Planning framework for public rural mental health services

A framework to guide the enhancement of public rural mental health services over the next five years
Planning framework for public rural mental health services

A framework to guide the enhancement of public rural mental health services over the next five years
Contents

Part 1 Background and context 1
Part 2 Planning framework 15
Part 3 Key directions 21

Appendix 1: Part A – Overview of service utilisation data and trends 39
    Part B – Profile of rural area mental health services 40
Appendix 2: Description of mental health service system components 41
Appendix 3: Description of statewide and specialist services 53
Appendix 4: Rural area mental health services compared with statewide averages 61
Appendix 5: Road travel times for rural ambulatory services (sMaps) 63
Part 1 Background and context

Preamble
Just over one quarter (27 per cent) of Victorians live in rural and regional areas. Thirty one per cent of these people live in regional centres with a population greater than 20,000 and, while there are 143 small communities across rural Victoria with a population between 200 and 1,000 people, only five per cent are located in these small communities. Rural urban centres are subject to sustained population growth and changing demographics. However, during recent years a declining number of smaller farms, ecological challenges such as drought, unemployment, poverty, higher than average suicide rates, out migration of young people and the resulting ageing population, have exposed rural communities to great hardship. Geographic isolation, lack of specialised services, workforce issues, and demographic changes serve as challenges to the provision of quality mental health care in rural Victoria and there is significant variation between rural areas in the factors that impact on the delivery of mental health services and the models under which they operate. Whilst satellite-based services are characteristic of small isolated rural environments, some regional urban hubs service both urban and smaller rural communities.

1.1 Introduction
The rural mental health planning framework (‘the planning framework’) defines the Government’s directions and associated priority areas for the improved provision of public mental health services to people with a serious mental illness living in regional and rural communities.

The rural public mental health system provides access to area based and statewide specialist services primarily targeted to the estimated three per cent of Victorians who experience serious mental illness. As such it forms part of an overall system of care to people with a mental illness. In line with this targeted role, public mental health services also support the broader health and welfare system in responding to the needs of this population group.

The need for a strategic action plan to improve the provision of public rural mental health services was identified in New Directions for Victoria’s Mental Health Services: The Next Five Years’, released in September 2002. The rural planning framework is also closely linked to existing mental health strategies building on the strengths of the current system.

The planning framework acknowledges that service development and planning for the rural mental health service system must take into account the range of structural, systemic and environmental issues that are specific to rural communities.

Building on the actions and priorities foreshadowed in New Directions, this Plan seeks to improve access to high quality, efficient and sustainable mental health services in rural and regional Victoria - particularly for people living in locations with limited access to public services due to geographical distance and other factors.

1 This includes children and adolescents with serious developmental disorders and older people experiencing psychiatric disorders associated with ageing.

2 New Directions describes the Government’s overall directions and strategic priorities for the development of mental health services over the period 2002-2006.
1.2 Recent enhancements

Since 1999, the Victorian Government has responded to a number of important rural mental health issues and invested over $18 million specifically for rural services. These investments include 18 new beds in adult acute, aged residential and sub-acute services, and over 160 additional clinical, Psychiatric Disability Rehabilitation and Rehabilitation Support (PDRSS) and other mental health support positions.

The following major initiatives have been funded between 1999-2000 and 2005-06. For information on further initiatives for rural mental health to be funded in 2006-07, see part three of this document.

**Academic positions in Mildura and Gippsland.**

Five Mental Health Court Liaison positions located at the Magistrates Courts in Bendigo, Ballarat, Geelong, Shepparton, and Moe to assist in the identification and management of people with mental illness in these settings.

**Eight Koori Mental Health Liaison positions have been established** across the rural area mental health service catchment areas to improve access to culturally sensitive services and to promote partnerships between specialist mental health services, Aboriginal Community Controlled Health Organisations and other Koori services. Positions are located in Ballarat, Mildura, Shepparton, Gippsland, Bendigo, Geelong and Wodonga.

**Eating Disorder pilots in Bendigo and Geelong** to pilot and evaluate rural specific service models for treating eating disorders to further enhance the provision of these services in rural/regional areas. Bendigo will receive recurrent funding for an Eating Disorder service from 2005/06.

**Conduct Disorder programs in Ballarat and North East Hume (Wodonga)** aimed at reducing the incidence and severity of conduct disorders in primary school age children.

**Early psychosis services in Bendigo, Mildura, Shepparton and Wodonga/Wangaratta** to provide timely appropriate treatment and care for young people 16-25 years experiencing first onset psychosis (including co-occurring substance misuse) and to link with other support services, schools and employers to promote recovery.

**A subacute (Prevention and Recovery Care) pilot in Shepparton** to provide pre- and post-acute treatment and support to people experiencing a mental health crisis or illness relapse.

**Primary Mental Health and Early Intervention teams in all rural areas** to provide education, training, secondary consultation and short-term (shared care) services to primary care providers.

**A range of workforce initiatives**, including:

- Creation of 30 senior psychiatric nursing positions and graduate year nursing positions in rural mental health services;
- Provision of expert clinical opinion and supervision targeted at allied health and medical staff in rural child and adolescent and aged persons mental health services;
- Expansion of consultation and liaison psychiatry to five rural hospitals;
- Mental health medical partnership projects across rural and metropolitan areas to investigate a range of professional development and support strategies to encourage recruitment and retention of medical staff.
Enhancements to inpatient services

• Four adult acute beds at Bendigo;
• Six aged residential based beds at Ballarat; and
• 16 additional positions for rural clinical inpatient services.

Growth in clinical and PDRSS services

• 14 community care beds under construction in Gippsland;
• 10 additional positions for people with co-existing mental illness and substance abuse (dual diagnosis);
• Additional positions for Bendigo Health Care Group to respond to demand across the Victoria/NSW border;
• 43 additional positions in rural clinical community services;
• 5.5 additional positions to increase specialist mental health assessment and treatment in rural child and adolescent mental health services;
• 16.5 additional positions for intensive services to older people as a substitute for inpatient care in Gippsland and Barwon;
• Seven additional staff in residential rehabilitation services across rural Victoria to better respond to the needs of young people with coexisting mental illness and substance abuse issues;
• Equity funding of 10 percent to rural PDRSS arising from the Pricing Review;
• Expansion of Intensive Home Based Outreach services to support people with serious mental illness living in the community in all rural regions to improve their quality of life.

Additionally, the Victorian Government has provided annual funding of $3.5 million to the national depression initiative, beyondblue, since 2000. This includes funding of $1.3 million for the Victorian Centre for Excellence in Depression and Related Disorders. beyondblue's Strategic Plan 2005-2010 identifies the implementation of prevention and early intervention programs across the lifespan for people living in rural and remote areas as a priority.

In recognition of the disadvantage experienced by people living in rural and remote areas, in addition to providing information especially targeted to people from rural and remote communities, beyondblue is also currently developing and implementing a number of e-Mental health programs to increase access to therapies for people with depression.

Mental health continued to be a high priority in the Victorian Government's 2005-2006 budget. A substantial commitment of $180 million has been made over the next four years, including $55.5 million for capital developments that will benefit both rural and metropolitan service users.

In the 2006-07 State Budget, the Victorian Government has made a substantial commitment of $170 million over the next five years for mental health service growth and improvement, including $20.5 million for planned capital developments, to address the sustained demand pressure being experienced by public mental health services across the state.
Initiatives will focus on early intervention across the age groups by providing:

- **Intervention and prevention during the early stages** of an emerging disorder in order to prevent the illness progressing and/or avert escalation and the need for a long period of support.
- **A quicker** service response to prevent a crisis developing or worsening.
- **A more intensive** service response to ensure that treatment is effective.
- **Better follow-up** and linkage with PDRSS services after discharge to prevent relapse.

### 1.3 Scope of the planning framework

This planning framework focuses on the needs of people in rural communities with serious mental illness. As such, it addresses only one part of the spectrum of services and activities that will improve mental health in rural Victoria. Further improvements in primary health services and activities aimed at promoting mental health and well being to prevent problems developing in rural communities will complement this work. Consequently, this plan is a companion document to *Rural directions for a better state of health*, which articulates the broad policy context for rural health and rural mental health. Additionally, VicHealth has developed *A Plan for Action 2005-2007: Promoting Mental Health and Wellbeing*, which identifies disadvantaged population groups for priority action within its Mental Health Promotion Framework, including rural communities. These two documents address further parts of the spectrum of services and activities.

This planning framework is limited to issues of a specific rural nature and forms part of the broader mental health policy framework in relation to a range of statewide priority areas such as an improved focus on young people, early intervention and prevention, and consumer and carer participation. These priorities are subject to separate but related work.

The funding model for clinical mental health services is not examined in this planning framework, as it requires detailed policy and technical consideration at a statewide whole of system level, which is beyond the scope of a rural plan. In 2004-2005, Mental Health Branch developed and implemented a new funding model for Psychiatric Disability Rehabilitation and Support Services. It is intended that this will be followed by a review of funding of clinical mental health services. Until this time, the basic funding methodology for clinical metropolitan and rural mental health services will remain unchanged.

The geographic focus of this planning framework is the eight area mental health services (AMHS) in the five Department of Human Services’ rural regions of Barwon South West, Gippsland, Grampians, Loddon Mallee, and Hume (refer Table 1). Refer to Appendix 1 for profiles of each rural AMHS.
Table 1: Rural Area Mental Health Services, Estimated Residential Population, ABS 2004

<table>
<thead>
<tr>
<th>Department of Human Services region</th>
<th>Area Mental Health Service</th>
<th>Population size (total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South West</td>
<td>Barwon</td>
<td>249,793</td>
</tr>
<tr>
<td></td>
<td>Glenelg</td>
<td>101,008</td>
</tr>
<tr>
<td>Gippsland</td>
<td>Gippsland</td>
<td>245,926</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>Loddon Campaspe (Southern Mallee)</td>
<td>246,730</td>
</tr>
<tr>
<td></td>
<td>Northern Mallee</td>
<td>55,313</td>
</tr>
<tr>
<td>Grampians</td>
<td>Grampians</td>
<td>213,316</td>
</tr>
<tr>
<td>Hume</td>
<td>Goulburn Valley</td>
<td>125,395</td>
</tr>
<tr>
<td></td>
<td>North Eastern (includes Wodonga)</td>
<td>126,296</td>
</tr>
</tbody>
</table>

Whilst clinical service provision is the major focus of this planning framework, PDRS services also play a critical role in the support of people with serious mental illness in rural communities. A number of activities regarding the funding model and service development of the PDRSS sector are currently underway. Consequently, this planning framework mainly deals with the interface between clinical and PDRS services, rather than rural PDRS service development.

The provision of services to rural communities within metropolitan area mental health service catchments, such as the Yarra Ranges Shire, has also been included within the scope of this planning framework, given the commonality of issues experienced in these communities. The interface between metropolitan-based acute and specialist statewide services and rural services is also examined.

The planning framework has been informed and shaped by extensive consultations and forums undertaken with a range of stakeholders since 2001. The planning framework has also been informed by:

- A comparative analysis of rural and metropolitan service utilisation data and trends.
- Consideration of current rural service structures and service delivery arrangements.
- An examination of the current level of integration, coordination and collaboration across rural areas and with external agencies.
- Identification of effective and innovative service models and service delivery structures in rural communities.
Planning framework for public rural mental health services

Core mental health services

**Child and Adolescent Mental Health Services (CAMHS) (0 – 18 years)**

- **Acute inpatient** - CAMHS services are linked to metropolitan based acute inpatient services
  - Royal Children’s Hospital – Geelong, Warrnambool and Ballarat
  - Austin Hospital – Bendigo and Mildura
  - Monash Medical Centre – Gippsland
  - Maroondah Hospital – Goulburn Valley and North East CAMHS

  In some cases rural services have small two bed suites co-located with adult inpatient services, the pediatric wards of hospitals and, in some instances, in adult acute inpatient services in regional hospitals for short-term crisis admissions.

- **Community services** - intensive mobile youth outreach service and continuing care, assessment, treatment and liaison services. New services include a conduct disorder program in the Grampians and North Eastern regions.

**Adult Mental Health Services (16-64 years)**

- **Acute inpatient** - In addition to mental health specific inpatient units, some small rural hospitals admit people with mental health conditions to general beds. This is usually facilitated through good local service relationships and local knowledge and expertise.

- **Secure Extended Care Units** - available in four rural area mental health services.

- **Community Care Beds** - available in five rural area mental health services.

- **Prevention and Recovery Care sub acute** pilot service diverting demand from acute inpatient services (Goulburn Valley) and under development in Bendigo and Barwon.

- **Clinical community services** - continuing care teams, mobile support and treatment, crisis assessment and treatment teams, dual diagnosis and primary mental health and early intervention teams. New services include the expansion of early psychosis programs to Geelong, Bendigo and Shepparton.

- **Mental Health Court Liaison positions** - located at the Magistrate Courts in Bendigo, Ballarat, Geelong, Shepparton and Moe.

- **Aboriginal Mental Health Liaison positions** in five rural locations.

**Psychiatric Disability Rehabilitation and Support Services (PDRSS):**

- Home Based Outreach Support
- Residential Rehabilitation
- Day Programs
- Planned Respite
- Residential Rehabilitation
- Mutual Support
- Carers Support
- Koori PDRSS

**Aged Mental Health Services (65 years and over)**

- **Acute inpatient** - Aged inpatient beds are mainly co-located with adult inpatient beds.

- **Clinical community services** – aged persons mental health teams at all AMHS.

- **Intensive aged acute community treatment positions** at Barwon Health (Barwon) and Latrobe Regional Hospital (Gippsland), and residential services at all rural AMHS except Mildura.

- **Aged persons mental health residential care.**

- **PDRSS aged** – pilot in Barwon

---

**Table 2: Mental health service types – rural Victoria**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Core Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent Mental Health Services (CAMHS)</td>
<td>Acute inpatient - CAMHS services are linked to metropolitan based acute inpatient services. Royal Children’s Hospital – Geelong, Warrnambool and Ballarat. Austin Hospital – Bendigo and Mildura. Monash Medical Centre – Gippsland. Maroondah Hospital – Goulburn Valley and North East CAMHS. In some cases rural services have small two bed suites co-located with adult inpatient services, the pediatric wards of hospitals and, in some instances, in adult acute inpatient services in regional hospitals for short-term crisis admissions. Community services - intensive mobile youth outreach service and continuing care, assessment, treatment and liaison services. New services include a conduct disorder program in the Grampians and North Eastern regions.</td>
</tr>
<tr>
<td>Adult Mental Health Services (16-64 years)</td>
<td>Acute inpatient - In addition to mental health specific inpatient units, some small rural hospitals admit people with mental health conditions to general beds. This is usually facilitated through good local service relationships and local knowledge and expertise. Secure Extended Care Units - available in four rural area mental health services. Community Care Beds - available in five rural area mental health services. Prevention and Recovery Care sub acute - pilot service diverting demand from acute inpatient services (Goulburn Valley) and under development in Bendigo and Barwon. Clinical community services - continuing care teams, mobile support and treatment, crisis assessment and treatment teams, dual diagnosis and primary mental health and early intervention teams. New services include the expansion of early psychosis programs to Geelong, Bendigo and Shepparton. Mental Health Court Liaison positions - located at the Magistrate Courts in Bendigo, Ballarat, Geelong, Shepparton and Moe. Aboriginal Mental Health Liaison positions - in five rural locations. Psychiatric Disability Rehabilitation and Support Services (PDRSS): Home Based Outreach Support. Residential Rehabilitation. Day Programs. Planned Respite. Residential Rehabilitation. Mutual Support. Carers Support. Koori PDRSS.</td>
</tr>
<tr>
<td>Aged Mental Health Services (65 years and over)</td>
<td>Acute inpatient - Aged inpatient beds are mainly co-located with adult inpatient beds. Clinical community services - aged persons mental health teams at all AMHS. Intensive aged acute community treatment positions at Barwon Health (Barwon) and Latrobe Regional Hospital (Gippsland), and residential services at all rural AMHS except Mildura. Aged persons mental health residential care. PDRSS aged - pilot in Barwon.</td>
</tr>
</tbody>
</table>
1.4 Summary of key directions

The planning framework is comprised of the following key directions and associated priority areas, which are examined in greater detail in part three of this document:

<table>
<thead>
<tr>
<th>Key direction 1: Improving mental health planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key direction 2: Building core service capacity</td>
</tr>
<tr>
<td>• Address gaps in service supply in adult based beds</td>
</tr>
<tr>
<td>• Address increasing demand for aged persons mental health services</td>
</tr>
<tr>
<td>• Enhance the capacity to respond to children and adolescents with a mental illness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key direction 3: Improving service access and viability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide more timely support to people living in remote communities needing urgent care</td>
</tr>
<tr>
<td>• Improve access to integrated treatment, rehabilitation and living support services</td>
</tr>
<tr>
<td>• Enhance and maintain specialist expertise in integrated teams</td>
</tr>
<tr>
<td>• Improve access to specialist and statewide services</td>
</tr>
<tr>
<td>• Enhance service responsiveness to special needs groups</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key direction 4: Strengthening the capacity of the broader health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Foster cross sector partnerships</td>
</tr>
<tr>
<td>• Strengthen the capacity of mental health services to support people with dual diagnosis</td>
</tr>
<tr>
<td>• Improve the expertise of rural general health and community services to support people with a mental illness</td>
</tr>
<tr>
<td>• Improve linkages with Commonwealth mental health initiatives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key direction 5: Building a strong, skilled and sustainable workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improve recruitment and retention of the public mental health workforce, including exploration of workforce redesign models relevant to rural environments</td>
</tr>
<tr>
<td>• Improve access to Commonwealth funded mental health services</td>
</tr>
</tbody>
</table>

---

3 For the purposes of this paper, the term “integrated” is taken to mean the bringing together of roles and functions at either the service level or the practitioner level, and as such is broadly meant to encompass both integrated treatment and parallel treatment.
1.5 System overview

The Victorian public mental health system is a comprehensive age-based treatment system consisting of area-based clinical mental health services, mainstreamed with general hospitals. It offers inpatient, community, residential and ambulatory services, as well as psychiatric disability rehabilitation and support services.

