+	4.05%	2.26%	2.21%	
Total	7217	8017	8918	

Chart 5: Comparison between Population Distribution and PDSS Population by Age.



Points to note:

- Proportions across the age groups have remained constant.
- There is a sharp decrease in people accessing PDSS after age 54 years.
- There is a higher rate of people aged 35–44 years in PDSS programs than is expected by the population distribution.

Comparison to earlier years:

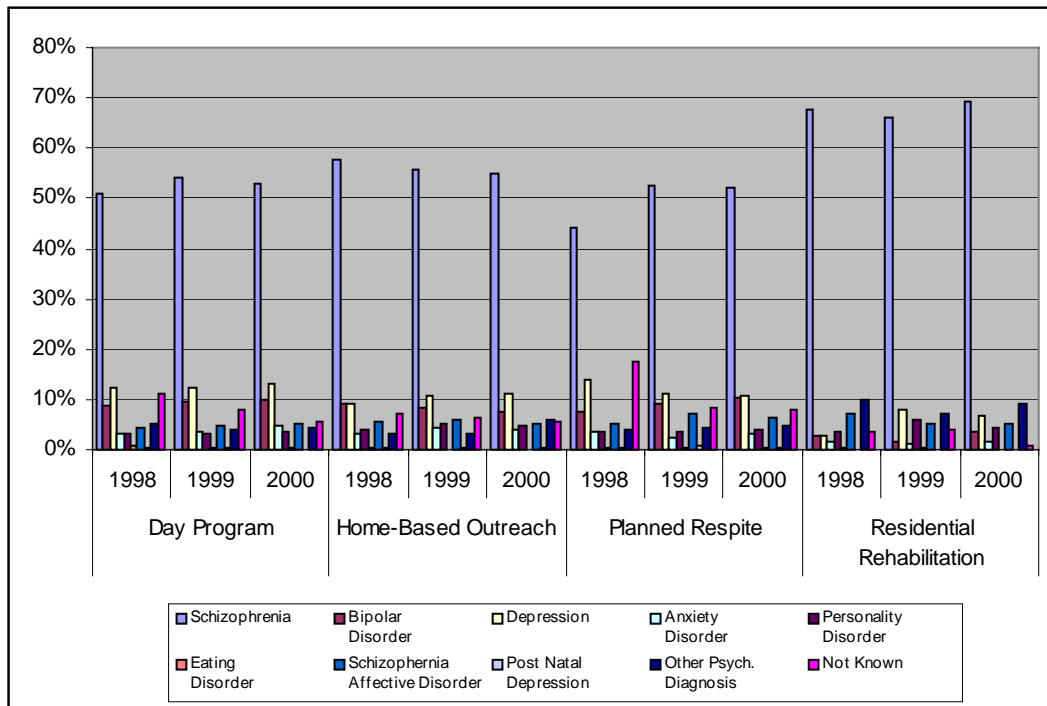
The age distribution is similar to previous years.

Discussion:

The lack of change in the age distribution over a six-year period suggests that people are exiting the program before the age of 54 years. This exiting could be a result of people having reached a level of recovery and community connection such that the PDSS service is no longer relevant, and/or because the service is no longer age appropriate. It is positive that the rate of participation of those 20–25 is comparable to the population. Services need to consider providing age-appropriate services for people aged less than 20 years or over 55 years.

3.4 Diagnosis

Chart 6: Primary Diagnosis of PDSS Participants by Program 1998-2000



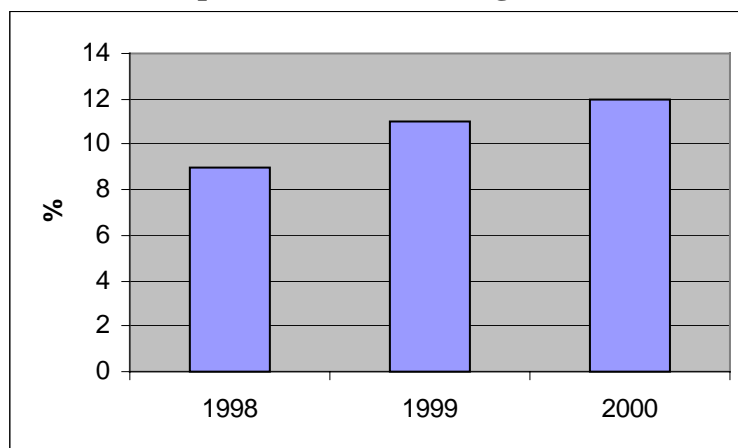
Points to note:

- The diagnosis of clients has remained constant over the reporting periods.
- Schizophrenia is the most common diagnosis. There are a higher percentage of clients with schizophrenia in the residential rehabilitation programs than the other programs.

Comparison with previous years:

The profile of diagnosis is similar to previous years.

Chart 7: Percentage of PDSS Participants with a Dual Diagnosis 1998-2000



Points to note:

- There has been a slight increase in the percentage of PDSS participants with a dual diagnosis ie. a mental illness and substance abuse problem.

4. Program Activity Information

4.1 Day Programs

Chart 8: Number of Participants in Drop In and Structured Components of Day Programs by Region 1998-2000.

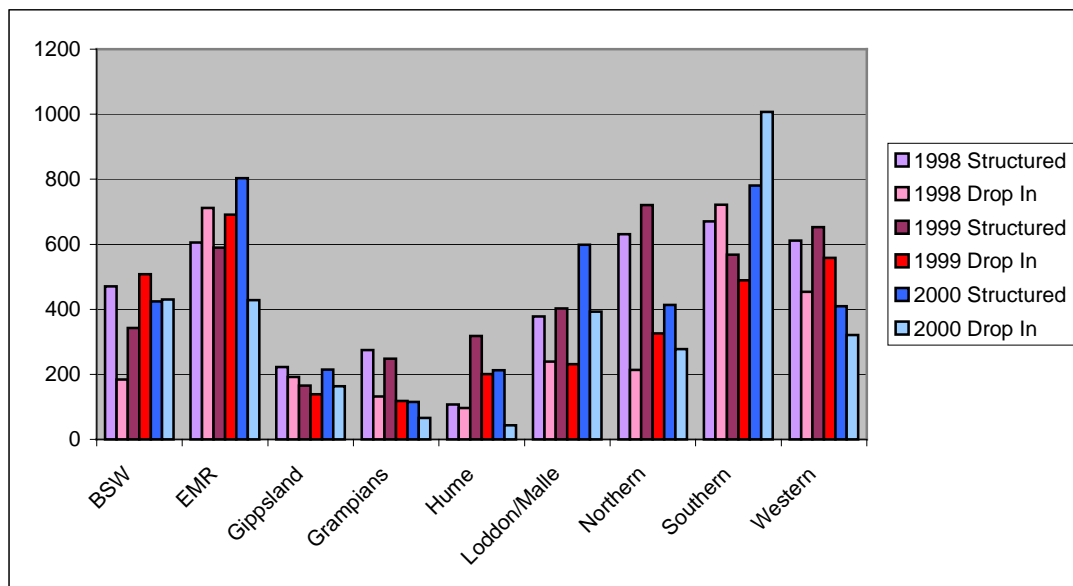


Table 8: Number of Day Program Participants.

Year	Day Program Structured	Day Program Drop In
1998	3970	2945
1999	4009	3261
2000	3973	3129

Points to note:

- There is not a consistent statewide trend regarding the relationship between the number of people in structured and drop in components of a day program.
- There has been very little overall change in the number of people participating in day programs over the reporting period.
- In all Regions, except Loddon Mallee and Eastern Metropolitan Region, there has been a decrease in the number of participants in the structured day program components.

Discussion:

Reasons for the variation in the number of participants across the structured and drop-in components of the day program could include:

- Services exploring different service delivery options
- Inaccurate data.

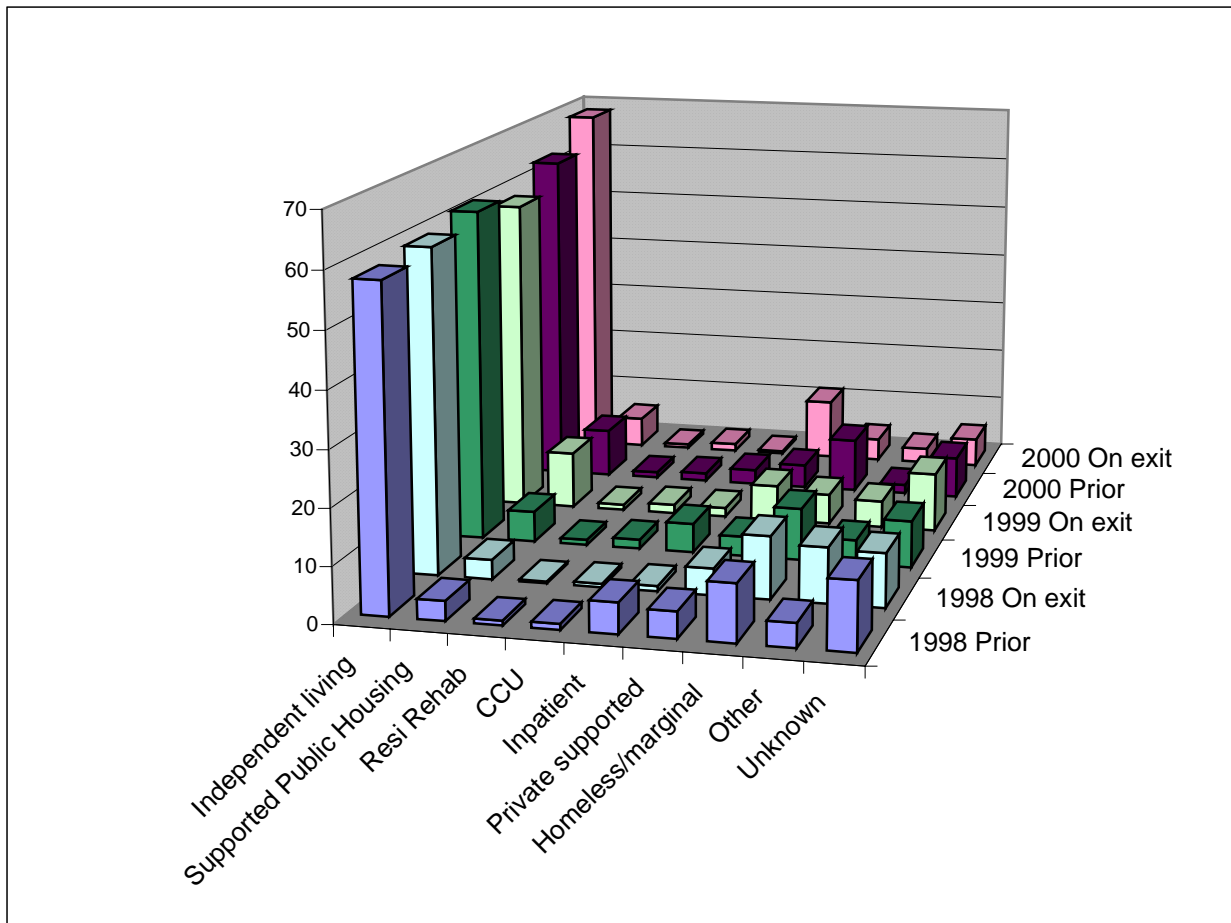
The absence of data on the proportion of time dedicated to drop in and structured activities makes it difficult to draw any real conclusions about change over time and/or differences in regions. For example, while the day programs in the Southern Metropolitan Region report a high number of participants attending drop in, it is possible that this is only for a small amount of time each week.

4.2 Home-Based Outreach Support

Table 9: Current and Exiting Participants in HBOS July–Dec Reporting Periods 1998–2000.

	1998	1999	2000
Current Clients	2415	2534	3354
Number of exiting clients	310	307	431
% exiting	13%	12%	13%
% of those exiting in less than 1 year	70%	59%	64%

Chart 9: Accommodation Prior to, and on Exit from, HBOS 1998-2000.



Points to note:

- In each reporting period, around 12% of clients exit the program. The majority of exiting clients have been in the program less than one year.
- Of those clients that exit the program, most exit to an independent living situation.
- While there has been a decrease in the number of people exiting to homeless/marginal accommodation types (11% in 1998 compared to 4% in 2000), there has been an increase in the proportion of people exiting the HBOS to private Supported Residential Services (5% in 1998 compared to 11% in 2000).
- Very few people exit the HBOS service (around 1%) to an acute inpatient service, CCU or residential rehabilitation.