Like their metropolitan counterparts, people in rural areas require timely access to early intervention and prevention services, comprehensive and assertive continuing care, integrated medical and psychosocial treatments and supports, acute care, and direct access for high need or high risk clients to urgently required services.

In rural Victoria, public mental health (clinical and psychiatric disability rehabilitation and support [PDRS]) service agreements are administered via Department of Human Services regional offices. In metropolitan areas, PDRS service agreements are administered via regional offices but clinical mental health service agreements are administered via DHS central office.

1.5.1 PDRS services

Psychiatric disability rehabilitation and support (PDRS) services are an integral component of the rural mental health system which complement the assessment and treatment functions of clinical services. Over fifty PDRS services are operated by a range of large and small non-government organisations in the five rural DHS regions.

Rural PDRS agencies include stand alone mental health service providers which only deliver PDRSS (such as Richmond Fellowship Victoria), auspice agencies such as community health centres that also provide general health services to the local community, and other health and welfare organisations such as St Lukes Anglicare in Bendigo.

Rural PDRS services also vary considerably in size, and range from one agency operating from a single service site to a larger auspice agency operating from a number of sites within a region and/or across several regions. They are similar to their metropolitan counterparts in terms of number of staff employed, number of clients supported, and funding levels.

1.5.2 Clinical services

In rural Victoria, clinical mental health services are organised into eight area services, incorporating adult, aged, and child and adolescent services provided on an area and sub-area basis. In addition to the area mental health services, there are statewide and cross regional specialist services available for different special needs groups, for example, eating disorders and mother and baby services. Further information on statewide and specialist services is provided in Appendix 3.

In rural Victoria, clinical ambulatory services are organised using a central service ‘hub’ located in urban regional centres. Central services commonly provide ‘single-service’ age-specific models of care, in most instances delivered by integrated teams of specialist staff with the same staff rostered on to different service functions. In rural Area Mental Health Services (AMHS), Child and Adolescent Mental Health Services (CAMHS) and Aged Persons Mental Health Services (APMH) are often co-located with adult services, with some services integrating adult, CAMHS and APMH services at the central service hub.
In addition, central rural service hubs also operate up to seven satellite services, which have adapted these elements differently to provide locally accessible and responsive services with a ‘critical mass’ of expertise. Satellite services also integrate adult clinical ambulatory functions (and in some instances, CAMHS and APMH clinical ambulatory services) in their community teams. The integration of clinical ambulatory services in this manner provides a relatively cost effective solution to the provision of services to communities located some distance from large population centres. Satellite services are commonly located in towns with a catchment of up to 20,000 people, or in locations that provide reasonable access to people living some distance from service hubs. Examples of service configurations from two rural AMHS are detailed in section 1.6 Service delivery structure. These examples highlight differing service delivery structures and co-location and integration arrangements.

Other specific examples of local level adaptations include the provision of mental health crisis services at some small local hospitals in rural Victoria and, in some areas, the admission of people with mental health presentations to general hospital wards (although it should be noted that this practice is not universal). Such practices need to be supported by clinical protocols regarding suitability for admission, risk management, and availability of local expertise and specialist input. There needs to be clear arrangements outlining the respective responsibilities of the local service and the AMHS in place to support these arrangements.

1.5.3 Workforce

There are relatively lower levels of primary health and community infrastructure and a paucity of private psychiatrists in rural Victoria compared to many metropolitan areas. As a result of the relative shortage of other mental health service providers, rural public mental health services often see a broader client group, providing a service response to a greater proportion of the eligible client population compared to their metropolitan counterparts (1.56 per cent in rural AMHS compared to 1.04 per cent for metropolitan AMHS in 2003-04)

Overall, staff employed are more mobile in metropolitan than rural settings, however, mobility is highest amongst young rural nurses and rural allied health staff. Analysis of the length of service of staff departing the rural public mental health workforce found that a higher proportion of staff departed in the first 12 months (45.8 percent compared to 31 percent in metropolitan services), with a smaller proportion departing between one and three years (24 percent compared to 31.4 percent in metropolitan services) and three and five years (15.3 percent compared to 21.3 percent in metropolitan services).

4 It is noted, however, that the proportion of people accessing rural services in 2003/04 across rural AMHS varies considerably, ranging from 1.2 per cent to 2.5 per cent of the population.
1.5.4 Catchments

Currently 21 adult, 13 child and adolescent, and 17 aged persons mental health services form the basis of the Victorian public mental health service delivery system. Service providers may provide one or more of the age-specific services, so catchment area and providers may vary depending on client age.

These recommendations arose from concerns that the current area based model could be improved. The application of boundaries, lack of alignment across aged based service catchments, lack of alignment with other health services and LGAs, issues arising from expectations of ‘self sufficiency’, and service viability issues arising from the size and differential population changes in rural catchments were among these concerns.

In 2005, the Minister for Health charged the Ministerial Advisory Committee on Mental Health with the task of considering mental health area catchments and ways to improve the operational efficiency and viability of services. A subcommittee undertaking this work recommended the retention of an area based service delivery model, but proposed a number of improvements, including the clustering of mental health services to:

- support the more efficient use of resources
- support the development of a hierarchy of progressive service elements
- facilitate the links between metropolitan and rural services
- create opportunities for collaboration within and beyond mental health, including with general practice and drug and alcohol services.

In this recommended clustering approach, not all service elements would be located within an existing mental health area. Instead, people living in the area would still be able to access all service elements through the clustering of their local service provider with other providers, who as a group could sustainably operate higher cost, lower volume service components. For example, an area may be self sufficient for ambulatory clinical services, part of a cluster for inpatient services, part of supra-regional configuration for mother-baby services, and have access to a statewide forensic service.

The Mental Health Branch is further considering the recommendations of the subcommittee.
1.6 Service delivery structures

The following descriptions of two rural service delivery structures illustrate the diverse ways in which rural services can be matched to local conditions using integration and co-location in a hub and satellite model.

Barwon

In Barwon, adult specialist mental health services are provided by five geographically based integrated teams managed by Barwon Health. Each team provides the full range of services, including the new early psychosis services.

All teams (with the exception of the Colac team) are co-located in Community Health Centres alongside a wide range of community services. Each team provides a comprehensive and integrated range of clinical ambulatory services between the hours of 8.30am and 8.00pm. If an adult consumer is admitted to an acute inpatient unit or Community Care Unit, the case manager and psychiatric consultant or registrar from the team retain responsibility for case management in collaboration with the primary nurse in these service settings. In this way continuity of care is maintained.

Aged Persons Mental Health (APMH) services are located on the Geelong Hospital acute unit site and team members have responsibility for the full range of APMH service responses within a geographic area. As with adult teams, if a consumer is admitted to an acute inpatient setting, the individual’s community based support team remains the treating team in collaboration with the primary nurse in this service setting.

A single child and adolescent mental health service (CAMHS) provides services to children up to 15 years across the whole Barwon region. CAMHS is co-located with other community health services.

Barwon Health’s clinical Homeless Outreach Program is integrated with the PDRSS Pathways program. Barwon Health and Pathways work collaboratively, sharing case record information electronically. Both organisations use outcome measurement scales to assess consumer outcomes, allowing both services to monitor the progress of shared consumers.

Gippsland

The entire Gippsland region constitutes one Area Mental Health Service (AMHS). The region is serviced by one clinical mental health provider, Latrobe Regional Hospital Mental Health Service (LRH). Access to all of the clinical mental health services provided by LRH is via the triage service.

The Gippsland region is divided into three sectors for the purposes of clinical service delivery; South and West sector; Latrobe Valley sector; and East Gippsland sector. These three sectors reflect the location of Integrated Adult Teams. South and West sector have three operational bases – Warragul, Korumburra and Wonthaggi. Latrobe Valley has one operational base – Traralgon, and East Gippsland sector has two operational bases – Sale and Bairnsdale, with outreach services to Yarram and Orbost.

Due to the extensive geographical area of Gippsland as well as the dispersed population, the bulk of public mental health services are provided through integrated adult community mental health teams, rather than discrete, stand-alone teams. In this context, “integrated” means that all members of the adult teams perform the full range of functions.

This structure aims to provide continuity of care between the adult acute inpatient unit and community adult teams. The case-managers and the consultant psychiatrists have ongoing responsibility for the clinical care for the client on the continuum from in-patient to the community. Video conferencing helps reduce the travel associated with this role, when clients are inpatients at Traralgon.
1.7 Service usage and supply

1.7.1 Service usage

Table 3 illustrates comparative information on service usage between rural and metropolitan based clinical mental health services in 2004-2005. In summary, the data indicates that:

- Rural area public mental health services provide a service response to a greater proportion of the population than metropolitan services (1.56 per cent of the population receiving a service response in 2004-2005 compared to just over one per cent in metropolitan services).
- Rural acute inpatient service have higher rates of self-sufficiency than metropolitan services.
- The majority of rural acute inpatient services operate with similar high occupancy levels to metropolitan services.
- Average length of stay in all but one rural acute inpatient service is below the statewide and metropolitan averages, with six rural areas recording average length of stay of less than 10 days.
- The level of people staying 35 days or more in rural acute inpatient services is almost half that of metropolitan services, with only two rural area mental health services experiencing rates comparable to metropolitan services.

Table 3: Comparative profiles – rural and metropolitan Area Mental Health Services

<table>
<thead>
<tr>
<th>Service profile</th>
<th>All rural</th>
<th>Range by rural area</th>
<th>All metro</th>
<th>Range by metro area</th>
<th>All AMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>% proportion of population accessing services</td>
<td>1.56</td>
<td>1.22/2.35</td>
<td>1.04</td>
<td>0.56/1.72</td>
<td>1.20</td>
</tr>
<tr>
<td>% proportion of all Victorian registered clients</td>
<td>36.33</td>
<td>2.20/7.15</td>
<td>63.67</td>
<td>3.07/6.93</td>
<td>100</td>
</tr>
<tr>
<td>% average annual growth (00/01 to 04/05)</td>
<td>2.0</td>
<td>-0.8/6.2</td>
<td>1.6</td>
<td>-1.4/6.3</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Demand management (adult 2004/05)

<table>
<thead>
<tr>
<th>Service profile</th>
<th>All rural</th>
<th>Range by rural area</th>
<th>All metro</th>
<th>Range by metro area</th>
<th>All AMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>% self sufficiency</td>
<td>86.4</td>
<td>69.5/93.3</td>
<td>74.4</td>
<td>53.5/87.0</td>
<td>78.5</td>
</tr>
<tr>
<td>Number of separations</td>
<td>4410</td>
<td>316/853</td>
<td>8879</td>
<td>296/1420</td>
<td>13,289</td>
</tr>
<tr>
<td>% inpatient occupancy</td>
<td>97.4</td>
<td>87.4/120.1</td>
<td>97.5</td>
<td>83.9/112.9</td>
<td>97.5</td>
</tr>
<tr>
<td>Average length of stay (excluding same day and &gt;35 bed days) in bed days</td>
<td>9.1</td>
<td>7.6/11.8</td>
<td>11.8</td>
<td>10.5/14.5</td>
<td>11.0</td>
</tr>
<tr>
<td>% greater than 35 days (bed days)</td>
<td>6.1</td>
<td>2.7/10.2</td>
<td>10.7</td>
<td>5.8/15.5</td>
<td>9.2</td>
</tr>
<tr>
<td>Separations-acute statewide &amp; specialist (including forensic)</td>
<td>258</td>
<td>7/52</td>
<td>1182</td>
<td>15/200</td>
<td>1448</td>
</tr>
</tbody>
</table>

Source: CMI/ODS 2004/05, ABS (ERP Population) 2004

Note: There is significant variability in the data reported in Table 3, as evidenced by the wide range of values between the low and high limits for rural services. This variability is also observed within metropolitan services.
1.7.2 Conclusion

Salient points that inform the following key directions include:

• Rural public mental services provide a service response to a greater proportion of the population than metropolitan public mental services.

• There is a significant variation in service configuration between rural public mental services.

It is recognised that there are differences in demand between rural and metropolitan public mental health services. Furthermore, in rural services community teams are required to perform a greater range of roles as there are fewer alternative service providers and relatively lower numbers of general practitioners, private psychiatrists, psychologists, and child and adolescent psychiatrists. Particularly in more distant and more isolated rural communities, there are also fewer PDRS services. Despite the recent funding of five small rural psychiatric consultation liaison services, these services to rural hospitals are still relatively limited. Additionally, many rural community teams spend significant time in traveling to distant communities. These differences mean that rural public mental health services operate in a different manner to metropolitan public mental health services.
Part 2 Planning framework

This section is intended to guide planning to address the key directions and associated priority areas detailed in Part 3 of this framework. It describes the principles that underpin service planning and provision at the local and regional level and provides broad area-based planning guidelines to underpin the long-term development of rural public mental health services.

1 Planning principles

The following principles provide the basis for the planned provision of clinical and Psychiatric Disability Rehabilitation and Support Services in rural Victoria:

- High-volume, low cost services will be provided as close to the consumer’s home as possible without compromising the quality of care provided and service viability.
- Low-volume, high cost services will be consolidated into central service hubs, to ensure service quality, sustainability and financial viability.
- Statewide and specialist services will be accessed from cross regional centres and the metropolitan area.
- As far as it is feasible, all future mental health capital development in rural Victoria will be co-located with other compatible services on consolidated sites/precincts.

Figure 1: Principles of Rural Service Provision
2 Planning guidelines

Optimal service structures for public mental health services in regional centres, towns, and small communities have been identified in these guidelines. The guidelines affirm and build on many of the existing configurations and relationships developed in rural areas. These structures will be enhanced over the next five years.

A key strength of rural public mental health services is their coherence, particularly the alignment of catchments and resources across age groups and with Department of Human Services regional boundaries, health services, and local government authorities. This level of coherence provides rural public mental health services with opportunities for service integration, innovation, and cross sector collaboration.

Although rural mental health services have developed a range of flexible and innovative responses to local needs in rural settings, recent developments have not occurred within a systematic framework. These planning guidelines are intended to provide area mental health services with the confidence and flexibility to adapt existing service models and funding arrangements in order to better respond to local needs and opportunities, whilst maintaining program integrity and quality of care.

The aim of these planning guidelines is to better support area mental health services to make informed decisions in respect to:

- Achieving a sustainable spread of public mental health services, particularly to small and geographically isolated communities.
- The development of models of care and funding that are sustainable and responsive to local needs and capabilities.
- Practice change that will improve service effectiveness within existing resources.
- Corporate and clinical governance, including accountability arrangements and quality management processes and systems, particularly in integrated service settings and where flexible funding and service configurations operate.
- Establishing and developing partnerships with other services including the governance arrangements and protocols needed to ensure the maintenance of service integrity, accountability and sustainability.

To maximise the benefits of coordinated planning, it is envisaged that planning encompass all aspects of the public mental health service system. Specifically, planning processes:

- take place and be coordinated at the local and regional levels;
- involve both clinical and PDRSS services;
- encompass the full life span of clients; and
- are undertaken in consultation with the Mental Health Branch to inform statewide planning and service development.

As the strengthening of consumer and carer participation is identified as a key direction in *New Directions for Victoria’s Mental Health Services*, it is expected that rural services will encourage and support effective consumer and carer participation in undertaking service planning and review.
2.1 Achieving a sustainable service response

Rural public mental health services are delivered in a context of community expectations regarding quality, timeliness and effectiveness. Providing an adequate and sustainable level and mix of core services to small rural and remote communities continues to be a critical challenge, particularly where the non-recurrent nature of some program and project funding for targeted initiatives makes future capacity uncertain. Balancing the competing need for local access against the requirement to maintain appropriate standards of care and adequate levels of specialist care are key planning considerations.

The concept of ‘one size fits all’ and ‘one for each area’ can result in compromises in respect to service quality and efficiency. Some bed based services, such as secure extended care inpatient units and acute inpatient services, are not viable in locations where there is not the area population to ensure adequate levels of utilisation. It is considered that these low volume/high cost services are best consolidated into central service hubs.

Consultations with stakeholders highlight that integrated community mental health services configured on the satellite service structure provide the capacity for flexible service responses and the necessary critical mass for service viability and the effective delivery of core service functions. While integrated, multi functioning mental health teams have been successfully operating in rural Victoria, attention must be given to developing and maintaining specialist expertise, particularly for children and adolescents and the aged.

Responses are required that will build on the innovation and strengths evident in the rural mental health service system, while putting in place strategies that will systemically improve service quality and access. These directions must be sufficiently flexible to allow for local adaptation within agreed parameters.

2.2 Developing alternative models of care

To ensure smaller population areas have adequate access to a comprehensive range of mental health services, consideration could be given to the development and implementation of alternative cost effective service models (service substitution) and delivery arrangements. Local consultation to ensure service models are adapted to local needs and conditions is critical to the successful implementation of alternative models of care.

Alternative models of care will contribute, together with service and workforce growth, to addressing the fundamental issue of demand for services. Developing alternative models can be time and resource intensive, so changes to service delivery models need to be considered in terms of the net benefit to communities.

Examples of alternative service models include:

- The provision of aged acute in the home services as a viable alternative to admission to an aged acute inpatient service, where appropriate, or the provision of a crisis assessment and treatment response into the person’s home or at a local health service in lieu of an inpatient admission.
- The co-location of specialist mental health workers in the emergency departments of larger hospitals to enable these services to support people with mental illness, facilitate a rapid crisis response, and enable these consumers to remain in their local community.
• Changing or redeveloping existing services to provide a more accessible and flexible service response tailored to local service needs. This may involve, for example, ‘cashing out’ an existing less flexible bed based service or using these services in a more flexible manner. An example of the latter is the use of several beds in a Community Care Unit to provide short term respite and care for consumers who require stabilisation due to deteriorating health or post an inpatient discharge, for example, ‘step up step down’ facilities.

2.3 Increasing funding flexibility

Flexible funding arrangements are integral to supporting service change and achieving better continuity of care between mental health services and other health services.

Funding flexibility is particularly relevant where:

• Reconfiguration of the overall service mix is required to meet changes in service demand and/or to facilitate a more cost effective response within available capabilities.

• Planned or existing models of care require modification to meet local service needs and/or to improve service viability.

The flexible use of funding will be considered where area services can demonstrate that this will support service developments and/or improve service effectiveness whilst retaining program integrity and quality assurance by delivering core functions and required service levels.

2.4 Facilitating positive practice change and new workforce models

Practice change that will improve treatment effectiveness, better enable practice to keep pace with the changing needs of consumers and carers, and reduce pressure on key parts of the broader health service system is encouraged. Proposed changes to existing practice should be supported by evidence that demonstrates improved outcomes for consumers and/or improved service efficiency.

Innovative approaches to addressing difficulties in recruiting and retaining specialist mental health staff in rural Victoria and projected shortfalls in workforce supply. Coupled with continuing to improve the supply of a skilled workforce on site the following examples include:

• Better utilising the skills of Psychiatric Services Officers and Division 2 nurses in mental health services, with appropriate training and support.

• The effective use of metropolitan based clinicians in the provision of clinical supervision and support.

• Telepsychiatry to facilitate access to specialist services.
2.5 Ensuring robust governance and accountability

Effective governance structures and processes to ensure responsibility and accountability for the quality of mental health service delivery. This is outlined in more detail in the *Victorian Strategy for Safety and Quality in Public Mental Health Services, 2004*. The development of robust corporate and clinical governance arrangements specific to the needs of integrated and/or co-located clinical mental health services are a central consideration, particularly where more flexible funding and service configurations operate together with a need to retain program integrity.

Clinical governance brings together clinical, administrative and quality processes in a transparent approach to service delivery. Managers of area mental health services have a key leadership role and must implement and monitor models that provide for effective governance at the area, sub-area (through satellite delivery structures), and local level. The authorized psychiatrist/clinical director also has a key role in providing clinical leadership and the development of clinical standards and processes that deal with the issues of clinical supervision for sole practitioners in rural areas, and sub specialist recruitment. Both need to work in partnership to ensure proper clinical and operational systems are in place. This includes the development and maintenance of staffing models that build expertise and ensure service sustainability.

Good governance arrangements are particularly important where services have limited access to a consultant psychiatrist, where there is a heavy reliance on an overseas trained medical workforce, where there are sole mental health workers, or where small teams are operating in isolation, such as when co-located or integrated in mainstream services. These factors give rise to issues such as clinical supervision, skill maintenance, and the monitoring of service quality.

Rural mental health services have a variety of interfaces with other providers, many of whom have different views about the targeting and delivery of specialist services. These issues can be difficult and time consuming to negotiate if effective governance structures are not in place.

2.6 Supporting cross sector partnerships

Cross sector partnerships must be supported by flexible funding arrangements within agreed accountability and service quality frameworks.

Voluntary shared infrastructure and service delivery arrangements are actively encouraged. These arrangements should result in a coordinated response to client need and involve the clustering of compatible services. They should also provide the opportunity for savings in respect to property and asset management, shared administrative support and recurrent infrastructure costs which can be redirected into service delivery activities. Examples include the co-location of youth mental health services with other compatible health and welfare services, which provides a ‘one stop shop’ response to the often complex health needs of young people.

As discussed previously, corporate and clinical governance arrangements are a primary consideration when small mental health teams are integrated and/or co-located with other non-mental health services.

Primary Care Partnerships in rural Victoria offer a key mechanism for public mental health services to collaborate with a broader range of health and welfare services regarding shared clients, referral practices and service coordination and planning arrangements. Similarly, the Multiple and Complex Needs Initiative provides appropriate service responses to complex clients who need multiple services at a local level through cross sector collaboration.
Further development of collaborative partnerships ranging from informal networking to structured collaboration will occur through the Ambulatory Care Policy and Planning Framework which proposes to enable the Victorian health care system to increasingly deliver person-centred health care in home and community settings, and reduce the need for inpatient care and improve the health outcomes of Victorians. It proposes four principles that focus on people and community, service delivery, capability and collaboration.

A continuum of partnerships

A distinction can be made between the purposes and nature of partnerships. Partnerships may usefully be seen on a continuum ranging from networking through to collaboration.

- **Networking** involves the exchange of information for mutual benefit. This requires limited sharing of knowledge between partners. For example, general practitioners may meet monthly with clinical case management to discuss issues of mutual concern, such as referral issues.

- **Coordinating** involves exchanging information and altering activities for a common purpose. For example, drug and alcohol services and clinical services undertake shared case planning (with client consent and involvement).

- **Cooperating** involves exchanging information, altering activities, and sharing resources. For example, the location of a clinician with a homeless support service to provide a multidisciplinary response to people with serious mental illness who are homeless.

- **Collaborating**. In addition to the other activities described, collaboration includes enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their responsibility to another agency to create a better or more seamless service system. For example, the integration of mental health youth resources with mainstream complementary youth health and welfare services which involves shared resources and infrastructure.

Part 3 Key directions

Statement of direction

This planning framework seeks to support rural mental health services to best use available resources to deliver a sustainable and improved system of mental health care to rural Victorians. The framework seeks to build on the inherent strengths and capacities of the current rural mental health service system and provide the environment to enable improved access, and continued service innovation, integration, and cross sector collaboration.

The planning framework is underpinned by the following five statements of direction to guide service growth and improvement:

1. Improved mental health planning will be based on a framework that enables flexible and innovative responses, whilst maintaining program integrity.

2. Rural Area Mental Health Services will have capacity at the area level to respond to the mental health needs of all clients except those requiring the most specialist services.

3. Rural Victorians will continue to access the full range of mental health services from an integrated system of care committed to continuous improvement and service quality.

4. Rural public mental health services will continue to establish and strengthen partnerships with other health and welfare services to enable rural communities to have access to efficient, sustainable and comprehensive service options.

5. New models in rural mental health services will continue to be explored and developed to ensure the most effective use is made of the available workforce, suitably qualified staff, and the development and maintenance of a skilled workforce.

This section details the key directions for the rural public mental health service system and associated priority areas for the next five years.

Key direction 1: Improving mental health planning

Improved mental health planning will be based on a framework that enables flexible and innovative responses whilst maintaining program integrity

The development of local plans for the development and delivery of rural public mental health services should be based on the broad guidelines outlined in Part 2: Planning framework and on the priority areas below.

Service development and planning for the rural public mental health services system must take into account the range of structural, systemic and environmental issues impacting on mental health service provision that are specific to rural communities. These issues include the need for rural service structures that deliver core service to be adapted to local needs and capabilities (including geographic, demographic and workforce factors), while improving consistency of service access and quality across the state.

Priority responses

• Undertake local, sub-area and area level planning that guides service development and delivery within the parameters defined in this planning framework.

• Develop service models that integrate service functions and locations.

• Develop a framework for applied mental health research, including research specific to rural Victoria, in the context of the Mental Health Research and Evaluation Strategy currently being developed.
Recent achievements and next steps for key direction 1 | Primary Responsibility | Time frame
--- | --- | ---
Improve local planning through use of this planning framework | Service providers and DHS regions | Determined by existing planning processes
Prioritise integrated service models in capital and service planning such as the integrated community health and community mental health facility in Warragul announced in 2005-2006. | Service providers, DHS regions and central office | As above
Develop priorities for rural research and evaluation to inform service planning and development. | DHS central office and Research & Evaluation Expert Advisory Committee | Commenced October 2005

Key directions 2: Building core service capacity

Rural mental health services will have capacity at the area level to respond to the mental health needs of all clients except those requiring the most specialised services.

There are some significant service gaps in rural areas which can be compounded by a lack of other service options. The rural average acute mental health beds per 100,000 population is less than the metropolitan average. Specifically, there are less adult community beds, aged acute beds, and aged residential beds. Rural services generally require a greater level of bed capacity due to the above mentioned issues. Other factors that impact on bed capacity include the lack of private beds in rural areas and the difficulties in providing substitute ambulatory services in more remote areas.

There are particular issues concerning the growing demand for aged services and providing timely early intervention and prevention services for children and young people. Additionally, the mix and numbers of professionals in the workforce have a major impact on service capacity. The medical workforce of rural mental health services is different from that of metropolitan services, with a significant shortage of psychiatrists and psychiatric registrars. This has important implications for the way which clients can be treated and for consultation with general practitioners.

This section focuses on the set of activities concerned with service planning to ensure operational viability, service quality and reasonable levels of access at the local, sub-area and area levels. The following proposed priority areas are to:

- Address gaps in service supply in adult bed based services
- Address emerging demand for aged persons mental health services
- Enhance the capacity to respond to children and adolescents with a mental illness
Priority area 1—Address gaps in service supply in adult bed based services

In respect to supply of adult acute inpatient services, rural area public mental health services are close to or exceed statewide averages (beds per 100,000 population) with the exception of Barwon. Where undersupply exists, utilisation patterns mirror those of metropolitan areas with high volume and short stays.

Priority responses

• Prioritise future growth to areas of significant under supply that have the capability to efficiently operate additional adult acute beds and secure extended care beds.
• Continue to implement substitute intensive ambulatory services in areas without these capabilities and, when required, facilitate access to bed based services in the closest possible alternative location.

Priority area 2—Address increasing demand for aged persons mental health services

Based on 2003 estimated resident population (ABS), the population in rural Victoria is expected to increase by 12 per cent by 206. This growth is particularly concentrated in those aged 65 and over (54 per cent). Current levels of relative under supply of aged services in rural Victoria will be further exacerbated by increasing demand due to the ageing population.

Priority response

• Develop and implement a strategy for the planned provision of aged mental health services in rural Victoria to provide access to the comprehensive range of services required into the future.

Priority area 3—Enhance the capacity to respond to children and adolescents with a mental illness

National surveys have shown that one in seven four to 7 year olds and one in four 8 to 24 year olds have mental health problems and/or disorders. There is now emerging evidence the origins of many psychiatric disorders are in childhood. Unresolved mental health problems in these early years can seriously damage young people’s psychosocial development and future life opportunities.

Evidence from pilot projects and studies show that early intervention initiatives targeted at youth and children (early psychosis and conduct disorder programs) will:

• Promote a quicker recovery from serious mental illness.
• Minimise the key disabling effects.
• Reduce poor clinical outcomes and social outcomes such as self-harm, criminality and homelessness.
• Improve capacity for community participation, education, and future employment.

Local government areas with the expected highest percentages of people aged 60 years and over are: West Wimmera, Strathbogie, Bass Coast, East Gippsland, Pyrenees, Hindmarsh, Queenscliff, Alpine, Buloke and Towong.
Cross sector collaboration and coordination is crucial for young people in order to provide a holistic response to their special health and welfare needs. This issue is examined in more detail in key direction 4, priority area 9.

**Priority responses**

- **Increase capacity in rural Victoria for early intervention and prevention for children and young people, including the full roll out of early psychosis and conduct disorder services.**
- **Encourage and support cross sector partnerships to provide an integrated response to the special health and welfare needs of young people.**
- **Strengthen the capacity of non-mental health services to support young people with mental health problems (for example, schools, welfare services, primary health services and youth health services) through the enhanced provision of consultation and liaison services.**

### Recent achievements and next steps for key direction 2

<table>
<thead>
<tr>
<th>Priority responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritise additional adult acute beds to areas with significant under supply</td>
<td>Over next 5 years</td>
</tr>
<tr>
<td>Develop new rural 'step down' prevention and recovery care services (PARC) in 2005-2006 and 2006-07</td>
<td>By June 2007</td>
</tr>
<tr>
<td>Strengthen rural adult community teams with 10 additional EFT in 2005-2006 and 2006-07</td>
<td>Completed by December 2005</td>
</tr>
<tr>
<td>Develop a plan for future rural aged services</td>
<td>Commence in 2005-2006</td>
</tr>
<tr>
<td>Provide a new aged intensive community treatment service in Bendigo in 2005-06</td>
<td>Operational in early 2006</td>
</tr>
<tr>
<td>Strengthen rural aged positions with 2 EFT in 2006-07</td>
<td></td>
</tr>
<tr>
<td>Strengthen rural CAMHS community teams with 5.5 EFT in 2005-2006</td>
<td>Completed by December 2005</td>
</tr>
<tr>
<td>Provide a new conduct disorder service in Hume and a new early psychosis service in Gippsland in 2005-2006</td>
<td></td>
</tr>
<tr>
<td>Provide a new conduct disorder service in Bendigo and new early psychosis services in Ballarat and Warrnambool in 2006-07</td>
<td></td>
</tr>
<tr>
<td>New Community Care Unit in Gippsland in 2006/07</td>
<td>Operational by September 2006</td>
</tr>
<tr>
<td>Provide 2.5 EFT to Families of Parents with a Mental Illness services in 2006/07</td>
<td>By June 2007</td>
</tr>
</tbody>
</table>
Key direction 3: Improving service access and viability

Rural Victorians will continue to access the full range of public mental health services from an integrated system of care committed to continuous improvement and service quality.