Discussion:

It would appear that the HBOS program is successfully targeting people who need long term support. It is interesting to note that of those people who do exit the program, most have received support for less than

a year and most either move to, or remain in, independent living options. It suggests that while most people require long term support, for a small number of people there may be value in short term interventions.

The increase in the proportion of people who are in Supported Residential Services on exit in July – December 2000 is of interest. Possible explanations include:

- an increase in people living in SRSs coming to the attention of PDSSs through closures of SRSs and other low cost accommodation, with PDSS HBOS providing a short term response until the person is resettled in new accommodation.
- a need for higher levels of support than can be provided by the HBOS program. However, if this was the case, it may be expected that there would also be increases in the number of people moving to residential rehabilitation and CCUs.

Data issues:

- The data reports that up to 10% of people exit the HBOS program to, or enter the HBOS program from, supported public housing. Unless people are moving between programs this is not theoretically possible, as supported public housing necessarily involves receiving an HBOS service. It is likely that this data reports those people who have been part of the Housing and Support Program but are no longer receiving the support. It is expected that the new data collection system will make reporting on accommodation type easier.

4.3 Residential Rehabilitation

Table 10: Number of Residential Rehabilitation Participants 1998-2000.

	1998	1999	2000
Current	657	1423	1277
On exit	35	52	72
% exiting	5%	4%	6%
% independent living on exit	39%	8%	48%
% more intensive support	16%	10%	23%
% homelessness/marginal on exit	2%	0%	1%
% other/unknown	21%	85%	14%
% of those exiting, those who do so in less than a year	47%	33%	67%

Table 11: % of Clients by Accommodation Type Prior to, and on Exit from, Residential Rehabilitation.

	Independent living	Supported public	Resi rehab	CCU	Inpatient	Private Supported	Homeless/ marginal	Other	Unknown
1998 Prior	6	1	0	2	8	1	2	0	81
1998 On Exit	37	0	9	3	6	3	23	6	14
1999 Prior	9	1	4	0	6	2	3	1	74
1999 On Exit	4	4	2	0	2	0	4	0	85
2000 Prior	27	2	6	2	11	0	4	0	48
2000 On Exit	49	14	10	0	7	3	4	10	4

Points to note:

- The proportion of people entering the program from living in their own house increased in 2000.
- There is a very small flow through of residents in the rehabilitation program. Until 2000, most people leaving the program had been in it for over a year.

Discussion:

The residential rehabilitation program appears to be an important program for people leaving acute inpatient care, with up to 10% of people entering the program from acute inpatient care.

Unlike the Home Based Outreach Program, people leaving residential rehabilitation are likely to have been in the program for over a year. This increases the likelihood that the people moving through the residential rehabilitation program are doing so as a result of a planned exit, rather than because the program was not suitable. Although the exit data is poor, it is interesting to note that over the three year reporting period there has been an increase in the percentage of people exiting to independent living situations. Up to 20% of people moved to more intensive support options (includes CCUs, inpatient and supported residential services), which suggests that there are still a number of people for whom the residential rehabilitation environment is not the most appropriate.

Assuming that people exited the residential rehabilitation program in the same reporting period as entering an HBOS program, it is estimated that 56% of people moving to their own house from residential rehabilitation received HBOS support in 1998 and 73% in 2000. This indicates good links between the residential rehabilitation and HBOS program, suggesting that for most people the system provides an appropriate pathway.

There are a very small number of people recorded as entering from and exiting to residential rehabilitation services, suggesting there may be some movement between services. In part this probably reflects the differences in services, and that the range of models allow for some consumer choice.

The increase in 2000 in the proportion of people entering the residential rehabilitation program from the acute inpatient unit and from their own home, and the increase in the percentage of people leaving the program within a 12 month period, probably reflects the impact of the introduction of the young persons residential rehabilitation program to the service system.

Data issues:

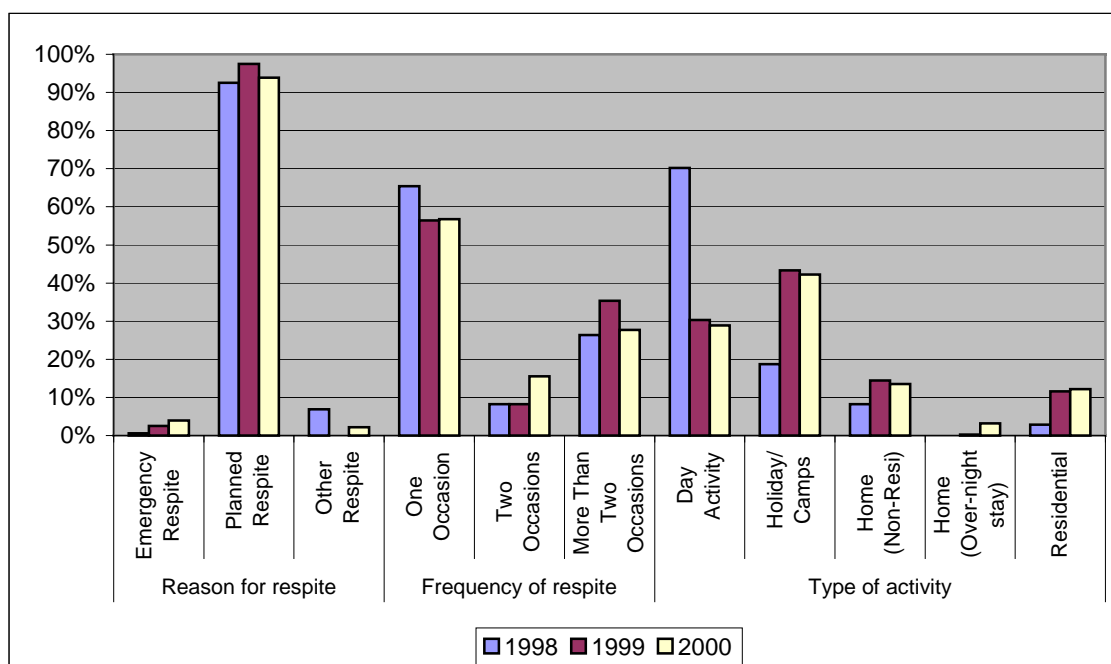
The data quality is poor in all years regarding prior accommodation and in 1999 to where people exited. This limits any substantial conclusions.