In this paper, disadvantage is defined as access to and/or remoteness from adequate public mental health care, as measured in road distance by the Accessibility/Remoteness Index of Australia (ARIA). ARIA defines localities that are more remote as having less access to service centres, and those that are less remote having greater access to service centres. These terms define the ends of the ARIA continuum.

While no rural statistical areas were assessed as having remote or very remote accessibility according to ARIA, four per cent of rural Victorians live in areas categorised as having significantly restricted accessibility to service centres. DHS regions with the lowest levels of service access are Gippsland, Grampians, and Loddon Mallee.

Available evidence indicates that in 2003-2004, clinical ambulatory direct contacts with people diagnosed with schizophrenia were 33 per cent lower in areas with ‘moderate accessibility’ than those with a category of ‘accessible’, illustrating the difficulties in providing a service response to geographically dispersed populations.

This section focuses on the set of activities concerned with the structural arrangements, funding and service models that enable the flexibility and responsiveness required to better respond to local needs and priorities, including special needs groups. The following proposed priority areas are to:

- Provide more timely support to people living in remote communities experiencing crisis and treatment issues
- Improve access to integrated treatment, rehabilitation and living support services
- Enhance and maintain specialist expertise in integrated teams
- Improve access to specialist and statewide services
- Enhance service responsiveness to special need groups.

Priority area 4–Provide more timely support to people living in remote communities needing urgent care

In geographically remote locations, the capacity to respond to the need for urgent care within reasonable timeframes can be impeded by lengthy travel times.

Although there are no established benchmarks for response times for these clinical ambulatory services, it is assumed that travel times of one hour for crisis responses and two hours for case management services are appropriate for the purposes of mapping service access (see Appendix 5 for SMaps showing road travel times from service outlets to rural communities for these services types). Data indicates that for case management services the vast majority of rural residents are located within two hours of these services.

In respect of crisis responses, areas of rural Victoria with dispersed populations are likely to experience response times longer than one hour.
Emergency Departments (EDs) are one of the many entry points into the mental health service system. While mental health presentations account for a relatively small percentage of all ED presentations (four to five per cent), it is nevertheless important that all ED clinicians have skills in the assessment and management of the common mental health problems they are likely to encounter.

A recent DHS forum on the management of mental health presentations in EDs concluded that workforce development was a key area for action to address deficits in staff confidence and skills in dealing with the needs of people with mental health problems. A project to develop ED triage skills in the assessment of people with mental health problems commenced in September 2005.

**Priority responses**

- Develop an improved response capacity in community teams.
- Further develop telephone triage services to enable a prompt response to people in crisis, particularly those living in areas more than one hour from a service location.
- Co-locate specialist mental health staff in formally designated emergency departments of smaller general hospitals.
- Improve triage skills of general ED staff to assist them identify people with a mental illness.
- Identify suitable sites and treatment locations nearer to isolated communities such as community health and GP clinics or small hospitals to reduce the distance travelled for consumers, carers and service providers and improve response times.
- Promote a systematic approach to mental health first aid in remote rural areas.

**Priority area 5—Improving access to integrated treatment, rehabilitation and living support services**

Improving access to treatment and living support services aimed at achieving long-term rehabilitation and recovery outcomes, particularly for consumers with chronic and complex needs, will provide rural consumers and their carers with a reduced rate of relapse and need for inpatient care, and will enhance independent functioning.

Improving access to these services will be achieved through the long term expansion of service capacity and by implementing practice change and service reform to optimise the use of existing resources, including exploiting opportunities for service co-location, integration and collaboration.

Examples of collaborative practice currently operating within several rural mental health services include:

- The Prevention and Recovery Care (PARC) sub acute service model, a collaborative partnership between a PDRSS provider and an area mental health service, which provides a step down service for acute inpatients who are not yet well enough to return home but do not need to remain in an acute inpatient unit.
- A single electronic shared case record established by a PDRSS and AMHS. The program automatically links case notes, care plans, alerts and crisis management plans so that the PDRSS key workers and the clinical case manager access the same information at the same time.
- A Homeless Outreach Psychiatric Service, a collaboration between a PDRSS, an AMHS and the regional Transitional Housing Manager, to ensure that appropriate housing (two emergency properties and eight transitional properties) is available alongside clinical support and psychosocial rehabilitation.
Priority responses

• Explore opportunities to co-locate clinical staff in small community health services to provide an integrated response across age groups.

• Integrate and co-locate clinical treatment and daily living support outreach services (PDRSS) to maximise service efficiency and available infrastructure and provide a more integrated response to people with psychiatric disability. This service model could operate from satellite centres or be co-located in small community health services to improve access for remote communities.

Priority area 6—Enhance and maintain specialist expertise in integrated teams

Integrated community mental health services configured on the satellite service structure have the capacity to provide flexible service responses and a range of core functions for consumers and carers. These geographically based teams incorporate clinicians performing a range of functions including triage, assessment, crisis management, continuing care, consultancy and case-management. They are also linked to psychiatrists so that the same psychiatrist supports the client through each phase of their care.

Integration can also exist across age specific services, with specialist Adult, Aged and CAMHS services physically co-located within satellite service structures. This provides treating clinicians with the opportunity to gain some experience across all three clinical areas, supported by experts for each age group.

These service configurations provide for the effective delivery of core service functions for consumers living outside large service centres, and the necessary critical mass for service viability. From an individual consumer’s perspective, the provision of one case manager regardless of where they are in the service continuum enables service continuity and improves geographic accessibility where the population is spread over a large area.

Integrated services, while an effective structural and service response, when combined with a lack of multidisciplinary staff, especially specialist psychiatrists and experienced staff with skills in the mental health speciality, present a number of challenges. These challenges include the maintenance of role delineation and the retention and maintenance of specialist expertise, particularly expertise in working with children and adolescents, and the aged.

Priority responses

• Implement strategies which will develop and maintain specialist expertise in integrated service delivery arrangements to ensure staff have an appropriate level of specialisation across age groups, particularly skills in working with children and adolescents, and the aged.

• Improve access to clinical leadership and supervision in order to maintain and develop clinical expertise, particularly for small teams and sole practitioners, through teleconferencing and cluster arrangements with other areas.
Priority area 7–Improve access to specialist and statewide services

Utilisation of specialist and statewide public mental health services by residents in rural Victoria is significantly lower in comparison to metropolitan residents. Although rural areas have a 27.6 per cent share of Victoria’s population, in 2003-2004 rural residents only accounted for around 13 per cent of the State’s separations from acute statewide and specialist mental health beds. A range of factors impact on this lower level of access including demand, and local practices and referring patterns as well as proximity to the client’s home. As most acute inpatient beds for children and adolescents are located in metropolitan based hospitals, immediate access for this cohort in regional and rural Victoria can be problematic. As a result, in some rural areas, adolescents experiencing crisis are admitted to adult acute inpatient units.

Priority responses

- Monitor access to specialist and statewide mental health services and identify strategies to enable rural Victorians to have better access to these services.
- Explore technologies to provide greater rural access to specialist services, information, and clinical supervision.
- Explore improved linkages, referral procedures and follow up between metropolitan and rural services, including ways in which specialist services can be involved in and visit rural services.

Priority area 8–Enhance service responsiveness to special needs groups

A range of diverse demographic, socio-economic and cultural factors in rural Victoria give rise to specific challenges in responding to special need groups. Rural mental health services need to give consideration to service models and delivery structures that are sensitive and responsive to the needs of vulnerable groups, particularly those experiencing crisis and social disadvantage.

A heightened risk of suicide

Whilst the overall suicide death rate in Victoria has been below the national average for over a decade, the suicide rate in 2003 in rural Victoria (16.0) was 1.5 times greater than for metropolitan Melbourne (10.5), and was significantly higher than the national rural average (12.9). The disparity between rural and metropolitan suicide rates is more pronounced in Victoria than in any other state or territory, other than Tasmania, where rural suicide rates are also 1.5 times greater.6

The poorer health status of Indigenous populations. Areas of regional and rural Victoria with the highest concentrations of Indigenous people are Greater Shepparton, Swan Hill, Mildura, Greater Bendigo, and East Gippsland.

Low population and changing needs of people from culturally and linguistically diverse (CALD) backgrounds. Consistent with the census data (Australian Bureau of Statistics, 2001), most consumers of public mental health services born in non-English speaking countries live in metropolitan Melbourne (21.9 per cent compared with 6.1 per cent in rural regions). The relatively low levels of presenting need from

6 Source: ABS (unpublished), Causes of Death, Australia, Cat. no. 3303.0, Canberra
this cohort is a challenge for rural services. As population demographics change, however, rural public mental health services are increasingly being required to respond to this growing client group (which includes refugees and new immigrant groups who are particularly vulnerable). This demand is especially apparent in areas such as Shepparton and Cobram. Limited access in rural areas to interpreters further compounds the difficulties in responding effectively to the mental health needs of CALD communities.

**Priority areas**

Targeted responses to the special needs of these vulnerable groups have been, or are currently being developed and are presented in specific policy and strategic documents. In particular, specific initiatives need to be considered for those living in small rural towns. A summary of the main strategic directions of these documents pertinent to rural mental health services follows.

**Next steps: Victoria’s suicide prevention forward plan**

- Improve continuity of care and reduce suicide rates post discharge from mental health inpatient services to ambulatory services.
- Develop clear protocols for assessment, treatment and assertive follow-up of those who present at emergency departments following suicide attempts.
- Develop training and associated support activities for mental health workforce and primary mental team services

**The Purro Birik social and emotional wellbeing strategy.** An evaluation report completed in September 2003 made eight recommendations on the implementation of a strategic plan to address Indigenous mental health issues:

- **Planning.** Establish an Indigenous Social and Emotional Wellbeing development committee to facilitate effective planning processes between key players.
- **Partnerships.** Designate a senior person within clinical services with responsibility for promoting ties with Indigenous communities.
- **Undertake assessment of community needs**
- **Training.** Focus the Diploma of Indigenous Social and Emotional Wellbeing on enabling workers to function within the mental health system.
- **Cross Cultural Training.** Strengthen and coordinate cross cultural training to clinical and non-clinical services.
- **Workforce development.** Provide support to enable individual Koori mental health workers to be part of a larger health team.
- **Policy and guidelines.** Establish statewide guidelines that promote good practice in mental health practice with Indigenous people.
- **Priorities and relationships.** Establish Primary Care Partnership networks between Indigenous and mainstream services to enhance those at the individual worker level.
Cultural and Linguistic Diversity Strategy

The need for culturally sensitive service planning and practice is embodied in State and National mental health policies, legislation, and service standards.

However, while programs and initiatives implemented over the last decade have improved mental health care for people from culturally and linguistically diverse backgrounds, the accessibility and responsiveness of mental health services to these groups requires further development.

The Mental Health Branch is examining its transcultural mental health investments, with a view to strengthening these programs’ capacity to support culturally sensitive practice in the specialist mental health sector. This development will commence with the discussion paper, *Towards a cultural and linguistic diversity strategy for the specialist mental health sector, 2005–08.*

<table>
<thead>
<tr>
<th>Recent achievements and next steps for key direction 3</th>
<th>Primary responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide funding to rural mental health services to improve the quality and consistency of triage functions in 2005-2006</td>
<td>DHS central office and regions</td>
<td>Completed by December 2005</td>
</tr>
<tr>
<td>Continue to develop strategies to strengthen mental health support to selected hospital emergency departments with an additional 5.5 EFT to rural emergency departments in 2006-07</td>
<td>DHS central office</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Undertake the integrated rehabilitation project to improve service access, targeting and responsiveness of clinical and PDRS services</td>
<td>DHS central office</td>
<td>Policy document by October 4 2006; progressive implementation commencing 2006/07</td>
</tr>
<tr>
<td>Commence implementation of the PDRS price review to achieve greater consistency and equity of funding to this sector to supports more uniform service delivery and access. Provision of growth funding to PDRSS in 2006-07</td>
<td>DHS central office and regions</td>
<td>Commence October 2005</td>
</tr>
<tr>
<td>Develop area clustering models to enhance collaboration between rural areas and improve linkages with metropolitan areas that support: • Access to more specialised services and workforce initiatives; and • Improved triage and bed management practices.</td>
<td>DHS central office and Ministerial Advisory Committee on Mental Health</td>
<td>First report completed by December 2005</td>
</tr>
</tbody>
</table>
Key direction 4: Strengthening the capacity of the broader health system

Rural mental health services will continue to establish and strengthen partnerships with other health and welfare services to enable rural communities to have access to efficient, sustainable and comprehensive treatment and care options.

A strength of rural public mental health services is their ability to develop partnerships with local health and welfare services. Rural stakeholders recognise the value in exploring collaborative opportunities in order to maximise service sustainability and access.

In one area service, for example, the local Primary Care Partnerships (PCP) has directly engaged with mental health services in mapping the local service system, and improving suicide follow up procedures and triage responses. This is an example of how PCPs can provide a significant vehicle for bringing public mental health services together with the primary health sector.

This section focuses on the set of activities concerned with enhancing cross sector partnerships to improve access, quality of care, and the operational efficiency of these services and maximise existing capabilities. Priority areas for action are to:

• Foster cross sector partnerships
• Strengthen the capacity of mental health services to support people with dual diagnoses
• Improve the expertise of rural general health and community services to support people with mental illness
• Improve linkages with Commonwealth mental health initiatives

Priority area 9–Foster cross sector partnerships

Due to the absence of alternatives, health professionals in rural locations tend to work collaboratively to solve local problems, and have greater contact with the broader community and other service providers. This often produces innovative solutions to local problems. Importantly, part of this collaboration includes developing clear understandings and expectations about the role, function and targeting of services delivered by the different providers in the partnership.

Successful collaborations of regional mental health services with general community health services results in better access, and a more comprehensive and cost efficient response to client need. An example of this is an integrated youth service model targeted to 16-25 year olds in a regional centre. A joint initiative of a rural area service, PDRSS provider, and a GP integrated youth health project, this initiative involves the co-location of specialist mental health staff with other youth related health services in a youth friendly environment. Services include Mental Health (child and adolescent, early intervention, and adult services), drug treatment services, community health services, sexual health services, youth health services and General Practice.

The following responses aim to enhance the capacity to develop partnerships across and between clinical mental health services, PDRSS, and general primary and acute health services.
Priority responses

- Explore opportunities for the co-location of rural public mental health services with other complementary health and community services, particularly in smaller towns where the services can be developed in a single health precinct. GP practice(s) may also be included as part of this precinct.
- Further develop shared care and supported discharge arrangements between rural AMHS and local health and community services (including drug and alcohol services and general practitioners).
- Further enhance cross sector collaboration by increasing the level and range of partnerships in rural public mental health service delivery, particularly the Primary Mental Health and Early Intervention teams and primary care partnerships, private psychiatrists, and GPs, where such arrangements exist.

Priority area 10–Strengthen the capacity of rural public mental health services to support people with dual diagnoses

A significant proportion of new mental health consumers have a co-morbid drug and alcohol problem. Dual diagnosis is associated with symptom exacerbation, treatment non-compliance, more frequent hospitalisation, greater depression and likelihood of suicide, offending, family breakdown, and homelessness. Of particular concern is the number of young people, particularly males, with a psychotic illness that has been triggered or exacerbated by drug use. Available evidence strongly supports an integrated mental health and drug and alcohol treatment response to the needs of this complex consumer group.

There are limited dual diagnoses services in rural areas, particularly outside regional centres. Expanded capacity in this area will require integrated efforts on the part of mental health and drug treatment services.

Priority responses

- Co-locate clinical case management services with drug treatment services in regional service centres and coordinate Dual Diagnosis responses where possible to improve outcomes for people with a mental illness and substance abuse.
- Improve the capacity of mental health and drug treatment services to better support dual diagnosis consumers through workforce training and staff rotation.
Priority area 1 – Improve the expertise of rural health and community services to support people with mental illness

Many services in the community are well placed to identify individuals at risk of, or showing, early signs of mental health problems, and to intervene before problems become more severe or entrenched. These services include early childhood services, schools, primary health providers, child protection agencies, aged care, homeless and drug and alcohol treatment services and the justice system. Rural mental health providers have indicated their need to better support other health and social services that often struggle to manage the mental health problems of their clients.

Secondary consultation and liaison services for non-mental health services are often limited, particularly in rural areas with limited or no access to private psychiatrists. Additionally, there are further limitations in smaller towns due to the lack of broader community service networks that can utilise secondary consultation services, and the limited skill and experience of many health workers in working with complex clients.

Priority response

- Provide access to secondary consultation to a broader network of community services to support them in managing people with mental illness.
- Develop the expertise of mainstream health services (including bush hospitals) located in small communities to equip them with the skills and confidence to support people with mental health problems.

Priority area 12 – Improve linkages with Commonwealth mental health initiatives

Primary Mental Health and Early Intervention Teams in each rural area mental health service have the potential to strengthen cross service responses and shared care arrangements with general practitioners and other primary health providers, maximising the use of available community resources and infrastructure. This includes strengthening links with Commonwealth funded initiatives.

North East Victoria has successfully pooled Commonwealth and State resources to achieve a strengthened level of support to primary health providers. This model provides a good example of innovation and integration in rural mental health.

Priority response

- Link, wherever possible, Commonwealth funded Better Outcomes in Mental Health with the activities of Primary Mental Health and Early Intervention teams.
- Explore ways of using Medicare items for case conferencing and telepsychiatry with rural mental health services.
<table>
<thead>
<tr>
<th>Recent achievements and next steps for key direction 4</th>
<th>Primary responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue the collaborative development of integrated local service models and management arrangements</td>
<td>DHS regions and service providers</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Further implement integrated dual diagnosis initiatives through agency collaboration and workforce development initiatives funded in 2005-2006</td>
<td>DHS central office and regions</td>
<td>March 2006</td>
</tr>
<tr>
<td>Undertake an evaluation of the primary mental health initiative and identify the most successful models of collaboration</td>
<td>DHS central office</td>
<td>December 2006</td>
</tr>
<tr>
<td>Continue to pilot education and training clusters and evaluate the benefits of collaborative workforce development approaches</td>
<td>DHS central office and service providers</td>
<td>December 2006</td>
</tr>
<tr>
<td>Through participation in beyondblue, the National Depression Initiative, continue promoting the uptake of Commonwealth mental health initiatives in Victoria and associated training</td>
<td>DHS central office</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
Key direction 5: Building a strong, skilled and sustainable workforce

New workforce and practice models in rural mental health services will continue to be explored and addressed to enable an adequate supply and distribution of suitably qualified staff, and the development and maintenance of a skilled workforce.

The long-term sustainability of rural mental health service delivery is dependent on obtaining a sufficient supply of an appropriately skilled workforce, retaining existing staff and ensuring the most effective use of qualified staff.

In many rural areas, access to private mental health services (GPs and psychiatrists) is limited, due primarily to workforce shortages and maldistribution. Access to GPs in some rural areas is becoming increasingly difficult, as the supply of GPs per head of population declines.

Given that 76 per cent of people receiving mental health care use the services of GPs, the under supply of these services in rural settings places additional pressures on public mental health services to meet the needs of people with low to moderate care needs or with mental health problems that could be equally well managed by an alternative provider, if available.

This section focuses on the set of activities concerned with workforce planning and development to ensure that workforce distribution, composition and skill-base are responsive to community and service system needs. The following proposed priority areas are to:

- Improve recruitment and retention of the public mental health workforce, including development of service delivery models and protocols relevant to rural environments.
- Improve access to Commonwealth funded mental health services.

Priority area 13–Improve workforce recruitment and retention and explore workforce redesign models

The recruitment and retention of the rural mental health workforce remains a significant problem, compounding the maldistribution of the workforce relative to the consumer population. Rural areas report difficulties in recruiting sufficient numbers of suitably qualified staff. In the case of psychiatrists, in rural areas there is a heavy reliance on recruiting overseas trained staff, with 11.2 percent of psychiatrists and 16.4 percent of rural psychiatric registrars and trainees reporting they had temporary residency in 2002.

Only 11 percent of medical staff in Victoria currently work in rural areas. A proportion of rural staff are employed across multiple settings, which in part reflects the move toward integrated community mental health services in rural Victoria.

For many rural staff, mobility is related to pursuing employment opportunities in metropolitan services. For example, of those psychiatrists whose first position was in a rural location, 59 percent were subsequently employed in a rural area. In contrast, 93 percent of psychiatrists whose first position was in a metropolitan location were subsequently employed in a metropolitan area. This is also consistent with the workforce census, which showed that whilst virtually all respondents who initially worked in a metropolitan area remained in the metropolitan area, a proportion of those staff that initially worked in a rural area had since moved to a position in a metropolitan location.
One area service works closely with their tertiary education provider to give trainee nurses the opportunity to gain experience in working with people with mental illness with the view to attracting more people to work in the mental health field.

Priority responses

- Explore initiatives with rural clinical schools regarding the medical workforce, especially those that integrate with the training requirements for the Royal Australian and New Zealand College of Psychiatrists and those that attract trainee psychiatrists to rural areas.
- Explore the strengthening of links to rural clinical schools through possible joint appointments.
- Strengthen the relationship between universities and rural area mental health services to attract graduate nurses.
- Consider ways to improve the professional mix in rural services, particularly with a view to increasing the medical component and capability of services through workforce redesign and recruitment and retention initiatives.
- Enhance access of all disciplines to high quality rural placements, continuing professional development, scholarships and graduate positions.
- Explore the use of vocationally trained direct care workers, such as psychiatric services officers and Division 2 nurses in mental health.
- Explore workforce models that integrate PDRSS into clinical settings.
- Support retention of newly arrived overseas trained psychiatrists who are working in rural services.
- Facilitate career pathways in rural communities across health and community services through, for example, joint positions, combined training programs and entry level positions in mental health.
- Increase exposure of trainee psychiatrists to rural mental health.
- Increase supports available in first 12 months in mental health for new employees via the relevant member organisation.

Priority area 15–Improve access to Commonwealth funded mental health services

The supply and distribution of private psychiatrists in Victoria is inequitable. Ninety one per cent of private psychiatrists have their main practice in metropolitan areas, with the highest concentrations in the inner urban east and inner south east. Private full time Medicare funded psychiatrists per 100,000 population varies from 9.4 in metropolitan areas to 1.1 per 100,000 in rural and remote areas. Access issues also exist in outer urban areas including Dandenong, Mornington Peninsula, the South West and the Outer East.

In large rural areas the supply of general practitioners is 13 per cent below that of capital centres. Under supply is more evident in small rural centres, which had a supply 23 per cent less than capital cities. For most people living in communities with limited access to service centres, GPs are the first point of entry for professional help with their mental health problems, and in some cases, their sole treating practitioner.
Priority response

- Work with the Commonwealth Government and the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of General Practitioners to address the maldistribution and under supply of private sector psychiatrists and general practitioners in rural areas.
- Seek to enhance public and private sector partnerships building on existing frameworks for such collaborations.

<table>
<thead>
<tr>
<th>Next steps for key direction 5</th>
<th>Primary responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement workforce initiatives funded in 2005-2006 and 2006-07 including:</td>
<td>DHS central office</td>
<td>Ongoing</td>
</tr>
<tr>
<td>• More post graduate nurse scholarships, graduate positions and sector forums.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A rural medical workforce project to develop a range of locally effective incentives and strategies to recruit and retain psychiatrists and medical officers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Continued exploration of the use of vocationally trained direct care workers and piloting of education and training clusters.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Continued development of nurse practitioner models applicable to rural environments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• An undergraduate nursing program with major in psychiatric nursing, commencing 2006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthen capacity in community teams through implementation of caseload management systems and allocation of future growth funding to support clients in shared care and supported discharge arrangements with GPs.</td>
<td>DHS central office and service providers</td>
<td>Over next five years</td>
</tr>
</tbody>
</table>
Appendix 1:
Part A - Overview of service utilisation data and trends

Introduction
In summary rural service utilisation data indicates that:

• Most rural area services provide a service response to a greater proportion of the population than the statewide average of 1.20%

• The majority of rural area services are experiencing sustained growth in registered clients with the exception of three area services, which experienced negative or negligible growth over the five year period 2000/01 to 2004/05.

• Rural acute inpatient services, compared to metropolitan services, have higher rates of self sufficiency and fewer out of area admissions.

• The majority of rural acute inpatient services operate with high occupancy levels comparable to metropolitan services.

• Average length of stay in all but one rural acute inpatient service is below the statewide and metropolitan averages, with six rural areas recording average length of stay of less than 10 days.

• The level of people staying 35 days or more in rural acute inpatient services is almost half that of metropolitan services, with only two rural area mental health services experiencing rates comparable to metropolitan services.

Annual growth in registered clients
Annual growth in the number of clients registered with rural services in 2004/05 was 2.0 per cent, equal to the average annual growth over the five year period (2000/01 to 2004/05) of 2.0 per cent. This plateau effect, which commenced in 2001-02, indicates that rural services, similar to their metropolitan counterparts, are reaching threshold capacity after several years of sustained growth above population growth rates. It should be noted that the rate of growth across rural services over the last five years shows considerable variation, with rural area services recording an annualised growth rate of between –0.8 and 6.2 per cent.

Demand for adult acute inpatient services
The adult acute inpatient system in rural Victoria operates at full capacity, evidenced by average occupancy levels of 97.4 per cent. Unlike other specialities, mental health inpatient services must have adequate capacity to admit the significant number of involuntary patients for which public mental health services have a non-discretionary statutory responsibility. An occupancy level of 85 per cent is generally regarded as optimal, as this enables sufficient flexibility and multi day capacity to effectively manage demand.

Occupancy levels in rural services (97.4 per cent) are comparable to metropolitan services (97.5 per cent). However considerable variation exists within rural services with occupancy rates varying from 87.4 – 120 per cent.

Average length of stay in rural AMHS is 9.1 bed days (11.8 bed days in metropolitan services). Again, considerable variation exists across rural services with the average length of stay as low as 7.6 and up to 11.8.

Long stays. Considered as a whole, rural services experience a considerably lower level (6.1 per cent) of long stays – stays longer than 35 days – compared to metropolitan services (10.7 per cent). This data indicates that pressure on adult acute inpatient beds, and resulting level of bed blockage, may be more characteristic of metropolitan inpatient services than rural services. There is significant variation amongst rural services, with the percentage of long stays ranging from 2.7 to 10.2.
Part B - Profile of rural area mental health services

Figure 1 Mental health service area, Rural Victoria
Barwon Area Mental Health Service
This service area covers the statistical local areas of Colac-Otway, Greater Geelong, Surfcoast and Queenscliff.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Colac-Otway</td>
<td>21,495</td>
<td>3.9%</td>
<td>1.3%</td>
<td>5,651</td>
<td>26.3%</td>
<td>13,175</td>
</tr>
<tr>
<td>Greater Geelong</td>
<td>202,615</td>
<td>7.4%</td>
<td>6.5%</td>
<td>49,893</td>
<td>24.6%</td>
<td>129,218</td>
</tr>
<tr>
<td>Surfcoast</td>
<td>22,471</td>
<td>15.9%</td>
<td>10.3%</td>
<td>5,964</td>
<td>26.5%</td>
<td>14,421</td>
</tr>
<tr>
<td>Queenscliff</td>
<td>3,212</td>
<td>-4.4%</td>
<td>1.3%</td>
<td>625</td>
<td>19.5%</td>
<td>1,713</td>
</tr>
</tbody>
</table>

ARIA
Of the 14 Statistical Local Areas (SLAs) in Barwon AMHS, 13 are categorised as ‘Highly Accessible’ in the ARIA index of accessibility/remoteness, and one as ‘Accessible’, indicating that the AMHS has only one area with some restrictions of accessibility to some goods and services and opportunities for social interaction.

Regional service providers
Clinical providers
Child & Adolescent, Adult Services, Aged Services Barwon Health Services

Psychiatric Disability Rehabilitation & Support Services (PDRSS)
Day Programs Pathways Rehabilitation & Support Services, Salvation Army – Kardinia Centre
Home Based Outreach Support Karingal, Pathways, Salvation Army-Kardinia, Wathaurong Aboriginal Cooperative
Mutual Support Self Help Barwon Disability Resource Council, Geelong Bipolar Support Group, Geelong Mental Health Consumers Union, Mental Illness Fellowship Victoria
Planned Respite Karingal
Residential Rehabilitation Mental Illness Fellowship Victoria

Service usage information

<table>
<thead>
<tr>
<th>Service usage</th>
<th>Comparative analysis</th>
<th>Barwon AMHS</th>
<th>All rural AMHS</th>
<th>All AMHS statewide</th>
<th>Child &amp; Adolescent</th>
<th>Adult</th>
<th>Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage population accessing services</td>
<td>1.26</td>
<td>1.56</td>
<td>1.2</td>
<td>0.85</td>
<td>1.46</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>Percentage all Victorian registered clients</td>
<td>5.33</td>
<td>36.33</td>
<td>100</td>
<td>5.19</td>
<td>5.55</td>
<td>4.73</td>
<td></td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>0.7</td>
<td>2.0</td>
<td>1.7</td>
<td>-2.6</td>
<td>-0.1</td>
<td>-4.5</td>
<td></td>
</tr>
<tr>
<td>Demand management (adult 2004/05)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Self sufficiency</td>
<td>87.1</td>
<td>86.4</td>
<td>78.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of separations</td>
<td>853</td>
<td>4410</td>
<td>13,280</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Inpatient occupancy</td>
<td>92.0</td>
<td>97.4</td>
<td>97.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average length of stay (excluding same day and &gt;35 bed days) in bed days</td>
<td>7.6</td>
<td>9.1</td>
<td>11.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Greater than 35 days (bed days)</td>
<td>2.7</td>
<td>6.1</td>
<td>9.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statewide and specialist beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separations-acute statewide &amp; specialist (including forensic)</td>
<td>52</td>
<td>258</td>
<td>1448</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Planning framework for public rural mental health services

Gippsland Area Mental Health Service
This service area covers the statistical local areas of Bass Coast, Baw Baw, East Gippsland, Latrobe, South Gippsland and Wellington.