4.4 Planned Respite Care

Table 12: Number of Participants Receiving Planned Respite Care 1998-1999.

Year	Number of Participants
1998	657
1999	1126
2000	1368

Chart 10: Reason, Frequency and Type of Planned Respite 1998-2000.



Points to note:

- The total number of people using respite care has almost doubled since 1998.
- Whilst the vast majority of people receiving respite have used respite once, over the three years there has been an increase in the proportion of people receiving two respite interventions (from 9% to 15%).

Discussion:

An important aim of planned respite is to assist in sustaining the caring relationship through having a break from usual circumstances. The data does not separate out respite focussed on the consumer and respite focussed on the consumer and/or carer. In funding terms, around two-thirds of the service should be focussed towards the consumer and/or carer. The high percentage of only one occasion of respite, and highest categories being day activities and holidays, suggests that planned respite is not being used sufficiently to provide planned breaks over a period of time. However, there appears to be a slight trend towards the provision of more than one occasion of respite and more in home services, perhaps indicating an increased responsiveness to ongoing carer need. It is unclear whether the lack of use of emergency respite and overnight respite is because these are not always available or because they are not desired.

Data Issues:

The quality of this data is affected by inconsistent totals, for example in the frequency of respite and the reasons for respite. As the planned respite program becomes more diverse in the type of respite activity it offers, including some direct support to carers, the data set does not accurately record activity. These omissions will be addressed in the revised MDS currently being developed.

Recommendation:

A trend to provide more than one occasion of respite to a client/family who are assessed as having higher needs is desirable and should continue. Opportunities to diversify the range of available respite options could also be explored.

4.5 Mutual Support/Self-Help

Table 13: Contacts in Mutual Support and Self Help Programs 1998-2000.

Year	Telephone Contacts	Face To Face Contacts	Support Groups Convened
1998	4967	2227	903
1999	22601	7503	1330
2000	15270	8805	2310

Points to note:

- Mutual Support contacts are mostly by telephone (between 63-75%).
- There has been a large increase across the state over the last three years in the number of support groups being convened (ie. more than double).

Discussion:

An increase in the number of support groups convened and face-to-face contacts has occurred. This may reflect increased activity as the result of the establishment of mental health carer support or resource workers over 1996/97 and 1997/98.

Data issues:

There is data missing from both 1998 and 2000 that may explain some of the anomalies. MSSH services are usually smaller agencies and historically have experienced more difficulties in completing the data requirements. In addition, due to the nature of mutual support and self help activities, providing accurate data on groups and telephone contacts is more complex than when recording individual service details and hence is more liable to omissions. Alternative means of recording data for this service type will be explored in future.

5. Staffing Information

5.1 Staff/Client Ratios

Table 14: Direct Staff/Client Ratios in Day Program (Structured) and Home Based Outreach Support 1998–2000.

	1998	1999	2000
Day Program - Structured	32	28	24
Home Based Outreach Support	12	11	12

Points to note:

- Client/staff ratios for structured day programs have decreased since 1998.
- Home based outreach support ratios have not changed.

Discussion:

The reported client/staff ratio for home based outreach has remained constant over the three year period. It would be expected that to manage this staff client ratio staff would be working with people with a range of different levels of need.

As client numbers have not changed in day programs, the decrease in staff/client ratio is due to increases in staff numbers.

6. Acronyms

BSW	Barwon South Western Region
CCU	Community Care Unit
DHS	Department of Human Services
DP	Day Program
EM	Eastern Metropolitan Region
EFT	Equivalent Full Time
HBOS	Home Based Outreach Services
IPP	Individual Program Plan
MDS	Minimum Data Set
MSSH	Mutual Support and Self Help
NESB	Non English Speaking Background
NGO	Non Government Organisation
NM	Northern Metropolitan Region
PDSS	Psychiatric Disability Support Services
PR	Planned Respite
PRISM	Psychiatric Records Information Services Manager
RFV	Richmond Fellowship of Victoria
RR	Residential Rehabilitation
SFV	Schizophrenia Fellowship of Victoria
SM	Southern Metropolitan Region
SRS	Supported Residential Service
WM	Western Metropolitan Region

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6. Primary Diagnosis of PDSS Participants by Program 1998-2000
7. Percentage of PDSS Participants with a Dual Diagnosis 1998-2000
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PDSS MDS Report July – December 2001

Data has been analysed from Psychiatric Disability Support Services (PDSS) for the reporting period July-December 2001. This analysis is provided as a supplement to the report for the period 1998-2000.

A selection of key data from July – December 2001 has been made for comparison purposes with previous data.

Points to note:

Table 4: Proportion of Clients Born in Australia, English Speaking Country or Non English Speaking Country and Proportion with Language Difficulty Jul-Dec 2001

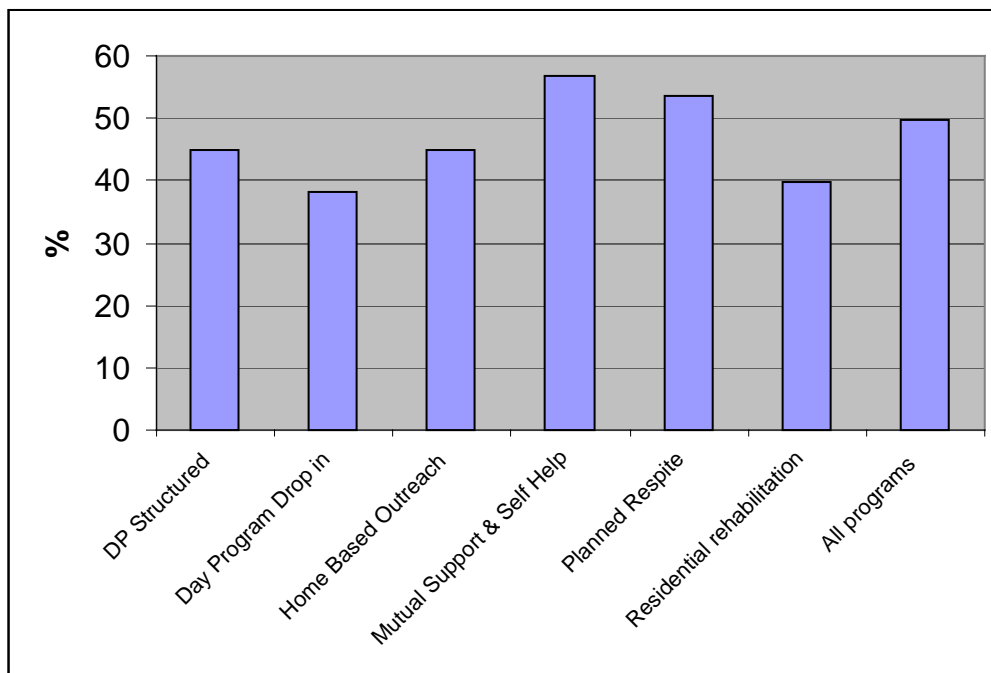
Proportion Born in Australia	Proportion English Speaking Country	Proportion Non-English Speaking Country	Percent with language difficulty	Total Clients
82.8%	6.81%	10.39%	5.8%	9220

- There has been virtually no change since 1998 in the

proportion of clients born in Australia.

- The slight upwards trend of clients with a language difficulty continued (from 5.12% in 2000 to 5.8% in July-December 2001).

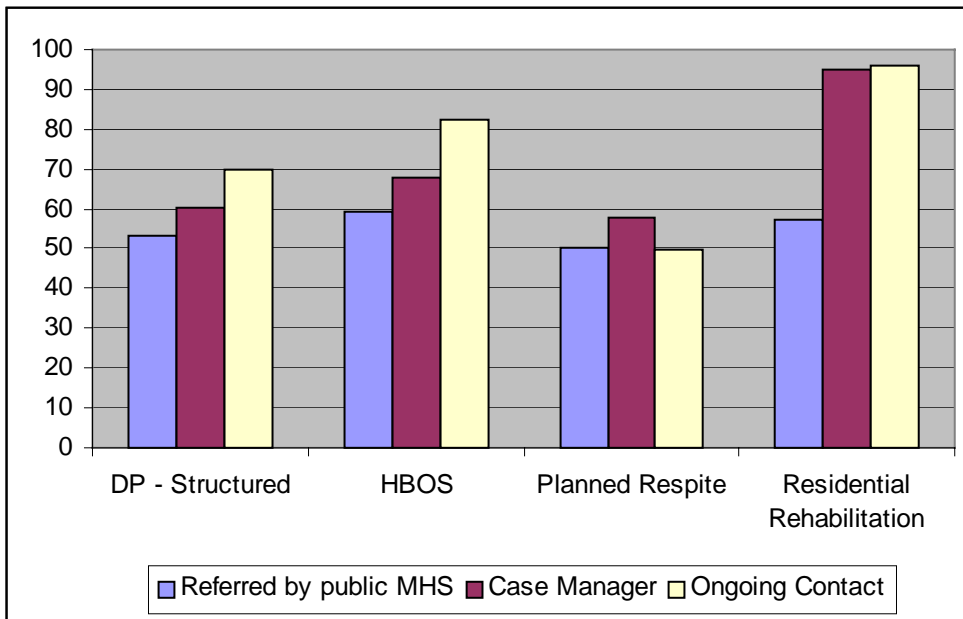
Chart 1: Proportion of PDSS Participants who are Female Jul-Dec 2001



Points to note:

- Identical pattern of female PDSS participation to previous years.
- Total female participation in PDSS now half of all participants.

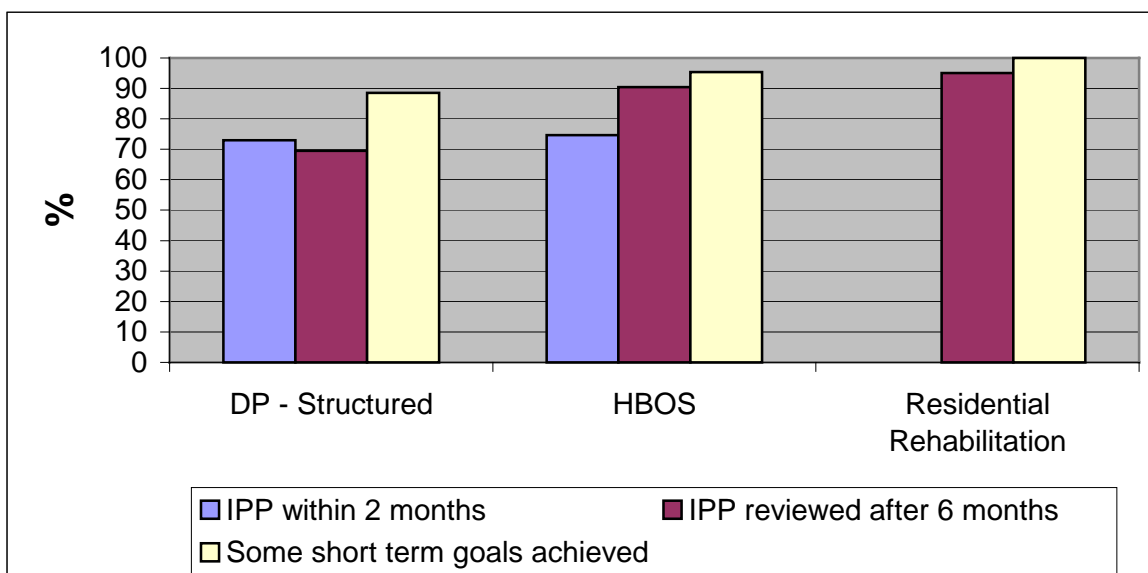
Chart 2: Percent of Clients with Case Managers, Ongoing Case Manager Contact and Referral from a Public Mental Health Service Jul- Dec 2001



Points to note:

- Identical pattern to previous year (2000)
- 95% of residential rehabilitation clients have a case manager