Area population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bass Coast</td>
<td>28,512</td>
<td>21.0%</td>
<td>10.5%</td>
<td>6,344</td>
<td>22.3%</td>
<td>16,742</td>
<td>58.7%</td>
<td>6,358</td>
<td>22.3%</td>
</tr>
<tr>
<td>East</td>
<td>37,935</td>
<td>7.3%</td>
<td>5.1%</td>
<td>19,696</td>
<td>28.2%</td>
<td>23,661</td>
<td>62.4%</td>
<td>5,397</td>
<td>14.2%</td>
</tr>
<tr>
<td>Gippsland</td>
<td>40,826</td>
<td>3.4%</td>
<td>3.8%</td>
<td>9,781</td>
<td>24.0%</td>
<td>24,495</td>
<td>60.0%</td>
<td>8,174</td>
<td>20.0%</td>
</tr>
<tr>
<td>Latrobe</td>
<td>70,315</td>
<td>-1.0%</td>
<td>0.3%</td>
<td>19,354</td>
<td>27.5%</td>
<td>44,790</td>
<td>63.7%</td>
<td>9,383</td>
<td>13.3%</td>
</tr>
<tr>
<td>South</td>
<td>26,888</td>
<td>4.3%</td>
<td>3.6%</td>
<td>7,018</td>
<td>26.1%</td>
<td>16,446</td>
<td>61.2%</td>
<td>4,614</td>
<td>17.2%</td>
</tr>
<tr>
<td>Wellington</td>
<td>41,450</td>
<td>-1.3%</td>
<td>0.0%</td>
<td>11,094</td>
<td>26.8%</td>
<td>26,087</td>
<td>62.9%</td>
<td>6,167</td>
<td>14.9%</td>
</tr>
</tbody>
</table>

ARIA
Of the 23 Statistical Local Areas (SLAs) in Gippsland AMHS, 11 are categorised as 'Highly Accessible' in the ARIA index of accessibility/remoteness, 10 as 'Accessible' and 2 as 'Moderately Accessible', indicating that the AMHS has areas of some to significantly restricted accessibility to a wide range of goods and services and opportunities for social interaction.

Regional service providers
Clinical providers
Child & Adolescent, Adult Services, Aged Services
LaTrobe Regional Hospital

Psychiatric Disability Rehabilitation & Support Services (PDRSS)

Day Programs
GARSS, Latrobe Community Health Centre, Mental Illness Fellowship Victoria, SNAP

Home Based Outreach Support
GARSS, SNAP, Yarra, & District Health Service, Central Gippsland Aboriginal Cooperative, Ramahyuck Aboriginal Cooperative, Gippsland & East Gippsland Aboriginal Cooperative, Lake Tyers Aboriginal Cooperative, Mookji Aboriginal Council.

Mutual Support Self Help
Mental Illness Fellowship Victoria

Planned Respite
Latrobe Community Health Centre, South Gippsland Community Support,

Residential Rehabilitation
Richmond Fellowship Victoria

Service usage information

<table>
<thead>
<tr>
<th>Service usage</th>
<th>Comparative analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage population accessing services</td>
<td>Gippsland AMHS</td>
</tr>
<tr>
<td>Percentage all Victorian registered clients</td>
<td>All rural AMHS</td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>All AMHS statewide</td>
</tr>
<tr>
<td></td>
<td>Child &amp; Adolescent</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
</tr>
<tr>
<td></td>
<td>Aged</td>
</tr>
<tr>
<td>Demand Management (adult 2004/05)</td>
<td>88.9</td>
</tr>
<tr>
<td>% Self sufficiency</td>
<td>86.4</td>
</tr>
<tr>
<td>Number of separations</td>
<td>4410</td>
</tr>
<tr>
<td>% Inpatient occupancy</td>
<td>97.4</td>
</tr>
<tr>
<td>Average length of stay (excluding same day and &gt;35 bed days) in bed days</td>
<td>11.0</td>
</tr>
<tr>
<td>Statewide and specialist beds</td>
<td>32</td>
</tr>
<tr>
<td>Separations-acute statewide &amp; specialist (including forensic)</td>
<td>258</td>
</tr>
<tr>
<td></td>
<td>1448</td>
</tr>
</tbody>
</table>
Goulburn Valley Area Mental Health Service
This service area covers the statistical local areas of Greater Shepparton, Mitchell, Moira (excluding Yarrawonga), Murrundindi and Strathbogie.

### Area population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater</td>
<td>60,025</td>
<td>7.2%</td>
<td>6.7%</td>
<td>16,750</td>
<td>27.9%</td>
<td>38,145</td>
</tr>
<tr>
<td>Shepparton</td>
<td>31,574</td>
<td>16.8%</td>
<td>10.5%</td>
<td>9,716</td>
<td>30.8%</td>
<td>20,408</td>
</tr>
<tr>
<td>De intricate</td>
<td>18,528</td>
<td>0.9%</td>
<td>2.4%</td>
<td>5,130</td>
<td>27.7%</td>
<td>10,990</td>
</tr>
<tr>
<td>Murrundindi</td>
<td>13,908</td>
<td>5.1%</td>
<td>4.0%</td>
<td>3,405</td>
<td>24.8%</td>
<td>8,880</td>
</tr>
<tr>
<td>Strathbogie</td>
<td>9,616</td>
<td>1.4%</td>
<td>2.5%</td>
<td>2,117</td>
<td>22.0%</td>
<td>5,765</td>
</tr>
</tbody>
</table>

ARIA
Of the 9 Statistical Local Areas (SLAs) in Goulburn Valley AMHS, 9 are categorised as ‘Highly Accessible’ in the ARIA index of accessibility/remoteness, and 2 as ‘Accessible’, indicating that the area has areas with some restrictions to accessibility to some goods and services and opportunities for social interaction.

### Regional service providers

#### Clinical providers
- Child & Adolescent, Adult Services, Aged Services: Goulburn Valley Health Services

#### Psychiatric Disability Rehabilitation & Support Services (PDRSS)
- Day Programs: Mental Illness Fellowship Victoria
- Home Based Outreach Support: Mental Illness Fellowship, Rumbalara Aboriginal Cooperative
- Mutual Support Self Help: GROW, Goulburn Valley Family Care
- Planned Respite: Mental Illness Fellowship Victoria
- Residential Rehabilitation: Mental Illness Fellowship Victoria, Richmond Fellowship Victoria
- Koori PDRSS: Rumbalara Aboriginal Cooperative

### Service usage information

<table>
<thead>
<tr>
<th>Service usage</th>
<th>Comparative analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goulburn Valley AMHS</td>
<td>All rural AMHS</td>
</tr>
<tr>
<td>Percentage population accessing services</td>
<td>1.67</td>
</tr>
<tr>
<td>Percentage all Victorian registered clients</td>
<td>3.78</td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>-0.8</td>
</tr>
<tr>
<td>Demand management (adult 2004/05)</td>
<td></td>
</tr>
<tr>
<td>% Self sufficiency</td>
<td>84.4</td>
</tr>
<tr>
<td>Number of separations</td>
<td>460</td>
</tr>
<tr>
<td>% Inpatient occupancy</td>
<td>96.6</td>
</tr>
<tr>
<td>Average length of stay (excluding same day and &gt;35 bed days) in bed days</td>
<td>9.1</td>
</tr>
<tr>
<td>% Greater than 35 days (bed days)</td>
<td>6.1</td>
</tr>
<tr>
<td>Statewide and specialist beds</td>
<td></td>
</tr>
<tr>
<td>Separations-acute statewide &amp; specialist (including forensic)</td>
<td>42</td>
</tr>
</tbody>
</table>
Grampians Area Mental Health Service

This service area covers the statistical local areas of Ararat, Ballarat, Golden Plains, Hepburn, Hindmarsh, Horsham, Moorabool, Northern Grampians, Pyrenees, West Wimmera and Yarriambiack.

Area population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ararat</td>
<td>11,539</td>
<td>-1.8%</td>
<td>-0.3%</td>
<td>2,777</td>
<td>24.1%</td>
<td>7,032</td>
<td>60.9%</td>
<td>2,132</td>
<td>18.5%</td>
</tr>
<tr>
<td>Ballarat</td>
<td>87,148</td>
<td>7.1%</td>
<td>5.7%</td>
<td>23,071</td>
<td>26.5%</td>
<td>55,893</td>
<td>64.1%</td>
<td>12,253</td>
<td>14.1%</td>
</tr>
<tr>
<td>Golden Plains</td>
<td>16,319</td>
<td>14.7%</td>
<td>7.1%</td>
<td>4,763</td>
<td>29.2%</td>
<td>10,790</td>
<td>61.6%</td>
<td>1,459</td>
<td>9.9%</td>
</tr>
<tr>
<td>Hepburn</td>
<td>14,828</td>
<td>4.6%</td>
<td>3.3%</td>
<td>3,649</td>
<td>24.6%</td>
<td>9,369</td>
<td>63.2%</td>
<td>2,409</td>
<td>16.2%</td>
</tr>
<tr>
<td>Hindmarsh</td>
<td>6,407</td>
<td>-5.2%</td>
<td>-4.3%</td>
<td>1,564</td>
<td>24.4%</td>
<td>3,636</td>
<td>56.8%</td>
<td>1,427</td>
<td>22.3%</td>
</tr>
<tr>
<td>Horsham</td>
<td>18,901</td>
<td>2.8%</td>
<td>3.1%</td>
<td>4,931</td>
<td>26.1%</td>
<td>11,552</td>
<td>61.1%</td>
<td>3,183</td>
<td>16.8%</td>
</tr>
<tr>
<td>Moortabool</td>
<td>26,138</td>
<td>7.6%</td>
<td>8.3%</td>
<td>7,793</td>
<td>29.8%</td>
<td>16,872</td>
<td>64.5%</td>
<td>2,712</td>
<td>10.4%</td>
</tr>
<tr>
<td>Northern Grampians</td>
<td>12,749</td>
<td>-3.5%</td>
<td>0.8%</td>
<td>3,307</td>
<td>25.9%</td>
<td>7,666</td>
<td>60.1%</td>
<td>2,288</td>
<td>17.9%</td>
</tr>
<tr>
<td>Pyrenees</td>
<td>6,532</td>
<td>-3.4%</td>
<td>-2.5%</td>
<td>1,531</td>
<td>23.4%</td>
<td>4,072</td>
<td>62.3%</td>
<td>1,180</td>
<td>18.1%</td>
</tr>
<tr>
<td>West Wimmera</td>
<td>4,741</td>
<td>-5.9%</td>
<td>-4.8%</td>
<td>1,207</td>
<td>25.5%</td>
<td>2,784</td>
<td>58.7%</td>
<td>932</td>
<td>19.7%</td>
</tr>
<tr>
<td>Yarrambig</td>
<td>8,014</td>
<td>-6.7%</td>
<td>-5.3%</td>
<td>2,024</td>
<td>25.3%</td>
<td>4,465</td>
<td>55.7%</td>
<td>1,427</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

ARIA

Of the 22 Statistical Local Areas (SLAs) in Grampians AMHS, 13 are categorised as ‘Highly Accessible’ in the ARIA index of accessibility/remoteness, 5 as ‘Accessible’ and 4 as ‘Moderately Accessible’, indicating that the area has areas of some to significantly restricted accessibility to a wide range of goods and services and opportunities for social interaction.

Regional service providers

Clinical providers

Child & Adolescent, Adult Services, Aged Services

Grampians Psychiatric Service

Psychiatric Disability Rehabilitation & Support Services (PDRSS)

Day Programs

APROCH, Grampians Community Health Centre, Outer Western Psychiatric Disability Support Association, Wimmera Uniting Care

Home Based Outreach Support

Ballarat & District Aboriginal Cooperative, Ballarat Community Health Centre, Grampians Community Health Centre, Centacare, Goolurn Goolurn Aboriginal Cooperative, Wimmera Uniting Care

Mutual Support Self Help


Planned Respite

Grampians Community Health Centre, Centacare, Wimmera Uniting Care

Residential Rehabilitation

Centacare

Service usage information

<table>
<thead>
<tr>
<th>Service usage</th>
<th>Grampians AMHS</th>
<th>All rural AMHS</th>
<th>All AMHS statewide</th>
<th>Child &amp; Adolescent</th>
<th>Adult</th>
<th>Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage population accessing services</td>
<td>1.22</td>
<td>1.56</td>
<td>1.20</td>
<td>0.92</td>
<td>1.34</td>
<td>1.25</td>
</tr>
<tr>
<td>Percentage all Victorian registered clients</td>
<td>4.41</td>
<td>36.33</td>
<td>100</td>
<td>5.11</td>
<td>4.32</td>
<td>5.03</td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>1.7</td>
<td>2.0</td>
<td>1.7</td>
<td>2.2</td>
<td>2.2</td>
<td>-1.8</td>
</tr>
<tr>
<td>Demand management (adult 2004/05)</td>
<td>88.5</td>
<td>86.4</td>
<td>78.5</td>
<td>22.2</td>
<td>2.2</td>
<td>-1.8</td>
</tr>
<tr>
<td>Number of separations</td>
<td>707</td>
<td>4410</td>
<td>13,289</td>
<td>53.1</td>
<td>4.32</td>
<td>5.03</td>
</tr>
<tr>
<td>% Inpatient occupancy</td>
<td>87.4</td>
<td>97.4</td>
<td>97.5</td>
<td>9.1</td>
<td>9.1</td>
<td>-1.8</td>
</tr>
<tr>
<td>Average length of stay (bed days)</td>
<td>9.2</td>
<td>9.1</td>
<td>11.0</td>
<td>6.1</td>
<td>6.1</td>
<td>9.2</td>
</tr>
<tr>
<td>% Greater than 35 days (bed days)</td>
<td>5.2</td>
<td>6.1</td>
<td>9.2</td>
<td>36</td>
<td>258</td>
<td>1448</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statewide and specialist beds</th>
<th>Separations-acute statewide &amp; specialist (including forensic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separations-acute statewide &amp; specialist (including forensic)</td>
<td>36</td>
</tr>
</tbody>
</table>
Loddon Mallee Area Mental Health Service
This service area covers the statistical local areas of Buloke, Campaspe, Central Goldfields, Gannawarra, Greater Bendigo, Loddon, Macedon Ranges, Mount Alexander and Swan Hill (excluding Robinvale).

Area population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Buloke</td>
<td>7,058</td>
<td>-7.3%</td>
<td>-5.5%</td>
<td>1,716</td>
<td>24.3%</td>
<td>4,061</td>
<td>57.5%</td>
<td>1,537</td>
<td>21.8%</td>
</tr>
<tr>
<td>Campaspe</td>
<td>37,193</td>
<td>3.8%</td>
<td>4.2%</td>
<td>10,104</td>
<td>27.2%</td>
<td>22,390</td>
<td>60.7%</td>
<td>6,016</td>
<td>16.2%</td>
</tr>
<tr>
<td>Central Goldfields</td>
<td>12,964</td>
<td>-0.3%</td>
<td>0.8%</td>
<td>3,148</td>
<td>24.3%</td>
<td>7,613</td>
<td>58.7%</td>
<td>2,747</td>
<td>21.2%</td>
</tr>
<tr>
<td>Gannawarra</td>
<td>11,837</td>
<td>-2.9%</td>
<td>-4.1%</td>
<td>3,051</td>
<td>25.9%</td>
<td>6,899</td>
<td>50.3%</td>
<td>2,337</td>
<td>19.7%</td>
</tr>
<tr>
<td>Greater Bendigo</td>
<td>94,614</td>
<td>7.8%</td>
<td>6.0%</td>
<td>24,866</td>
<td>26.3%</td>
<td>60,378</td>
<td>63.8%</td>
<td>13,703</td>
<td>14.5%</td>
</tr>
<tr>
<td>Loddon</td>
<td>8,407</td>
<td>-5.3%</td>
<td>-1.1%</td>
<td>1,990</td>
<td>23.7%</td>
<td>4,953</td>
<td>58.9%</td>
<td>1,779</td>
<td>21.2%</td>
</tr>
<tr>
<td>Macedon Ranges</td>
<td>40,004</td>
<td>10.1%</td>
<td>8.7%</td>
<td>11,572</td>
<td>28.9%</td>
<td>26,090</td>
<td>65.2%</td>
<td>4,085</td>
<td>10.2%</td>
</tr>
<tr>
<td>Mount Alexander</td>
<td>17,242</td>
<td>1.4%</td>
<td>2.7%</td>
<td>4,254</td>
<td>24.7%</td>
<td>10,491</td>
<td>60.8%</td>
<td>3,189</td>
<td>18.5%</td>
</tr>
<tr>
<td>Swan Hill</td>
<td>17,411</td>
<td>2.5%</td>
<td>0.6%</td>
<td>4,843</td>
<td>27.8%</td>
<td>10,452</td>
<td>60.0%</td>
<td>2,816</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

ARIA
Of the 25 Statistical Local Areas (SLAs) in Loddon Campaspe AMHS, 19 are categorised as 'Highly Accessible' in the ARIA index of accessibility/remoteness, 4 as 'Accessible' and 2 as 'Moderately Accessible', indicating that the AMHS has areas of some to significantly restricted accessibility to a wide range of goods and services and opportunities for social interaction.