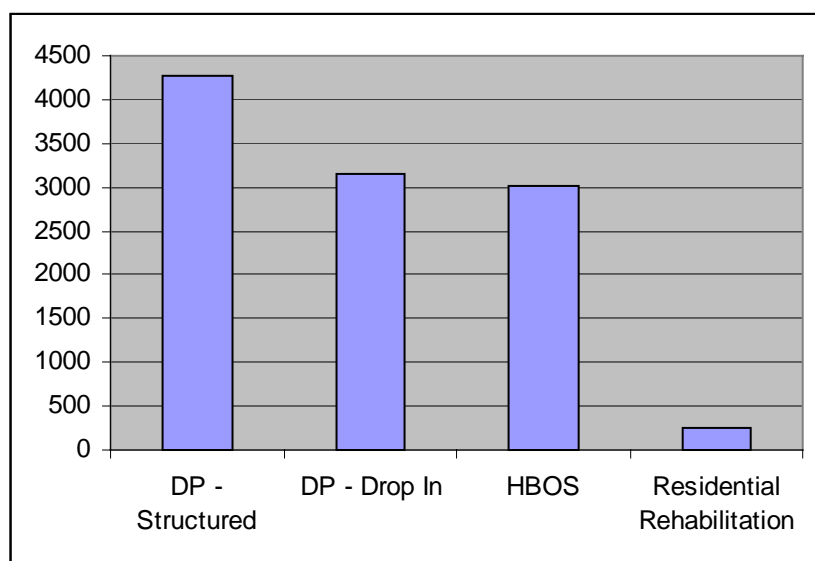
Chart 3: Completion of Individual Program Plans and Achievement of Short Term Goals by Program Type Jul-Dec 2001



Point to note:

A slight rise in the rate of completion of IPPs within 2 months for structured day programs (from 68% in 2000 to 73%).

Chart 4: Number of Participants by Program Jul-Dec 2001



Points to note:

- Similar distribution of PDSS participants across program as in previous years
- Total number of participants for this reporting period was 10,675 (excluding Mutual Support and Self Help participants).

Table 6: Accommodation Type of PDSS Participants by Program Jul-Dec 2001 (%)

Accommodation Type	DP - Structured	HBO	PR
Private Housing	50	35	61
Public Housing	18	19	19
Supported Public Housing	10	27	10
Supported Residential Service	7	6	6
Boarding/Rooming house	2	4	0
Homeless Persons Shelter	0	1	0
Psychiatric Inpatient Unit	1	1	0
Caravan	1	1	1
CCU	3	1	0
Resi rehab NGOs	1	1	0
No Accommodation	0	1	0
Other	0	0	1
Not Known	7	3	2
	100%	100%	100%
Total number	4349	3537	1036

Point to note:

Very similar accommodation types by program to previous years.

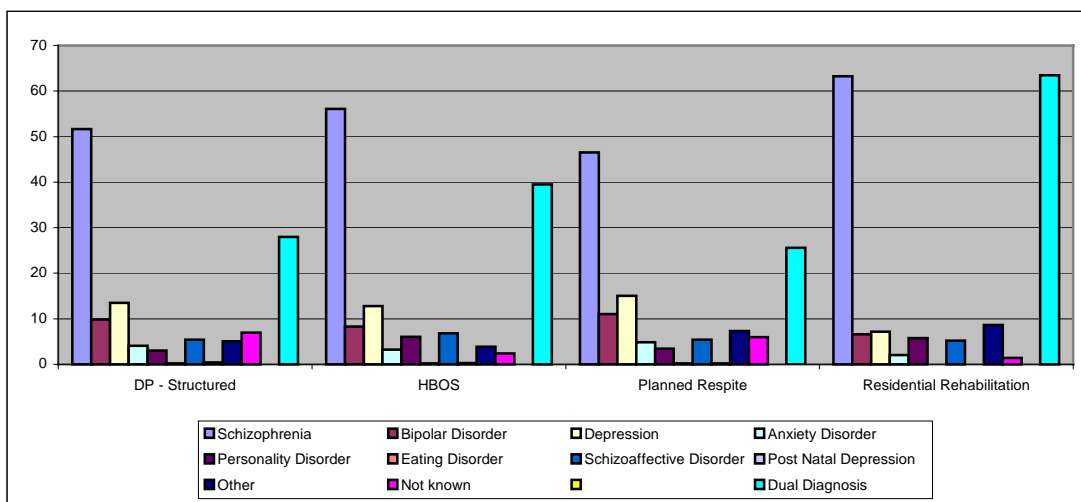
Table 7: Age of PDSS Participants Jul-Dec 2001 (%)

10-19	2
20-24	10
25-34	26
35-44	29
45-54	21
55-64	10
65+	2
Total	9268

Points to note:

Slight increases in 20-24 year old participants (from 8.23% in 2000 to 9.8%) and 55-64 year old participants (from 8.04% in 2000 to 9.5%).

Chart 7: Primary Diagnosis of PDSS Participants by Program Jul-Dec 2001



Points to note:

- Identical pattern to previous years.
- Participants with a dual diagnosis (ie. mental illness and substance abuse problems) have remained at 12%.
- The highest proportion of participants with a dual diagnosis is in the residential rehabilitation program (63%).

Table 13: Contacts in Mutual Support and Self Help Programs Jul – Dec 2001

Telephone Contacts	Face to face contacts	Support Groups Convened
33904	17096	1041

Points to note:

- Telephone contacts have doubled from 15270 in 2000 to 33904 in July – December 2001.
- Support groups have halved from 2310 to 1041.