Regional service providers

<table>
<thead>
<tr>
<th>Clinical providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent, Adult, Services, Aged Services</td>
</tr>
</tbody>
</table>

Psychiatric Disability Rehabilitation & Support Services (PDRSS)

<table>
<thead>
<tr>
<th>Program</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Programs</td>
<td>Echuca Community Support, Golden City Support Services, Mallee Family Care, St Lukes Community Support</td>
</tr>
<tr>
<td>Home Based Outreach Support</td>
<td>Loddon Mallee Housing Service, Mallee Family Care, Njernda Aboriginal Cooperative, St Lukes Community Support</td>
</tr>
<tr>
<td>Mutual Support Self Help</td>
<td>Golden City Support Services, Mallee Family Care</td>
</tr>
<tr>
<td>Planned Respite</td>
<td>St Lukes Community Support</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>Richmond Fellowship Victoria</td>
</tr>
</tbody>
</table>

Service usage information

<table>
<thead>
<tr>
<th>Service usage</th>
<th>Comparative analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loddon AMHS</td>
</tr>
<tr>
<td>Percentage population accessing services</td>
<td>1.71</td>
</tr>
<tr>
<td>Percentage all Victorian registered clients</td>
<td>7.15</td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>4.2</td>
</tr>
<tr>
<td>Demand management (adult 2004/05)</td>
<td>88.1</td>
</tr>
<tr>
<td>Number of separations</td>
<td>598</td>
</tr>
<tr>
<td>% Inpatient occupancy</td>
<td>103.4</td>
</tr>
<tr>
<td>Average length of stay (excluding same day and &gt;35 bed days) in bed days</td>
<td>11.8</td>
</tr>
<tr>
<td>% Greater than 35 days (bed days)</td>
<td>10.2</td>
</tr>
<tr>
<td>Statewide and specialist beds</td>
<td>42</td>
</tr>
</tbody>
</table>
North East Hume Area Mental Health Service
This service area covers the local government areas of Alpine, Mansfield, Benalla, Indigo, Moira East (Yarrawonga), Towong, Wangaratta and Wodonga.

### Area population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpine</td>
<td>13,168</td>
<td>4.5%</td>
<td>2.7%</td>
<td>3,257</td>
<td>24.7%</td>
<td>8,055</td>
</tr>
<tr>
<td>Mansfield</td>
<td>6,997</td>
<td>3.5%</td>
<td>5.8%</td>
<td>1,301</td>
<td>27.2%</td>
<td>4,291</td>
</tr>
<tr>
<td>Benalla</td>
<td>14,067</td>
<td>0.7%</td>
<td>2.3%</td>
<td>3,707</td>
<td>26.4%</td>
<td>8,469</td>
</tr>
<tr>
<td>Indigo</td>
<td>15,091</td>
<td>4.2%</td>
<td>3.7%</td>
<td>4,116</td>
<td>27.3%</td>
<td>9,388</td>
</tr>
<tr>
<td>Moira East (Yarrawonga)</td>
<td>8,936</td>
<td>11.8%</td>
<td>8.5%</td>
<td>2,159</td>
<td>24.2%</td>
<td>5,143</td>
</tr>
<tr>
<td>Towong</td>
<td>6,204</td>
<td>-3.7%</td>
<td>-0.5%</td>
<td>1,539</td>
<td>24.8%</td>
<td>3,736</td>
</tr>
<tr>
<td>Wangaratta</td>
<td>26,641</td>
<td>0.3%</td>
<td>2.0%</td>
<td>6,888</td>
<td>25.9%</td>
<td>16,405</td>
</tr>
<tr>
<td>Wodonga</td>
<td>34,831</td>
<td>11.3%</td>
<td>10.2%</td>
<td>10,131</td>
<td>29.1%</td>
<td>22,991</td>
</tr>
</tbody>
</table>

### ARIA

Of the 14 Statistical Local Areas (SLAs) in North Eastern AMHS, 8 are categorised as 'Highly Accessible' in the ARIA index of accessibility/remoteness, and 6 as 'Accessible', indicating that the AMHS has areas of some restrictions to accessibility to some goods and services and opportunities for social interaction.

### Regional service providers

**Clinical providers**

- Child & Adolescent, Adult Services, Aged Services
  - Wodonga Regional Health Service
  - Northeast Health Wangaratta
  - Northeast Child and Adolescent Services
  - Beechworth Health Service

**Psychiatric Disability Rehabilitation & Support Services (PDRSS)**

### Day Programs

- Richmond Fellowship Victoria, Upper Hume Community Health Service

### Home Based Outreach Support

- Richmond Fellowship Victoria

### Mutual Support Self Help

- Queen Elizabeth Centre, Familycare

### Planned Respite

- Mental Illness Fellowship Victoria

### Residential Rehabilitation Youth

- Richmond Fellowship Victoria

### Residential Rehabilitation Adult

- Wodonga Regional Health Service, Beechworth Health Service

### Koori PDRS Services

- Mungabareena Aboriginal Cooperative

### Service usage information

<table>
<thead>
<tr>
<th>Service usage</th>
<th>NE Hume AMHS</th>
<th>All rural AMHS</th>
<th>All AMHS statewide</th>
<th>Child &amp; Adolescent</th>
<th>Adult</th>
<th>Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage – population accessing services</td>
<td>1.68</td>
<td>1.56</td>
<td>1.20</td>
<td>1.13</td>
<td>1.79</td>
<td>0.56</td>
</tr>
<tr>
<td>Percentage – all Victorian registered clients</td>
<td>3.59</td>
<td>36.33</td>
<td>100</td>
<td>3.75</td>
<td>3.38</td>
<td>1.38</td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>5.7</td>
<td>2.0</td>
<td>1.7</td>
<td>9.9</td>
<td>6.0</td>
<td>-14.3</td>
</tr>
</tbody>
</table>

### Demand management (adult 2004/05)

- % Self sufficiency: 69.5
- Number of separations: 318
- % Inpatient occupancy: 89.6
- Average length of stay (excluding same day and >35 bed days) in bed days: 9.7
- % Greater than 35 days (bed days): 10.1

### Statewide and specialist beds

- Separations-acute statewide & specialist (including forensic): 29
- Separations-specialist forensic: 258
- Separations-specialist forensic (including forensic): 1448
Northern Mallee Area Mental Health Service
This service area covers the statistical local areas of Mildura and Swan Hill (Robinvale).

### Area population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mildura</td>
<td>51,263</td>
<td>6.7%</td>
<td>5.9%</td>
<td>14,537</td>
<td>28.4%</td>
<td>31,642</td>
<td>61.7%</td>
<td>7,275</td>
<td>14.2%</td>
</tr>
<tr>
<td>Swan Hill (Robinvale)</td>
<td>4,050</td>
<td>2.4%</td>
<td>0.7%</td>
<td>1,216</td>
<td>30.0%</td>
<td>2,598</td>
<td>64.1%</td>
<td>417</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

### ARIA

Of the 3 Statistical Local Areas (SLAs) in Northern Mallee AMHS, one is categorised as 'Accessible' in the ARIA index of accessibility/remoteness, and two as 'Moderately Accessible', indicating that the AMHS has no areas of relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.

### Regional service providers

**Clinical providers**
- **Child & Adolescent, Adult Services, Aged Services**
  - Mildura Base Hospital

**Psychiatric Disability Rehabilitation & Support Services (PDRSS)**
- **Day Programs**
  - Mallee Family Care
- **Home Based Outreach Support**
  - Mallee Family Care, Mildura Aboriginal Corporation
- **Mutual Support Self Help**
  - Mallee Family Care
- **Planned Respite**
  - St Lukes Community Support
- **Residential Rehabilitation**
  - Richmond Fellowship Victoria

### Service usage information

<table>
<thead>
<tr>
<th>Service usage</th>
<th>Comparative analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Northern Mallee AMHS</td>
</tr>
<tr>
<td>Percentage population accessing services</td>
<td>2.35</td>
</tr>
<tr>
<td>Percentage all Victorian registered clients</td>
<td>2.20</td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>Demand management (adult 2004/05)</strong></td>
<td></td>
</tr>
<tr>
<td>% Self sufficiency</td>
<td>79.9</td>
</tr>
<tr>
<td>Number of separations</td>
<td>316</td>
</tr>
<tr>
<td>% Inpatient occupancy</td>
<td>114.5</td>
</tr>
<tr>
<td>Average length of stay (excluding same day and &gt;35 bed days) in bed days</td>
<td>8.2</td>
</tr>
<tr>
<td>% Greater than 35 days (bed days)</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Statewide and specialist beds</strong></td>
<td></td>
</tr>
<tr>
<td>Separations-acute statewide &amp; specialist (including forensic)</td>
<td>7</td>
</tr>
</tbody>
</table>
South Western (Glenelg) Area Mental Health Service

This service area covers the local statistical areas of Corangamite, Glenelg, Moyne, Southern Grampians and Warrengbool.

### Area population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Corangamite</td>
<td>17,327</td>
<td>-2.4%</td>
<td>-1.8%</td>
<td>4,792</td>
<td>27.7%</td>
<td>10,266</td>
<td>59.2%</td>
<td>2,990</td>
<td>17.3%</td>
</tr>
<tr>
<td>Glenelg</td>
<td>20,220</td>
<td>-2.2%</td>
<td>-0.5%</td>
<td>5,521</td>
<td>27.3%</td>
<td>12,333</td>
<td>61.0%</td>
<td>3,134</td>
<td>15.5%</td>
</tr>
<tr>
<td>Moyne</td>
<td>15,851</td>
<td>-0.5%</td>
<td>-0.8%</td>
<td>4,344</td>
<td>27.4%</td>
<td>9,818</td>
<td>61.9%</td>
<td>2,341</td>
<td>14.8%</td>
</tr>
<tr>
<td>Southern Grampians</td>
<td>16,902</td>
<td>-2.4%</td>
<td>-3.0%</td>
<td>4,437</td>
<td>26.3%</td>
<td>10,099</td>
<td>59.8%</td>
<td>3,167</td>
<td>18.7%</td>
</tr>
<tr>
<td>Warmambool</td>
<td>30,708</td>
<td>7.2%</td>
<td>6.7%</td>
<td>8,467</td>
<td>27.6%</td>
<td>19,077</td>
<td>62.1%</td>
<td>4,453</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

### ARIA

All six of the Statistical Local Areas (SLAs) in South Western AMHS are categorised as ‘Highly Accessible’ in the ARIA index of accessibility/remoteness, indicating that the AMHS has relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.

### Regional Service Providers

#### Clinical Providers

Child & Adolescent, Adult Services, Aged Services  
South West Psychiatric Service

### Psychiatric Disability Rehabilitation & Support Services (PDRSS)

- **Day Programs**  
  Aspire
- **Home Based Outreach Support**  
  Aspire, Gunditjmara, Kirrae Health Service, Winda Mara, Dhauwurd Wurrung
- **Mutual Support Self Help**  
  Aspire, DASH, Southwest Advocacy Association
- **Planned Respite**  
  Aspire
- **Residential Rehabilitation**  
  Francis Foundation, Richmond Fellowship Victoria

### Service usage information

#### Comparative Analysis

<table>
<thead>
<tr>
<th>Service usage</th>
<th>South Western AMHS</th>
<th>All rural AMHS</th>
<th>All AMHS statewide</th>
<th>Child &amp; Adolescent</th>
<th>Adult</th>
<th>Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage - population accessing services</td>
<td>2.26</td>
<td>1.56</td>
<td>1.2</td>
<td>1.54</td>
<td>2.79</td>
<td>0.17</td>
</tr>
<tr>
<td>Percentage all Victorian registered clients</td>
<td>3.87</td>
<td>36.33</td>
<td>100</td>
<td>4.18</td>
<td>4.14</td>
<td>0.35</td>
</tr>
<tr>
<td>Percentage annual growth (00/01 to 04/05)</td>
<td>5.3</td>
<td>2.0</td>
<td>1.7</td>
<td>1.9</td>
<td>6.5</td>
<td>-17.6</td>
</tr>
<tr>
<td>Demand Management (adult 2004/05)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Self sufficiency</td>
<td>93.3</td>
<td>86.4</td>
<td>78.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of separations</td>
<td>476</td>
<td>4410</td>
<td>13,329</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Inpatient occupancy</td>
<td>120.1</td>
<td>97.4</td>
<td>97.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average length of stay (excluding same day and &gt;35 bed days) in bed days</td>
<td>7.6</td>
<td>9.1</td>
<td>11.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Greater than 35 days (bed days)</td>
<td>3.8</td>
<td>6.1</td>
<td>9.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statewide and specialist beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separations-acute statewide &amp; specialist (including forensic)</td>
<td>18</td>
<td>258</td>
<td>1,448</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Description of mental health service system components

Victorian Mental Health Service System

Clinical

Child & adolescent services
- Intensive youth support
- Continuing care, clinical
- Acute inpatient services
- Day programs
- Conduct disorder services

Adult services
- Crisis assessment and treatment
- Mobile support and treatment
- Continuing care teams
- Primary mental health & early intervention teams
- Community care units
- Acute inpatient services
- Secure/extended care inpatient services
- Homeless outreach services
- Consultation and liaison services
- Prevention and recovery care
- Youth program – Early psychosis services

Aged persons services
- Aged persons mental health teams
- Acute inpatient services
- Aged persons mental health residential care

State-wide and specialist services
- Victorian Institute of Forensic Mental Health
- Personality disorder service
- Brain disorders service
- Mother-baby services
- Eating disorder services
- Koori services
- Child inpatient unit
- Dual disability service
- Neuropsychiatric service
- Early Psychosis Prevention and Intervention Centre (EPPIC) statewide

Psychiatric disability rehabilitation and support services

Mutual support/self help
- Day activities
- In-home respite
- Holiday/adventure activities
- Residential respite

Planned respite
- Rehab. day program

Non-residential PDRSS
- Home-based outreach

Residential PDRSS

Appendix 2: Description of mental health service system components
Appendix 3: Description of statewide and specialist services 2004–05

Description of mental health service system components

The specialist public mental health system consists of clinical services and psychiatric disability rehabilitation and support services (PDRSS). Clinical mental health services are managed by public hospitals and provide assessment, diagnosis, treatment and clinical case management to people with a serious mental illness. Psychiatric disability rehabilitation and support services are provided by non-government community organisations.

Specialist clinical mental health services in Victoria are provided on an area basis and are often referred to as area mental health services (AMHS). They include adult mental health services, child and adolescent mental health services, and aged persons mental health services. Each of these service categories provides inpatient psychiatric services, in addition to a range of residential and other community-based services.

Adult specialist mental health services (16-64 years)

Target group

Adult specialist mental health services are aimed primarily at people with serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder. Commonly these will be people with a diagnosis of a major mental illness, such as schizophrenia or bipolar disorder, but will also include some people with other conditions such as severe personality disorder, severe anxiety disorder, or those who present in situational crisis that may lead to self-harm or inappropriate behaviour towards others. The distinguishing factor is the level of severity of the disturbance and impairment. Increasingly, adult mental health service consumers have more than one disorder, with drug and alcohol related disorders (dual diagnosis) being most prevalent.

Service components

All specialist mental health services are required to provide a range of components so that consumers have access to similar service responses and functions wherever they live. However, the health services and hospitals deliver their public specialist mental health services differently depending on the local service environment and catchment area. Some services have separate teams for each component function; others operate ‘integrated teams’ which perform a number of functions by rostering staff to undertake the required activities for a given period. The critical factor is that all area mental health services provide the full range of functions.