Appendix 1
Cultural Awareness by Region

		Born In Australia	English Speaking Country	Non-English Speaking Country	Language Difficulty	Total Clients
BSW	1998	92.14%	4.37%	3.49%	1.16%	687
	1999	89.64%	6.61%	3.76%	1.04%	772
	2000	82.35%	16.11%	1.54%	1.18%	844
Gippsland	1998	91.55%	5.15%	3.30%	0.41%	485
	1999	89.98%	5.12%	4.90%	0.00%	449
	2000	80.40%	14.54%	5.07%	0.22%	454
Grampians	1998	95.27%	2.46%	2.27%	0.95%	529
	1999	96.20%	1.66%	2.14%	0.48%	421
	2000	97.40%	1.73%	0.87%	0.87%	346
Hume	1998	97.56%	1.74%	0.70%	2.79%	287
	1999	77.27%	19.38%	3.35%	2.15%	418
	2000	78.77%	18.32%	2.91%	1.37%	584
Loddon Mallee	1998	91.46%	4.60%	3.94%	2.13%	609
	1999	93.30%	3.78%	2.91%	16.89%	687
	2000	95.48%	1.83%	2.69%	0.54%	930
NM	1998	77.29%	10.35%	12.36%	3.39%	1092
	1999	77.90%	5.05%	17.05%	4.02%	1466
	2000	79.01%	3.52%	17.47%	5.46%	1391
SM	1998	75.74%	9.62%	14.64%	1.13%	1154
	1999	77.03%	10.64%	12.32%	1.82%	1428
	2000	78.67%	9.17%	12.16%	12.91%	1603
WM	1998	74.45%	5.03%	20.52%	6.60%	1272
	1999	72.12%	6.48%	21.40%	7.08%	1327
	2000	74.03%	6.38%	19.60%	7.23%	1286
EM	1998	81.67%	6.90%	11.43%	10.34%	1102
	1999	83.98%	8.29%	7.72%	3.72%	1049
	2000	82.50%	9.32%	8.18%	3.65%	1480

**Appendix 2
Gender by Program and Region**

1998	BSW			EMR			Gippsland			Grampians			Hume			Loddon/Mallee			Northern			Southern			Statewide			Western			TOTAL
	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?	
Day Program Structured	253	218	0	354	251	0	134	88	0	143	132	0	67	40	0	187	191	0	344	284	3	337	324	9	0	0	0	337	274	0	3696
Day Program Drop In	98	86	0	465	247	0	110	82	0	68	64	0	50	46	0	121	118	0	112	102	0	493	229	0	0	0	0	187	97	170	2678
HBOS	42	34	0	171	141	0	62	71	0	71	64	0	74	55	6	93	101	0	189	192	2	265	184	0	0	0	0	374	227	0	2191
MSSH	71	165	39	0	0	36	60	292	0	28	30	11	0	0	0	63	105	0	15	9	0	6	3	0	1904	2720	1419	30	57	0	7006
Planned Respite	41	51	0	86	85	0	60	70	0	46	73	0	24	21	0	18	19	0	35	28	0	0	0	0	0	0	0	0	0	0	657
Residential Rehabilitation	36	12	0	6	6	2	0	0	0	0	0	0	0	0	0	0	0	0	8	7	0	18	16	0	0	0	0	35	24	0	146
TOTAL	541	566	39	1082	730	38	426	603	0	356	363	11	215	162	6	482	534	0	703	622	5	1119	756	9	1904	2720	1419	y	679	170	15411
1999																															
Day Program Structured	185	158	0	342	248		87	78		121	127		113	205		205	198	0	384	336	1	312	255	1				401	252		3757
Day Program Drop In	291	217	0	448	243		81	58		71	47		67	134		134	97	0	195	131		310	179	0				335	223		3038
HBOS	156	122	0	95	110		83	89		42	38		104	119		119	95	0	255	269		271	215	11				220	190		2413
MSSH	1428	1323	26	0	0		56	248		42	93		0	115		115	199	3	41	90		456	1058	0	2509	3292	1452	19	51		12565
Planned Respite	49	101	1	94	112		49	63		31	57		79	32		32	31	0	95	82		158	154	2				120	81		1342
Residential Rehabilitation	0	0	0	25	23		0	0		3	2		8	6		6	1	0	20	24		21	28	0				36	27		203
TOTAL	2109	1921	27	1004	736	0	356	536	0	310	364	0	371	611	0	611	621	3	990	932	1	1528	1889	14	2509	3292	1452	1131	824	0	23318
2000																															
Day Program Structured	240	184		455	348		117	98		53	62		128	85		289	310		233	180		419	350	12				261	149		3824
Day Program Drop In	240	190		245	183		97	66		31	35		28	15		208	185		172	106		697	283	27				211	110		3019
HBOS	144	104	5	278	252		76	77		63	76	1	145	84		156	133		396	317		336	327	0				328	263		3298
MSSH	1144	990		5	32		63	160		74	295	80	61	142		194	226	3	12	9		1223	1938	0	1201	2890	842	25	81		11609
Planned Respite	88	72		37	59		46	40		40	41	1	66	57		18	18		87	80	27	125	162	1				115	97		1180
Residential Rehabilitation	6	1		26	25		0	0		8	1		12	7		4	2		25	18		38	40	0				47	26		260
TOTAL	1862	1541	5	1046	899	0	399	441	0	269	510	82	440	390	0	869	874	3	925	710	27	2838	3100	40	1201	2890	842	987	726	0	23190

Appendix 3
Age (proportion) by region

Region	Age Group	1998	1999	2000	Region	Age Group	1998	1999	2000
BSW	10-19	3%	2%	1%	NM	10-19	2%	3%	3%
	20-24	7%	8%	7%		20-24	6%	7%	9%
	25-34	25%	18%	21%		25-34	31%	32%	30%
	35-44	28%	30%	31%		35-44	31%	31%	30%
	45-54	21%	25%	23%		45-54	21%	18%	19%
	55-64	11%	13%	12%		55-64	8%	8%	7%
	65+	3%	4%	3%		65+	1%	1%	2%
	TOTAL	687	772	844		TOTAL	1092	1466	1391
Gippsland	10-19	4%	5%	5%	SM	10-19	1%	2%	2%
	20-24	11%	7%	7%		20-24	7%	10%	9%
	25-34	20%	20%	22%		25-34	26%	27%	26%
	35-44	38%	38%	35%		35-44	27%	29%	30%
	45-54	18%	20%	20%		45-54	19%	21%	22%
	55-64	7%	8%	8%		55-64	8%	7%	8%
	65+	2%	2%	2%		65+	11%	3%	4%
	TOTAL	485	449	454		TOTAL	1154	1428	1603
Grampians	10-19	1%	4%	4%	WM	10-19	1%	1%	2%
	20-24	7%	5%	8%		20-24	7%	8%	7%
	25-34	23%	22%	19%		25-34	32%	32%	29%
	35-44	33%	29%	28%		35-44	32%	34%	33%
	45-54	21%	26%	31%		45-54	19%	17%	19%
	55-64	12%	12%	9%		55-64	6%	7%	7%
	65+	3%	2%	1%		65+	3%	2%	3%
	TOTAL	529	421	346		TOTAL	1272	1327	1286
Hume	10-19	2%	2%	1%	EM	10-19	1%	2%	2%
	20-24	9%	12%	9%		20-24	10%	13%	10%
	25-34	28%	23%	33%		25-34	29%	31%	31%
	35-44	38%	33%	29%		35-44	30%	30%	32%
	45-54	17%	20%	17%		45-54	20%	17%	18%
	55-64	7%	9%	9%		55-64	7%	6%	7%
	65+	0%	0%	1%		65+	3%	2%	1%
	TOTAL	287	418	584		TOTAL	1102	1049	1480
Loddon/M	10-19	2%	1%	2%					
	20-24	5%	7%	7%					
	25-34	24%	27%	30%					
	35-44	33%	32%	33%					
	45-54	21%	22%	18%					
	55-64	9%	8%	8%					
	65+	6%	3%	2%					
	TOTAL	609	687	930					

Appendix 4
Individual Program Plans Completed by Region

		2 months			6 months		
		1998	1999	2000	1998	1999	2000
BSW	IPP Reviewed	118	102	104	383	466	527
	No IPP Reviewed	7	3	4	87	50	49
	TOTAL	125	105	108	470	516	576
Gippsland	IPP Reviewed	55	65	47	199	219	231
	No IPP Reviewed	9	10	37	80	43	53
	TOTAL	64	75	84	279	262	284
Grampians	IPP Reviewed	65	72	32	183	200	190
	No IPP Reviewed	12	9	9	150	52	33
	TOTAL	77	81	41	333	252	223
Hume	IPP Reviewed	55	64	78	133	202	299
	No IPP Reviewed	7	17	26	43	70	58
	TOTAL	62	81	104	176	272	357
Loddon Mallee	IPP Reviewed	106	112	124	383	415	666
	No IPP Reviewed	33	21	38	50	76	66
	TOTAL	139	133	162	433	491	732
NM	IPP Reviewed	116	126	191	571	801	755
	No IPP Reviewed	129	51	61	238	311	190
	TOTAL	245	177	252	809	1112	945
SM	IPP Reviewed	357	159	173	696	800	982
	No IPP Reviewed	39	68	106	62	122	216
	TOTAL	396	227	279	758	922	1198
WM	IPP Reviewed	129	152	161	632	712	690
	No IPP Reviewed	116	49	95	395	213	128
	TOTAL	245	201	256	1027	925	818
EM	IPP Reviewed	187	143	139	602	552	848
	No IPP Reviewed	43	35	52	99	113	345
	TOTAL	230	178	191	701	665	1193

Appendix 5
Number of Participants by Region and Program

		BSW	EMR	Gippsland	Grampians	Hume	Loddon Mallee	Northern	Southern	Western	Statewide	TOTAL
Day Program Structured	1998	471	605	222	275	107	378	631	670	611	0	3970
	1999	343	590	165	248	318	403	721	568	653	0	4009
	2000	424	803	215	115	213	599	413	781	410	0	3973
Day Program Drop In	1998	184	712	192	132	96	239	214	722	454	0	2945
	1999	508	691	139	118	201	231	326	489	558	0	3261
	2000	430	428	163	66	43	393	278	1007	321	0	3129
HBOS	1998	76	312	133	135	135	194	383	449	601	0	2418
	1999	278	205	172	80	223	214	524	497	410	0	2603
	2000	253	530	153	140	229	289	713	663	591	0	3561
MSSH	1998	275	36	352	69	0	168	24	9	87	6043	7063
	1999	2777	0	304	135	115	317	131	1514	70	7253	12616
	2000	2134	37	223	449	203	423	21	3161	106	4933	11690
Planned Respite	1998	92	171	130	119	45	37	63	0	0	0	657
	1999	151	206	112	88	111	63	177	314	201	0	1423
	2000	160	96	86	82	123	36	194	288	212	0	1277
Residential Rehabilitation	1998	48	14	0	0	0	0	15	34	59	0	170
	1999	0	48	0	5	14	7	44	49	63	0	230
	2000	7	51	0	9	19	6	43	78	73	0	286

Appendix 6 Frequency and Type of Planned Respite by region

		Type of Respite					Frequency of Respite		
		Day Activity	Holiday/ Camps	Home (Non-Resi)	Home (Over- night stay)	Residential	One Occasion	Two Occasions	More Than Two Occasions
1998	BSW	92	0	0	0	0	85	0	7
	Gippsland	49	68	12	0	1	114	4	12
	Grampians	73	39	3	0	4	36	23	60
	Hume	45	0	0	0	0	45	0	0
	Loddon/Mallee	6	15	14	0	2	5	7	25
	NM	59	0	4	0	0	31	10	22
	SM	0	0	0	0	0	0	0	0
	WM	0	0	0	0	0	0	0	0
	EM	84	1	21	0	12	61	10	47
	Statewide	53	0	0	0	0	53	0	0
	Total	461	123	54	0	19	430	54	173
1999	BSW	82	134	35	0	0	187	8	56
	Gippsland	13	16	8	0	1	23	3	6
	Grampians	52	16	5	0	2	15	6	54
	Hume	16	3	29	0	31	32	10	23
	Loddon/Mallee	15	42	3	0	3	43	12	8
	NM	74	74	13	2	14	108	18	51
	SM	73	107	72	0	62	53	9	0
	WM	24	145	30	2	0	72	4	125
	EM	77	71	8	0	50	117	26	63
	Statewide	0	0	0	0	0	0	0	0
	TOTAL	426	608	203	4	163	650	96	386
2000	BSW	12	43	40	32	0	81	8	38
	Gippsland	0	0	0	0	0	0	0	0
	Grampians	35	30	2	0	15	25	8	49
	Hume	43	45	25	0	10	123	0	0
	Loddon/Mallee	0	0	0	0	0	0	0	0
	NM	69	94	12	1	18	115	23	56
	SM	116	125	0	0	47	170	18	100
	WM	10	128	70	3	1	141	23	48
	EM	41	0	6	0	49	40	18	38
	Statewide	8	24	2	1	1	18	8	10
	Total	334	489	157	37	141	713	106	339