Specialist services are usually provided on a regional or statewide basis.

Crisis assessment and treatment (CAT) services

These services operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis. CAT services have a key role in deciding the most appropriate treatment option and in screening all potential inpatient admissions. CAT services provide intensive community treatment and support, often in the person’s own home, during the acute phase of illness as an alternative to hospitalisation. CAT services also provide a service to designated hospital emergency departments through an onsite presence.
Mobile support and treatment services (MSTS)
These services provide intensive long-term support to people with prolonged and severe mental illness and associated high-level disability. They utilise an assertive outreach approach and operate extended hours seven days a week. MSTSs differ from continuing care services in the frequency and intensity of intervention offered and work more closely with psychiatric disability rehabilitation and support services.

Continuing care services
These are the largest component of adult community based services. These services provide non-urgent assessments, treatment, case management, support and continuing care services to people with a mental illness in the community. The length of time case management services are provided to a person varies according to clinical need. Continuing care services may be involved with people for extended periods of time or may provide more episodic care. Continuing care clinicians frequently liaise with, and refer to, generalist services including general practitioners for ongoing support and provision of services to people with a mental illness.

Primary mental health and early intervention teams (PMHEI)
These teams support and enhance the capacity of primary care providers, especially general practitioners and community health services, to recognise and respond to mental disorders more effectively. They provide consultation, liaison, education and training services to primary care providers for both low and high prevalence disorders. The teams have a particular focus on disorders such as depression and anxiety, and also provide some short-term direct care treatment and assessment for these high prevalence disorders.

Community care units
Community care units provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide a ‘home like’ environment where people can learn or re-learn everyday skills necessary for successful community living. While it is envisaged that people will move through these units to other community residential options, some consumers require this level of support and supervision for a number of years.

Acute inpatient services
These services provide voluntary and involuntary short-term inpatient management and treatment during an acute phase of mental illness, until the person has recovered enough to be treated effectively and safely in the community. These units are located within acute general hospitals. People admitted to an inpatient unit from the community are usually assessed by a CAT service to see if a less restrictive option is possible.
Secure extended care inpatient services

These services provide medium to long-term inpatient treatment and rehabilitation for consumers who have unremitting and severe symptoms of mental illness, together with associated significant disturbance that inhibits their capacity to live in the community. These services are provided on a regional basis and are gazetted to take involuntary consumers. They are typically located on hospital sites with acute mental health units or other extended care bed based services. They represent the highest level of care on the continuum of mental health services and provide extended clinical treatment, supervision and support.

Homeless outreach services

Homeless outreach psychiatric services (HOPS) provide a specialist clinical and treatment response for people who do not engage readily with mental health services. HOPS work in partnership with homelessness services and use assertive outreach to locate and engage with their clients to create a pathway out of homelessness by providing early and appropriate treatment. HOPS link clients into the mental health service system, including access to long-term housing augmented with outreach support, and improve the coordination and working relationships between mental health and homelessness services. HOPS also provide assessment and secondary consultation to homelessness services and other mental health workers. HOPS are not currently available in all catchment areas.

Consultation and liaison services

Consultation and liaison psychiatry is the diagnosis, treatment and prevention of psychiatric morbidity among physically ill patients who are patients of an acute general hospital. This includes the provision of psychiatric assessment, consultation, liaison and education services to non-psychiatric health professionals and their clients/patients. This service is not currently available in all general hospitals.

Prevention and recovery care services (PARC)

PARC services are a new supported residential service for people experiencing a significant mental health problem but who do not need or no longer require a hospital admission. In the continuum of care, they sit between adult acute psychiatric inpatient units and a client’s usual place of residence. PARC aims to assist in averting acute inpatient admissions and facilitate earlier discharge from inpatient units. They are not a substitute for an inpatient admission, rather they provide clinical treatment and short-term residential support. PARC services are usually a partnership between PDRSS and clinical services. PARCs are not currently available in all catchment areas.

Youth program – Early psychosis services

Early psychosis services focus on providing a service to young people between 16-25 who are experiencing a first episode of psychosis. They aim to provide for earlier and more intensive treatment as well as minimising disability associated with psychosis, including the impact of distress/trauma on both the young person and their family. These services are sub-specialty programs within the specialist clinical adult area mental health service, with close links to child and adolescent mental health services, primary care services and other community services and organisations. Early psychosis services are not currently available in all catchment areas.
Child and adolescent mental health services (0-18 years)

Target population
Specialist child and adolescent mental health services are provided for children and adolescents up to the age of 18 years with serious emotional disturbance. This includes young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth or development and/or where there are substantial difficulties in the person's social or family environment. Emotional disturbance in childhood and adolescence may present in a variety of ways. While symptoms may include impaired reality testing, hallucinations, depression and suicidal behaviour, emotional disturbance in childhood presents more often in other ways. Hyperactivity, nightmares, fearfulness, bed-wetting, language problems, refusal to attend school, and stealing are among the behaviours that may indicate distress or disturbance. Young people from 6 to 18 years of age may receive a service from either child and adolescent mental health services or adult area mental health services depending on their needs.

Service components

Intensive mobile youth outreach services (IMYOS)
IMYOS provide intensive outreach mental health case management and support to adolescents who display substantial and prolonged psychological disturbance, and have complex needs that may include challenging, at risk and suicidal behaviours. These services work with young people who have been difficult to engage using less intensive treatment approaches.

Continuing care, clinical
These teams provide a range of services starting with initial intake to provide advice, information and screening. They undertake assessment and treatment of children and adolescents experiencing significant psychological distress and/or mental illness and their families. Services include crisis assessment, case management, multi-modal treatments, individual, family and group therapy and parent or carer support. They also provide consultancy services to other community agencies and service providers. Child and adolescent mental health services work extensively with other service sectors including schools, general practitioners, paediatricians, youth and family services, child protection and welfare agencies.

Acute inpatient services
These services provide short-term assessment and/or inpatient treatment for children and adolescents who have a severe emotional disturbance that cannot be assessed satisfactorily or treated safely and effectively within the community. They are usually located with general hospitals. Links with metropolitan inpatient services exist for the admission of consumers from rural services.

Day programs
Child and adolescent mental health services’ adolescent day programs offer an integrated therapeutic and educational program for young people with behavioural difficulties; emotional problems such as severe depression and/or anxiety; emerging personality difficulties or a severe mental illness such as early psychosis. Issues such as relationship and/or social difficulties and non-attendance of an educational or vocational setting are addressed through intensive group therapy. These programs are not currently available in all catchment areas.
Conduct disorder programs

Conduct disorder is the most severe type of disruptive behaviour in children and young people, with such behaviours as extreme aggression, truancy, lying, stealing, lack of empathy and running away. Programs offering multilevel early intervention and prevention designed to reduce the prevalence and impact of conduct disorder are currently being piloted in Victoria and are not currently available in all catchment areas.

Aged persons mental health services (65 years+)

Target group

Aged persons mental health services are primarily for people with a long-standing mental illness who are now over 65 years of age, or who have developed functional illnesses such as depression and psychosis in later life. They also provide services for people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

Service components

Aged persons mental health teams

These services provide community-based assessment, treatment, rehabilitation and case management for older people. The service is delivered through multidisciplinary teams. They provide specialist expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions. The teams also provide education for consumers and carers as well as consultation to other service providers.

Acute inpatient services

These services provide short-term inpatient management and treatment during an acute phase of mental illness until sufficient recovery allows the person to be treated effectively in the community. These services are located with other aged care facilities and/or general hospitals. In some rural services, aged acute inpatient beds are co-located with an adult inpatient unit.

Aged persons mental health residential (APMH) care

These services provide a range of specialist bed-based services to consumers who cannot be managed in mainstream aged care residential services due to their level of persistent cognitive, emotional or behavioural disturbance. APMH nursing homes and hostels specialise in caring for older persons with a mental illness and provide longer-term accommodation, ongoing assessment, treatment and rehabilitation. They are designed to have a familiar, homelike atmosphere and residents are encouraged to participate in a range of quality of life activities. Consumers may remain in these units for lengthy periods but opportunities are sought where possible to achieve discharge to a less restrictive environment such as a generic nursing home.
Non-clinical specialist mental health services

Psychiatric disability rehabilitation and support services (PDRSS)
The non-government psychiatric disability rehabilitation and support services sector is a core component of specialist mental health services complementing clinical mental health services. PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person’s daily activities and the social disadvantage resulting from illness.
They work within a recovery and empowerment model to maximise people’s opportunities to live successfully in the community.

Target group
Psychiatric disability support services are aimed at people with serious mental illness and associated significant psychiatric disability. Services cater primarily for people aged between 16 and 64 years. The precise eligibility criteria will depend on the type of service or program being offered. Consumers receiving case management services from the public mental health service who are referred by the service are automatically eligible for support from the PDRSS.

Service components

Psychosocial rehabilitation day programs and home based outreach
Rehabilitation day programs assist people with severe psychiatric disabilities to improve their quality of life, participate in everyday living activities, and function as independently as possible in the community. This may involve the development of social and living skills in a group context, through centre-based and community access programs. Home based outreach services provide support to consumers living in their own homes, or other community residential settings. Training in social and living skills is provided in the resident’s home, with a focus on the activities and interactions of everyday life.

Residential rehabilitation
Residential rehabilitation services provide intensive psychosocial rehabilitation and support in group accommodation preparatory to residents living independently in their own setting. Emphasis is on developing or regaining skills to enable each resident to deal with daily living activities, developing confidence to commence or continue schooling, training or employment, as well as supporting positive contact with their family and friends.

Planned respite
These services provide a short-term change in environment for a consumer and a break for carers, and include both formal and informal psychosocial rehabilitation components. Planned respite services may involve social and recreational day activities, including in-home support, holiday and adventure activities, and residential components.

Mutual support and self help
These services provide information and peer support to people with a mental illness and/or their carers. This can involve the sharing of experiences and coping strategies, the provision of information and referral services, and the promotion of community awareness.
Statewide and specialist services

In addition to the local area services, a number of specialist services are delivered on a statewide basis. These services offer an additional level of expertise or service response for people with particular clinical conditions or high level needs. It is important for the area services to be aware of what the specialist services offer, as some consumers will benefit from their input.

Statewide services include:

**Victorian Institute of Forensic Mental Health (Forensicare)**

Forensicare provides a range of services to mentally disordered offenders. These include secure hospital inpatient services at Thomas Embling Hospital and community based services. Forensicare also provides specialist assessment and treatment for mentally ill prisoners, and an on site assessment and advice court liaison service to some Magistrates’ Courts to assist in the identification and management of people in these settings.

**Personality disorder service (Spectrum)**

Spectrum provides consultation, training, treatment and research in relation to people with severe and borderline personality disorder who are at risk of serious self-harm or suicide. Spectrum works closely with area mental health services and clinicians to support their work and develop their skills in providing a more effective response.

**Brain disorders service**

The brain disorders program provides services to adults with acquired brain injury or neurodegenerative conditions with associated psychiatric disorder. The program has a range of inpatient, residential and community oriented programs, including outreach services and secondary consultation.

**Mother-baby services**

Specialist mother and baby services provide for the admission of mothers with a mental illness with their baby, in addition to associated community and multidisciplinary services. Services are available at Austin Health, Southern Health and Mercy Health.

**Eating disorder services**

Specialist inpatient and community based services for people with eating disorders are available at Austin Health, Southern Health and Melbourne Health.

**Koori services**

A number of services to support Kooris are provided throughout Victoria. These include Koori Mental Health Liaison Workers in rural Victoria to assist rural clinical mental health services provide culturally appropriate services, assist with policy development and liaison and provide practical support to Aboriginal people attending these services. In addition, the Victorian Aboriginal Health Service (VAHS) provides a number of mental health and counselling services for the Indigenous community in Victoria.
Child inpatient unit

The statewide child inpatient unit is a 12-bed service located on campus at the Austin and Repatriation Medical Centre in Heidelberg providing admission for children up to 12 years of age and, where appropriate, their families. The unit also provides consultation to, and assessment of, referrals from child and adolescent mental health services across the state.

Dual disability service

The Victorian Dual Disability Service, auspiced by St Vincent’s Hospital, provides consultation and education and training to specialist clinical mental health services in relation to people with both intellectual disability and mental illness.

Neuropsychiatric service

This is a statewide specialist service located at the Royal Melbourne Hospital. It is a specialist eight-bed inpatient service that offers assessment, short-term admission and treatment in relation to neuropsychiatric disorders.

Early Psychosis Prevention and Intervention Centre, Statewide (EPPIC Statewide)

The statewide component of EPPIC supports other specialist mental health services across the state to achieve best practice in first onset psychosis through consultation, education and training and the provision of key resources. (EPPIC Statewide is part of Orygen Youth Health, an early psychosis program operating in the western and north western suburbs of Melbourne).
Appendix 4:
Rural area mental health services compared with statewide averages

<table>
<thead>
<tr>
<th>Service usage</th>
<th>South Western</th>
<th>Northern Mallee</th>
<th>North east Hume</th>
<th>Loddon</th>
<th>Grampians</th>
<th>Goulburn Valley</th>
<th>Barwon</th>
<th>Gippsland</th>
<th>Rural</th>
<th>Metropolitan</th>
<th>All AMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of population accessing services</td>
<td>2.26</td>
<td>2.35</td>
<td>1.68</td>
<td>1.71</td>
<td>1.22</td>
<td>1.67</td>
<td>1.26</td>
<td>1.44</td>
<td>1.60</td>
<td>1.04</td>
<td>1.20</td>
</tr>
<tr>
<td>Proportion of all Victorian registered clients</td>
<td>3.87</td>
<td>2.20</td>
<td>3.59</td>
<td>7.15</td>
<td>4.41</td>
<td>3.78</td>
<td>5.33</td>
<td>6.00</td>
<td>36.33</td>
<td>63.67</td>
<td>100</td>
</tr>
<tr>
<td>Average annual growth (00/01 to 04/05)</td>
<td>5.3</td>
<td>6.2</td>
<td>5.7</td>
<td>4.2</td>
<td>1.7</td>
<td>-0.8</td>
<td>-0.7</td>
<td>-0.4</td>
<td>2.0</td>
<td>1.6</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Demand Management (adult 2004/05)

| % self sufficiency                                | 93.3          | 79.9            | 69.5            | 88.1   | 88.5       | 84.4            | 87.1   | 88.9      | 86.4  | 74.4        | 78.5     |
| Number of separations                             | 476           | 316             | 318             | 598    | 707        | 460             | 853    | 682       | 4,410 | 8,879       | 13,289   |
| % inpatient occupancy                             | 120.1         | 114.5           | 89.6            | 103.4  | 87.4       | 98.6            | 92.0   | 93.5      | 97.4  | 97.5        | 97.5     |
| Average length of stay (excluding sameday and >35 bed days) | 7.6           | 8.2             | 9.7             | 11.8   | 9.2        | 9.1             | 7.6    | 10.2      | 9.1   | 11.8        | 11.0     |
| % greater than 35 days (bed days)                 | 3.8           | 4.4             | 10.1            | 10.2   | 5.2        | 6.1             | 2.7    | 8.4       | 6.1   | 10.7        | 9.2      |

Statewide and specialist beds

<table>
<thead>
<tr>
<th>Separations-acute statewide &amp; specialist (including forensic)</th>
<th>18</th>
<th>7</th>
<th>29</th>
<th>42</th>
<th>36</th>
<th>42</th>
<th>52</th>
<th>32</th>
<th>258</th>
<th>1,182</th>
<th>1,448</th>
</tr>
</thead>
</table>
Appendix 5: Road travel times for rural ambulatory services (sMaps)

Travel times to a rural Crisis Assessment and Treatment Team
Travel times to a rural Continuing Care Service

[Map showing travel times to rural Continuing Care Services with various regions shaded to indicate service access]

- CCS service
- Rural mental health catchments
- Areas within two hours of a service
- Areas more than two hours from a service
- Metropolitan areas
Travel times to a rural Mobile Support and Treatment Services